## NCEPOD self-assessment checklist

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| **#** | **Recommendations** | **Is it met? Y/N/Partially/Planned** | **Comments (Examples of good practice or deficiencies identified)** | **Action required** | **Timescale** | **Person responsible** |
| The overarching purpose of these recommendations is to improve the quality of care provided to patients receiving acute non-invasive ventilation (NIV). Issues in relation to the timeliness, appropriateness, location, level of care and competency of staff treating patients with acute NIV have been highlighted.Those who should be primarily responsible for leading on the recommendations are listed in parentheses after each recommendation. These are NCEPOD’s suggestions and can be extended to others as appropriate. |
| **1** | All hospitals should have a clinical lead for their acute non-invasive ventilation (NIV) service. The clinical lead should have time allocated in their job plan with clear objectives, including audit and governance for this service. *(Medical Directors and Nursing Directors)* |  |  |  |  |  |
| **2** | Continuous positive airways pressure (CPAP) and non invasive ventilation (NIV) should be coded separately. They are two distinct treatments given for different conditions and separate coding will reduce clinical confusion and improve reporting of outcomes.*(NHS Digital and the Association of Clinical Coders)* |   |   |   |   |   |
| **3** | Acute non-invasive ventilation treatment should only be provided in clinical areas equipped with: a. Continuous pulse oximetry; b. Continuous ECG monitoring; and c. Rapid access to the results of blood gas analysis. *(Medical Directors and Nursing Directors)* |   |   |   |   |   |
| **4** | In line with current British Thoracic Society guidelines, patients with known chronic obstructive pulmonary disease, or other known risk factors for hypercapnic respiratory failure, should have an oxygen saturation of 88-92% maintained, both prior to admission and on admission to hospital. The device used for oxygen delivery, the concentration of oxygen administered and the target saturation should be documented in the relevant patient record. *(Ambulance Trusts and Emergency Medicine Physicians)* |   |   |   |   |   |
| **5** | Treatment with acute non-invasive ventilation (NIV) must be started within a maximum of one hour of the blood gas measurement that identified the need for it, regardless of the patient’s location. A service model whereby the NIV machine is taken to the patient to start treatment prior to transfer for ongoing ventilation will improve access to acute NIV. *(All Clinical Staff Providing Acute Non-Invasive Ventilation and Acute Non-Invasive Ventilation Service Leads)* |   |   |   |   |   |
| **6** | In all areas providing acute non-invasive ventilation (NIV), a minimum staffing ratio of one nurse to two acute NIV patients must be in place, as recommended in the British Thoracic Society guideline. The duration for which this should continue will be determined by each individual patient’s response to ventilation. *(Nursing Directors and Medical Directors)* |   |   |   |   |   |
| **7** | All hospitals where acute non-invasive ventilation (NIV) is provided must have an operational policy that includes, but is not limited to: a. Appropriate clinical areas where acute NIV can be provided, and in those areas the minimum safe level of staff competencies; b. Staff to acute NIV patient ratios; c. Escalation of treatment and step down care procedures; d. Standardised documentation; and e. Minimum frequency of clinical review, and seniority of reviewing clinician. Compliance with this policy should be part of the annual audit process. *(Medical Directors, Nursing Directors and Acute Non-Invasive Ventilation Service Leads)**\*See Appendix 1 – British Thoracic Society competency checklist**www.brit-thoracic.org.uk/ standards-of-care/guidelines/btsrcpics-guideline-for-non- invasive-ventilation/* |   |   |   |   |   |
| **8** | All staff who prescribe/make changes to acute non-invasive ventilation treatment must have the required level of competency as stated in their hospital operational policy. A list of competent staff should be maintained.*(Medical Directors and Nursing Directors)**\*See Appendix 1 – British Thoracic Society competency checklist**and NIV prescription chart www.brit-thoracic.org.uk/ standards-of-care/guidelines/btsrcpics-guideline-for-non- invasive-ventilation/* |   |   |   |   |   |
