EAST CHESHIRE NHS TRUST

OXYGEN POLICY

(Adult)
Policy Title: OXYGEN POLICY

Executive Summary: THIS POLICY SETS OUT THE GUIDELINES FOR PRESCRIBING, ADMINISTRATION AND MONITORING OF OXYGEN THERAPY IN THE ACUTE SETTING

Supersedes: Version 1.0

Description of Amendment(s):

This policy will impact on:

All Medical and Non-Medical prescribers, and all nursing staff involved in administration and monitoring of patients on oxygen therapy in the acute setting

Financial Implications:

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<th>Policy Area:</th>
<th>All acute clinical areas</th>
<th>Document Reference:</th>
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<tbody>
<tr>
<td>Version Number:</td>
<td>2.0</td>
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<td>Issued By:</td>
<td>Respiratory Consultants</td>
<td>Review Date:</td>
</tr>
<tr>
<td>Author:</td>
<td>Jackie Bayliss Advanced Respiratory Specialist Practitioner (Integrated Respiratory Team)</td>
<td>Impact Assessment Date:</td>
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APPROVAL RECORD

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<th>Committees / Groups</th>
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<td>Consultation / Approval:</td>
<td>Sept 2016</td>
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<td>Respiratory Consultants</td>
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<td>Ward 4 Staff, Medical Nurse Practitioners, Medical Staff, Modern Matrons, Ward Managers, Respiratory Nurse Specialists</td>
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Fraud Screen: Is this required? Yes | No |

Received for information: OCF/Trust Board/Team Brief | Sept 2016 |
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1.0 Introduction

Oxygen is probably the commonest drug to be used in the care of patients who present with medical emergencies. Currently, ambulance teams and emergency department teams are likely to give oxygen to virtually all breathless patients and to a large number of patients with other conditions such as ischaemic heart disease, sepsis or trauma.

The North West Ambulance Service serves a population of about 7.25 million people and transports about 700 000 people to hospital emergency departments each year. About 34% of these journeys involve oxygen use at some stage. This translates to about two million instances of emergency oxygen use per annum by all UK ambulance services, with further use in patients’ homes, GP surgeries and in hospitals (Hale et al 2008)

At present, oxygen is administered for three main indications of which only one is evidence-based. First, oxygen is given to correct hypoxaemia as there is good evidence that severe hypoxaemia is harmful. Second, oxygen is administered to ill patients in case they might become hypoxaemic. Recent evidence suggests that this practice may actually place patients at increased risk if severe hypoxaemia does actually develop.

Third, a very high proportion of medical oxygen is administered because most clinicians believe that oxygen can alleviate breathlessness. However, there is no evidence that oxygen relieves breathlessness in non-hypoxaemic patients and there is evidence of lack of effectiveness in non-hypoxaemic breathless patients with chronic obstructive pulmonary disease (COPD) and advanced cancer.

Most clinicians who deal with medical emergencies will encounter adverse incidents and occasional deaths due to underuse and overuse of oxygen. Audits of oxygen use and oxygen prescription have shown consistently poor performance in many countries. One major problem is that healthcare professionals receive conflicting advice about oxygen use from different “experts” during their training and during their clinical careers, and many are confused about the entire area of oxygen prescription and use (Dodd et al 2000).

The British Thoracic Society (BTS) introduced guidelines on the use of emergency oxygen in adults in 2008. Those guidelines have been embraced and incorporated within local practise within the Acute Trust. This policy aims to consolidate the guidelines and provide a more robust evidence-based framework for all health care professionals who prescribe, administer or monitor patients on oxygen therapy within the acute setting.
2.0 Philosophy of the BTS Guidelines

Oxygen is a treatment for hypoxaemia, not breathlessness.

