Model of Care for Specialised Weaning Units

APPENDICES
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Appendices

The following are the appendices that accompany the main Model of Care Document.

1. Patient Story 1
2. Patient Story 2
3. QI Tool
4. NIV/CPAP Safety checklist
5. Whole body rehabilitation care strategy
6. Pathway flowcharts
7. Referral criteria
8. Referral flow diagram
9. Whole body rehabilitation pathway
10. Equipment list
11. Product/consumables list
Appendix One – Story from parents of adult patient with deteriorating neuromuscular condition

What do you see as important elements of patient-centred and family-centred care that should be present in all weaning centres?

From our perspective as parents of a young man with a deteriorating neuro muscular condition being able to stay with him throughout his hospital stay was for us non negotiable. He needed help will all daily activities which became second nature to us over the years and meant that the care he received was predictable comfortable and stress free. To place him in a hospital ward which is stressful enough and to have various staff providing his care would have been extremely difficult for him, even if the care he received was of a high standard. Some facilities to support this such as a fold down bed by his side, showering facilities and tea/ coffee/ kitchen facilities would in an ideal world be of great help.

We think that strong links with an assistive technology team could make a big and positive difference to patients with a disability. Support with communication, ability to watch tv, use an iPad or computer are things that are set up at home specific to the persons needs but on coming into hospital are lost even if there is general provision on the ward. From a personal perspective and as an example my son was unable to press a hospital buzzer due to muscle weakness and then lost his voice following tracheostomy so had no means of attracting the attention of staff.

Using his computer or watching tv on his iPad created challenges as it was difficult to position them adequately. With the right kind of help these barriers could probably have been overcome quite easily with a few adaptations and would have made such a difference to his long hospital stay.

We think it would be great to have a hospital to home link nurse/professional to help with the transition from hospital to home, which can feel scary and daunting when the patient is going home in a very different situation to when they were admitted. Support with changing tracheostomy tubes at home, help with training for carers, assistance with medical issues as they arise and liaison with the hospital staff would feel very supportive.

Links with the local wheelchair service could be helpful in getting alterations for example holders for oxygen cylinders, ventilators etc as soon as needed and prior to discharge from hospital.

Psychological support we feel is really important as there can be many changes and traumatic events taking place that deeply affect patients and families which you somehow have to cope with and carry on.
The right kind of professional having a presence on the ward, getting to know them over time means that when you do need support you can access it easily with someone who you are familiar with and who understands the situation you are in.

A family centred approach to breaking bad news or starting difficult conversations in a gentle and collaborative manner is crucial to alleviate some of the stress and upset for the patient and their families. Young people with a lifelong physical disability may be in a very different place developmentally and emotionally than a person of the same age who has grown into an independent adult, having had many different life experiences.

The weaning unit should have access to specialist skills and expertise specific to the end of life care needs of younger patients and those with additional developmental needs.

The weaning centre should make sure to tap into knowledge and experience of parents and families as experts in the patient’s needs, not viewing the patient in isolation but considering the family unit as a whole when planning and delivering care, for example, learning from families how might be best to collaboratively progress difficult conversations.
Appendix Two – Story from adult patient weaned from intensive mechanical ventilation

Intensive care saved my life but broke my spirit.

Once I was out of danger and left on a breathing machine because they said that I could not breathe on my own, I felt forgotten.

I became the woman in the side room who kept “failing”... to come off the breathing machine.

I did not know who I was. What time of day it was? Who was supposed to be looking after me?

I saw a different nurse each day. Some were nice, some were indifferent. Some talked to me either as a child or as an adult and some talked at me. Some did not talk to me at all.

There was no routine in my life. I felt lost. I did not know what my future was or even if I had one.

I thought my family had been kidnapped as I had not seen them or spoken to them for what seemed a lifetime.

I always felt really hungry and thirsty.

I was uncomfortable for most of the time in bed and out of bed.

I felt that I needed a really good wash, I thought that I smelt terrible.

There was something in my neck (I now know it was a trache tube). – it was uncomfortable.

I had no control.

The kind things that kept me going:

Being able to talk again with my “cuff” down

Soaking my feet in a bowl of warm soapy water

Having ice cold water to drink

Having a normal conversation about other things rather than me, my body, my health, the ventilator.

