NON-INVASIVE VENTILATION - BIPAP and CPAP PRESCRIPTION for Acute Respiratory Failure

South Tees Hospitals NHS
NHS Foundation Trust

WRITE OR ATTACH ADDRESSOGRAPH

Surname_____

Forenames_____

DOB dd / mm / yyyy Age_____

Hospital number_____

NHS number_____

Date_____ Time_____

Unit/Ward_____

Speciality_____

Consultant_____

Prescriber_____ Grade_____

Requested by (name/grade) _____

☐ Senior doctor aware - NAME _____

☐ Nurse in charge aware - NAME _____

Please complete the following at the time of initiating NIV

Current diagnosis

☐ AECOPD ☐ Pneumonia ☐ Pulmonary Oedema ☐ Post-op respiratory failure

☐ Viral pneumonitis_____ ☐ Other _____

Type of Respiratory Failure

☐ Type 1 ☐ Type 2

ABG or CBG prior BIPAP/CPAP therapy

DATE/TIME_____ FiO_2_____ SaO_2_____

pH_____ pO_2_____ pCO_2_____ BE_____ HCO_3^-_____

NEWS2 prior BIPAP/CPAP therapy_____

RR_____ SpO_2_____on FiO_2_____ BP_____/_____ HR_____

Temp_____ GCS_____ /15_ Acute confusion/Agitation Yes/No

Treatment already received

☐ Oxygen_____ L/Min or %

☐ Bronchodilators

☐ Steroids

☐ Chest Physiotherapy

☐ Other_____

☐ Analgesia

☐ Antibiotics

☐ Nitrates

☐ Furosemide

Are there any contraindications to non-invasive therapy?

(Please refer to NIV guidelines)

☐ NO ☐ YES _____

If YES, DO NOT initiate NIV/CPAP unless discussed with senior doctor in critical care, acute or respiratory medicine

Complete a STEP form in all cases

Discuss escalation treatment prior to commencement or within 1 hour of starting non-invasive respiratory support.

☐ STEP form completed Date / Time _____

Name _____

Grade _____ Reg no _____

Patient Name _____ DOB_____ Hosp no_____

INTERFACE, VENTILATOR TYPE AND VENTILATION MODE

INTERFACE *Specify type, size, model*	☐ Face mask_____ ☐ Full face mask_____ ☐ Nasal mask_____ ☐ Other_____
VENTILATOR	☐ TRILOGY ☐ FOCUS ☐ CARINA ☐ OTHER _____ ☐ PATIENTS OWN *(make/model)* _____
VENTILATION MODE	☐ S/T (spontaneous/timed) ☐ BIPAP ☐ Other _____ ☐ CPAP ☐ PC _____

TARGET SpO_2 _____ TARGET pO_2 _____ TARGET pCO_2 _____ (arterial/capillary BG)

INITIAL SETTINGS

Mode	Oxygen (% or L/min)	IPAP (Inspiratory pressure)	EPAP/PEEP (Expiratory pressure)	CPAP	Respiratory Rate (RR)	Ti (Inspiratory time)	Other settings

Set by (Name / Reg. no) _____ Date/Time_____

CHANGE OF SETTINGS

Date / Time	Changed by (Name/Reg no)	Reason for change	Mode	IPAP	EPAP	CPAP	RR	Other

COMMENTS LOG *(include change of interface / incidents /troubleshooting)* Please Date and Sign