Oxygen has not been shown to have any effect on the sensation of breathlessness in non-hypoxaemic patients. The essence of the guideline can be summarised simply as a requirement for oxygen to be prescribed according to a target saturation range and for those who administer oxygen therapy to monitor the patient and keep within the target saturation range. The guideline suggests aiming to achieve normal or near-normal oxygen saturation for all acutely ill patients apart from those at risk of hypercapnic respiratory failure or those receiving terminal palliative care.

3.0 Assessing the patient

For critically ill patients, high concentration oxygen should be administered immediately and this should be recorded afterwards in the patient’s health record. Oxygen saturation, “the fifth vital sign”, should be checked by pulse oximetry in all breathless and acutely ill patients (supplemented by blood gases when necessary) and the inspired oxygen concentration should be recorded on the observation chart with the oximetry result. (The other vital signs are pulse, blood pressure, temperature and respiratory rate).

Fully trained clinicians should assess all acutely ill patients by measuring pulse, blood pressure, respiratory rate and assessing circulating blood volume and anaemia. Expert assistance from specialists in intensive care or from other disciplines should be sought at an early stage if patients are thought to have major life-threatening illnesses and clinicians should be prepared to call for assistance when necessary, including a call for a 999 ambulance in pre-hospital care or a call for the resuscitation team or ICU outreach team in hospital care.

Initial clinical assessment and subsequent monitoring of acutely unwell patients should include the use of a recognised physiological “track and trigger” system, such as the Modified Early Warning Scoring System (MEWS), and a change in this score should require medical review even if there is no change in oxygen saturation.

Oxygen saturation, “the fifth vital sign”, should be checked by trained staff using pulse oximetry in all breathless and acutely ill patients (supplemented by blood gases when necessary) and the inspired oxygen concentration should be recorded on the observation chart with the oximetry result.

Pulse oximetry must be available in all locations where emergency oxygen is used.

All critically ill patients should be assessed and monitored using a recognised physiological track and trigger system.
**4.0 Prescribing oxygen**

Oxygen should be prescribed to achieve a target saturation of 94–98% for most acutely ill patients or 88–92% for those at risk of hypercapnic respiratory failure (See Appendix for Flow Diagram)

This guideline recommends aiming to achieve normal or near-normal oxygen saturation for all acutely ill patients apart from those at risk of hypercapnic respiratory failure. The recommended target saturation range for acutely ill patients not at risk of hypercapnic respiratory failure is 94–98%. Some normal subjects, especially people aged 70 years and over, may have oxygen saturation measurements below 94% and do not require oxygen therapy when clinically stable.

Most non-hypoxaemic breathless patients do not benefit from oxygen therapy, but a sudden reduction of more than 3% in a patient’s oxygen saturation within the target saturation range should prompt fuller assessment of the patient (and the oximeter signal) because this may be the first evidence of an acute illness.

For most patients with known Chronic Obstructive Pulmonary Disease (COPD) or other known risk factors for hypercapnic respiratory failure (e.g. morbid obesity, chest wall deformities or neuromuscular disorders), a target saturation range of 88–92% is suggested pending the availability of blood gas results.

The target saturation should be written or circled on the drug chart.

In the past, oxygen was often not prescribed at all or prescribed on a standard hospital drug chart as “oxygen”. It was unusual for the prescription to include full details of what device to use, what flow rate(s) to administer and whether the prescription was for a fixed dose of oxygen or to aim at a specific oxygen saturation target.

It has been shown that a purpose-designed oxygen prescription sheet can improve oxygen prescribing in the short term, but experience has shown that free-standing oxygen prescription charts are often forgotten and unused.

**5.0 Administration of oxygen**

Oxygen should be administered by staffs that are trained in oxygen administration.

Safe prescribing and safe administration of oxygen are closely linked. In emergencies oxygen therapy should be started immediately and prescribed as soon as possible. In all other situations oxygen should be prescribed in accordance with BTS guidelines before administration is
commenced. The healthcare professional who administers the oxygen therapy (usually a nurse or physiotherapist) should be fully trained and should follow local or national protocols. These staff should use appropriate devices and flow rates in order to achieve the target saturation range.