| **9** | All patients treated with acute non-invasive ventilation (NIV) must have a treatment escalation plan in place prior to starting treatment. This should be considered part of the prescription for acute NIV and include plans in relation to: a. Escalation to critical care; b. Appropriateness of invasive ventilation; and c. Ceilings of treatment. This should take into account: d. The underlying diagnosis; e. The risk of acute NIV failure; and f. The overall management plan.*(All Clinical Staff Responsible for Starting Acute NIV)**\*See Appendix 1 – British Thoracic Society NIV prescription chart**www.brit-thoracic.org.uk/ standards-of-care/guidelines/btsrcpics-guideline-for-non- invasive-ventilation/* |   |   |   |   |   |
| **10** | All patients treated with acute non-invasive ventilation (NIV) must be discussed with a specialist competent in the management of acute NIV at the time treatment is started or at the earliest opportunity afterwards. Consultant specialist review to plan ongoing treatment should take place within a maximum of 14 hours.*(Acute Non-Invasive Ventilation Service Leads)* |   |   |   |   |   |
| **11** | All patients receiving acute non-invasive ventilation (NIV) should receive, as a minimum, daily consultant review while they remain on ventilation. This consultant must be competent in acute NIV management.*(Clinical Directors and Consultants Responsible for Acute NIV)* |   |   |   |   |   |
| **12** | All patients treated with acute non-invasive ventilation must have their vital signs recorded at least hourly until the respiratory acidosis has resolved. A standardised approach such as the National Early Warning Score is recommended.*(Nurses and Acute Non-Invasive Ventilation Service Leads)**\*See Appendix 3 – National Early Warning Score (NEWS)**www.rcplondon.ac.uk/projects/outputs/national-early-warningscore-news* |   |   |   |   |   |
| **13** | Documentation of all changes to ventilator settings is essential and the use of a standardised proforma is recommended.*(Acute Non-Invasive Ventilation Service Leads)**\*See Appendix 1 – British Thoracic Society NIV prescription and settings chart**www.brit-thoracic.org.uk/ standards-of-care/guidelines/btsrcpics-guideline-for-non- invasive-ventilation/* |   |   |   |   |   |
| **14** | The use of acute non-invasive ventilation could act as a flag to consider referral to palliative care services, as this may be valuable for both active symptom control and end of life care. *(Clinical Staff)* |   |   |   |   |   |
| **15** | Following an acute non-invasive ventilation episode, a structured plan for future treatment should be discussed with the patient and/or carer either at the point of discharge from hospital or at subsequent follow-up. This must be documented and a copy of the plan given to the patient and to the patient’s general practitioner. *(Clinical Staff)* |    |   |   |   |   |
| **16** | In the absence of a recognised indication for acute non-invasive ventilation (e.g. chronic obstructive pulmonary disease) patients with acute ventilatory failure and evidence of pneumonia have a high risk of death and acute NIV should not be considered standard treatment. Escalation of treatment should be actively considered. There should be close liaison between senior members of the medical and critical care teams to agree the most appropriate approach to management. *(Consultants)* |   |   |   |   |   |
| **17** | Governance arrangements for acute non-invasive ventilation (NIV) services should be in place in all organisations that provide acute NIV treatment. These should include all disciplines and specialities involved in the delivery of NIV. Depending on the local service model, those involved in the governance of acute NIV services are likely to include medical, nursing and physiotherapy staff from Emergency Medicine, Acute Medicine, Respiratory Medicine and Critical Care. *(Medical Directors, Nursing Directors and Acute Non-Invasive Ventilation Service Leads)* |   |   |   |   |   |
| **18** | All acute non-invasive ventilation services should have a record kept of the number of patients treated, to aid service planning. *(Acute Non-Invasive Ventilation Service Leads)* |   |   |   |   |   |
| **19** | All acute non-invasive ventilation services should be audited annually. The audit results should be reported to the Hospital Board. *(Acute Non-Invasive Ventilation Service Leads and Medical Directors)* |   |   |   |   |   |
| **20** | All hospitals should monitor their acute non-invasive ventilation mortality rate and quality of acute NIV care. This should be reported at Board level. *(Chief Executives, Medical Directors, Nurse Directors and Acute Non-Invasive Ventilation Service Leads)* |   |   |   |   |   |
| **21** | A quality standard for acute non-invasive ventilation is required to facilitate quality improvement in acute non-invasive ventilation services. *(British Thoracic Society and Local Quality Improvement Leads)* |   |   |   |   |   |