Eventually seeing my family

What I think would help other patients like me:

A routine / plan for each day – achievable goals so we don’t keep failing

Given choices

Having staff who were interested in the “failures” – that can’t breathe on their own when they should or supposed to
Be part of planning my own care.

Daily family time – or letting my family help with my care

Get dressed in clothes
### Appendix 3
Check List/Quality Improvement Tool

<table>
<thead>
<tr>
<th>Appendix 3</th>
<th>1. Involve patient and family in goal setting and decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Involve patient and family in goal setting and decision making</td>
<td>Develop a care plan that includes weaning and rehabilitation with patient and family outlining goals of care</td>
</tr>
<tr>
<td></td>
<td>Involve patient in bedside rounds/goals of care discussions as early as able</td>
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<tr>
<td></td>
<td>Provide regular proactive family meetings to set goals, devise a care plan, and share information. Last family update: __________</td>
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<tr>
<td></td>
<td>Engage family in medical care (present/participate on rounds, participate in care, minimize visiting restrictions)</td>
</tr>
<tr>
<td>2. Optimise Patient Communication</td>
<td>Restore voice and communication to facilitate patient participation in care and treatment decisions, and enable humanisation of care.</td>
</tr>
<tr>
<td>3. Promote physical comfort and minimize complications</td>
<td>Prevent/treat complications associated with prolonged bed rest/ICU stay</td>
</tr>
<tr>
<td></td>
<td>Provide regular oral care including toothbrushing</td>
</tr>
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<td></td>
<td>Prevent ocular disorders arising from incomplete eyelid closure</td>
</tr>
<tr>
<td></td>
<td>Minimize physical restraint</td>
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<tr>
<td></td>
<td>Assess/manage symptoms (pain, breathlessness, tiredness, thirst)</td>
</tr>
<tr>
<td></td>
<td>Use patient preferences for strategies to promote sleep</td>
</tr>
<tr>
<td>4. Promote self-care and restore normalcy</td>
<td>Enable access to activities and personal possessions (including clothes) to prevent boredom, loneliness, and restore normalcy</td>
</tr>
<tr>
<td></td>
<td>Provide activities to promote cognitive stimulation based on patient preference</td>
</tr>
<tr>
<td></td>
<td>Engage patient in self-care activities (washing face, brushing hair) as able</td>
</tr>
<tr>
<td>5. Optimize ventilator weaning</td>
<td>Assess and track ventilator weaning progress</td>
</tr>
<tr>
<td></td>
<td>Use a structured tool (protocol or individualized weaning plan) to plan and guide weaning</td>
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<tr>
<td></td>
<td>Include the patient (when able) and family in the development of the weaning plan</td>
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<tr>
<td></td>
<td>Assess readiness to deflate the tracheostomy cuff, downsize or decannulate the tracheostomy as part of the weaning process</td>
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<tr>
<td></td>
<td>Use strategies to manage excess secretions or inability to cough up secretions</td>
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<tr>
<td>6. Optimize physical therapy</td>
<td>Assess endocrine function and treat in relation to weaning failure</td>
</tr>
<tr>
<td></td>
<td>Establish and track rehabilitation/physiotherapy goals</td>
</tr>
<tr>
<td></td>
<td>Assess and treat non-respiratory muscle wasting</td>
</tr>
<tr>
<td></td>
<td>Assess respiratory muscle weakness and provide respiratory muscle training as appropriate</td>
</tr>
<tr>
<td>7. Assess swallowing function and establish safe return to normal drinking and eating</td>
<td>Assess and treat swallow dysfunction</td>
</tr>
<tr>
<td></td>
<td>Assess and optimise saliva management</td>
</tr>
<tr>
<td></td>
<td>Develop a care plan for oral or alternative feeding in line with patient and family wishes</td>
</tr>
<tr>
<td>8. Deescalate/optimize pharmacotherapy including previous medications for existing comorbidities</td>
<td>Provide activities to promote cognitive stimulation based on patient preference</td>
</tr>
<tr>
<td>9. Assess and treat psychological and emotional issues</td>
<td>Use patient preferences for strategies to promote sleep</td>
</tr>
<tr>
<td></td>
<td>Minimize physical restraint</td>
</tr>
<tr>
<td></td>
<td>Minimize practices such as nighttime light/noise</td>
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<tr>
<td>10. Minimize delirium risk</td>
<td>Review ongoing need for sedation and decrease as able</td>
</tr>
<tr>
<td>11. Ensure appropriate referrals are made</td>
<td>Palliative care</td>
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<tr>
<td></td>
<td>Occupational therapy</td>
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<tr>
<td></td>
<td>Speech &amp; language therapy</td>
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<tr>
<td></td>
<td>Dietetics</td>
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<tr>
<td></td>
<td>Psychology</td>
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<tr>
<td></td>
<td>Social worker</td>
</tr>
<tr>
<td></td>
<td>Spiritual care</td>
</tr>
<tr>
<td></td>
<td>Skin and wound specialist</td>
</tr>
<tr>
<td></td>
<td>Pain Specialist</td>
</tr>
<tr>
<td></td>
<td>Other (describe)</td>
</tr>
</tbody>
</table>
Appendix 4