5.1 Devices

High concentration reservoir mask (non-rebreathing mask)

This type of mask delivers oxygen at concentrations between 60% and 85% when used at a flow rate of 10–15 l/min. The concentration is not accurate and will depend on the flow of oxygen and the patient’s breathing pattern. These masks are most suitable for trauma and emergency use where carbon dioxide retention is unlikely.

Venturi System

A Venturi mask will give an accurate concentration of oxygen to the patient regardless of oxygen flow rate (the minimum suggested flow rate is written on each Venturi device and the available options are shown in Appendix 2). The oxygen concentration remains constant because of the Venturi principle.

The gas flow into the mask is diluted with air which is entrained via the cage on the Venturi adaptor. The amount of air sucked into the cage is related to the flow of oxygen into the Venturi system. The higher the flow the more air is sucked in.

The proportions remain the same and therefore the Venturi mask delivers the same concentration of oxygen as the flow rate is increased. Venturi masks are available in the following concentrations: 24%, 28%, 35%, 40% and 60%. They are suitable for all patients needing a known concentration of oxygen, but 24% and 28% Venturi masks are particularly suited to those at risk of carbon dioxide retention (e.g. patients with COPD). A further benefit of Venturi masks is that the flow rate of gas from the mask will usually exceed the inspiratory flow rate of the patient.

Nasal Cannulae

Nasal cannulae can be used to deliver low- and medium-dose oxygen concentrations. However, there is wide variation in patients' breathing patterns so the same flow rate of nasal oxygen may have widely different effects on the blood oxygen and carbon dioxide levels of different patients. Nasal cannulae at 1–4 l/min can have effects on oxygen saturation approximately equivalent to
those seen with 24–40% oxygen from Venturi masks. The oxygen dose continues to rise up to flows above 6 l/min, but some patients may experience discomfort and nasal dryness at flows above 4 l/min, especially if maintained for several hours.

**Medium concentration masks**

Medium concentration masks and nasal cannulae are usually sufficient for post-operative care (target saturation 94–98%) except for patients with known significant COPD who should receive oxygen from a 24% or 28% Venturi mask or 1–2 l/min from nasal cannulae aiming at a saturation range of 88–92%.

**Delivering oxygen to patients who require nebulised bronchodilator therapy**

**Nebulised bronchodilator therapy in asthma;**
In patients with acute severe asthma oxygen should be used as the driving gas for the nebulised bronchodilators whenever possible at a gas flow rate of 6–8 l/min because these patients are at risk of hypoxaemia.

**Nebulised bronchodilator therapy for patients with COPD and other risk factors for hypercapnic respiratory failure;**
When an oxygen-driven nebuliser is given to patients with COPD there is a risk of hypercapnia and acidosis due to the high FiO2 which is delivered. In acute exacerbations of COPD the carbon dioxide level can rise substantially within 15 min of commencing high-dose oxygen therapy. When nebulised bronchodilators are given to hypercapnic patients, they should ideally be given using an electrical compressor and, if necessary, supplementary oxygen should be given concurrently by using nasal cannulae at 1–4 l/min to maintain an oxygen saturation of 88–92%.

For oxygen administration via Non Invasive Ventilation (NIV) or Invasive Positive Pressure Ventilation (IPPV) see separate policies.

**5.2 Use of humidification**

Humidification is not required for the delivery of low-flow oxygen or for the short-term use of high-flow oxygen. It is not therefore required in pre-hospital care. Pending the results of clinical trials, it is reasonable to use humidified oxygen for patients who require high-flow oxygen systems for more than 24 hours or who report upper airway discomfort due to dryness.
In the emergency situation, humidified oxygen use can be confined to patients with tracheostomy or an artificial airway although these patients can be managed without humidification for short periods of time (e.g., ambulance journeys).

Humidification may also be of benefit to patients with viscous secretions causing difficulty with expectoration. This benefit can be achieved using nebulised normal saline.

6.0 Monitoring of the patient

Oxygen saturation and delivery system should be recorded on the patient’s monitoring chart alongside the oximetry result. Oxygen delivery devices and flow rates should be adjusted to keep the oxygen saturation in the target range. Oxygen should be signed for on the drug chart following every medication round. Pulse oximetry should be available to all healthcare staff managing patients receiving oxygen therapy and they should be trained in their use. Clinicians should be aware that pulse oximetry gives no information about the PCO2 or pH and most pulse oximeters are unreliable when a patient’s SpO2 falls below about 85%. Pulse oximetry is dependent on pulsatile flow, and it may not be possible to achieve a satisfactory oximeter reading in patients with cold hands, especially those with severe Raynaud’s phenomenon due to collagen vascular diseases (which may also cause hypoxic lung disease). The readings may also be affected by shock, skin pigmentation, nail varnish, etc.

It is essential to record the oxygen delivery system alongside the oximetry result. All measurements of oxygen saturation should be recorded in the observation chart along with the code for the oxygen delivery system that is being used. If the patient is breathing air at the time of the observation, this should also be recorded in the chart.

7.0 Weaning and discontinuation of oxygen

Oxygen should be reduced in stable patients with satisfactory oxygen saturation.

In most acute illnesses, oxygen therapy will be reduced gradually as the patient recovers and oxygen therapy can be discontinued once the patient can maintain a saturation of 94–98% while breathing air (or the patient’s baseline oxygen saturation level if known). However, some patients may be continued on oxygen therapy to palliate breathlessness, often on a PRN basis (as required, not continuous). Some patients may have episodic hypoxaemia during recovery from acute illness (e.g. patients with COPD with intermittent mucus plugging) and some convalescent patients may be comfortable at rest with normal oxygen saturation but may desaturate and become breathless when they start to mobilise. There is no evidence that oxygen, either before or after
exercise, is of benefit to non-hypoxaemic patients either by relieving breathlessness or by shortening length of stay in hospital. Some patients with chronic lung diseases will already be established on long-term oxygen therapy and should be tapered slowly to their usual maintenance dose of oxygen. A small number of patients who have suffered major respiratory or cardiac injury may require a prescription for home oxygen to permit safe discharge from hospital. However, many patients with COPD exacerbations may have a low PaO2 on discharge from hospital but a reasonable PaO2 at a subsequent clinic visit, so decisions about long-term oxygen should not be made on the basis of blood gas measurements made during acute exacerbations of COPD. Oxygen should be crossed off the drug chart once oxygen is discontinued.

8.0 REFERENCES


9.0 APPENDIX

See Page 11
Clinical Indication for O2 therapy i.e. Critically ill patient or Respiratory Insufficiency?

- Administer High Flow Oxygen via Non rebreath Mask
- Aim for SpO2 94-98%
- If known COPD give 24-28% via Venturi Mask
- Aim for SpO2 88-92%
- Monitor Respiratory Rate
- Do ABGs within 1 hour

YES

Is this patient at risk of hypercapnic respiratory failure?
E.g. COPD, Obesity, Cystic Fibrosis, Neuromuscular Disease, Chest wall or spinal disease,

NO

Aim for SpO2 94-98%

Give O2

Aim for SpO2 94-98%

Monitor Respiratory Rate

YES

Aim for SpO2 88-92%

or as directed on Alert card

Titrated FiO2

- e.g. 24 or 28% via Venturi mask for SpO2 88-92%
- Do ABGs

NO

- pH < 7.35 and pCO2 > 6.0 kPa? (Respiratory Acidosis)
  - Seek immediate senior review.
  - Consider BiPAP or Invasive Ventilation as appropriate.
  - Treat with lowest FiO2 to keep SpO2 between 88-92%.

- pH > 7.35 and pCO2 >6KPa? (Hypercapnia)
  - Treat with lowest FiO2 via Venturi Mask to keep SpO2 88-92%.
  - Repeat ABGs after 1 hour
  - If Respiratory Acidosis, seek immediate senior review.
  - Consider BiPAP / ICU as appropriate

- pCO2>6.0Kpa
  - Or signs of clinical deterioration?
    - Seek senior review.
    - Consider Invasive Ventilation.
      - Aim for SpO2 94-98%. Consider undiagnosed chronic hypercapnic respiratory failure

- SpO2 < 90%?
  - Check ABGs
  - If pO2 < 8 Kpa
    - Administer High flow oxygen via Non-Rebreath Mask
    - Seek immediate senior review.
  - Consider CPAP or Invasive Ventilation.
    - Aim keep SpO2 94 - 98%.
Equality Analysis (Impact assessment)

Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.

Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

Oxygen Policy (Adult)

Details of person responsible for completing the assessment:

- Name: Jackie Bayliss
- Position: Advanced Respiratory Specialist Practitioner
- Team/service: Integrated Respiratory Service

State main purpose or aim of the policy, procedure, proposal, strategy or service:

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

The aim of the policy is to act as guidance for the management of patients requiring oxygen therapy in the acute and pre-hospital setting.


2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).
Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- Jewish: 0.16% of Cheshire East and 0.2% of Cheshire West & Chester
- Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- None: 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester
Carers: In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

No

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

No

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes □

Explain your response:
If the patients’ first language is not English, then full explanation of the delivery of oxygen therapy can be given and consent gained via telephone interpretation. All staff should be aware of the trust’s interpretation and translation policy.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? No □

Explain your response:
No differential impact identified regarding gender

DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes □

Explain your response: Following an initial equality impact assessment the Learning Disabilities group of patients may need to be excluded from the proposal, depending on the level of severity, due to the potential complexity of their needs and ability to comply with the treatment.

Full explanations would need to be given before and during oxygen therapy administration, as the patient may not be able to see what is happening. If the patient is Deaf, then a British Sign language interpreter may be used, or the new Sign translate on line BSL interpretation system, when this is rolled out across all areas. For a hearing impaired person. Staff can use a portable induction loop if the patient wears a hearing aid or a hand held communicator if not (these can be
located in ward communications boxes). There are picture communication books in the boxes to assist people with limited understanding.

**AGE:**
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently? No  □

**Explain your response:**
Oxygen therapy would be administered regardless of age groups for any adult patient.

**LESBIAN, GAY, BISEXUAL:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? No  □

**Explain your response:**
Oxygen therapy would be delivered as per clinical need regardless of sexual orientation. The Staff have access to equality and diversity training as part of stat/mandatory programme.

**RELIGION/BELIEF:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes  □

**Explain your response:**
For Muslim women wearing a burkha, they should be attended to by females only, where possible, as it would offend their religious beliefs if seen uncovered by a male. If the patient is conscious, then staff should ask the patient their preference. In an acute emergency, safety of the patient is paramount.

**CARERS:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently? No  □

**Explain your response:**
If a carer / relative is in attendance, they would also be given a full explanation as to the rationale for oxygen delivery.

**OTHER:** EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? No  □

**Explain your response:**
The treatment delivered regardless of other status. The Staff have access to equality and diversity training as part of stat/mandatory programme.

### 4. Safeguarding Assessment - CHILDREN

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<tr>
<td><strong>a.</strong> Is there a direct or indirect impact upon children?</td>
<td>No  □</td>
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<td><strong>b.</strong> If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:</td>
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<td><strong>c.</strong> If no please describe why there is considered to be no impact / significant impact on children</td>
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adult policy only

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

Respiratory Consultants, Integrated Respiratory Team, Medical Nurse Practitioners, Critical Care Outreach Practitioners, Peri-operative Practitioners, Night Nursing Sisters and Respiratory / MAU Ward Staff

6. Date completed: Sept 2016           Review Date: Sept 2018

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

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<th>Lead</th>
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8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:

Date: 11.10.16