**SAFER NIV/CPAP**
A checklist for use in Pandemic Response and on Respiratory Support Units
Complete on initiating NIV/CPAP and every shift change
**DO NOT PROCEED WITH NIV/CPAP UNTIL ALL QUESTIONS ANSWERED YES**
Where doubt exists, or where an answer is NO - give supplemental oxygen sufficient to prevent desaturation, and STAY WITH THE PATIENT.

<table>
<thead>
<tr>
<th>System</th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has each team member read and understood the NIV machine quick start guide?</td>
<td></td>
</tr>
<tr>
<td>(This guide should be laminated, and permanently attached within arms’ reach of the machine)</td>
<td></td>
</tr>
<tr>
<td>Has a suitable filter been fitted to the expiratory/exhaust pathway?</td>
<td></td>
</tr>
<tr>
<td>Are all machine alarms on and set appropriately?</td>
<td></td>
</tr>
<tr>
<td>Has the patient been reviewed as being at higher risk of deterioration?</td>
<td></td>
</tr>
<tr>
<td>If higher risk, are they in the appropriate place on the ward (i.e. proximity to nurses’ station etc)</td>
<td></td>
</tr>
<tr>
<td>Is their Treatment Escalation Plan known, documented and handed over?</td>
<td></td>
</tr>
<tr>
<td>Has the machine been checked for security, and then double checked?</td>
<td></td>
</tr>
<tr>
<td>Has the mask fit been checked and there is minimal leak?</td>
<td></td>
</tr>
<tr>
<td>Airway</td>
<td></td>
</tr>
<tr>
<td>Is the machine tubing as short, direct, and protected as possible?</td>
<td></td>
</tr>
<tr>
<td>Confirm that the patient cannot disconnect the oxygen supply by moving, rolling, or pulling?</td>
<td></td>
</tr>
<tr>
<td>Can the machine tubing be better protected by loosely taping (masking tape) the tubing out of reach?</td>
<td></td>
</tr>
<tr>
<td>Has operation of the mask bypass valve been checked as operational?</td>
<td></td>
</tr>
<tr>
<td>Has each and every connection between the patient and the machine been checked for security, and then double checked?</td>
<td></td>
</tr>
<tr>
<td>FiO2</td>
<td></td>
</tr>
<tr>
<td>Have you confirmed that the machine is attached to oxygen (not medical air)</td>
<td></td>
</tr>
<tr>
<td>Are the target ranges for key observations documented?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ $O_2$ saturation</td>
</tr>
<tr>
<td></td>
<td>○ RR</td>
</tr>
<tr>
<td>Does the patient have continuous pulse oximetry with alarms set appropriately and within earshot of a staff member?</td>
<td></td>
</tr>
<tr>
<td>Electricity supply</td>
<td></td>
</tr>
<tr>
<td>Is the electricity supply to the NIV/CPAP machine as safe and protected as possible?</td>
<td></td>
</tr>
<tr>
<td>Where the electricity supply cable must cross a walkway, has the cable been taped to the floor, using masking tape, or covered with a rubberised mat?</td>
<td></td>
</tr>
<tr>
<td>Has the electricity supply cable been checked for pinch hazards?</td>
<td></td>
</tr>
<tr>
<td>Rescue</td>
<td></td>
</tr>
<tr>
<td>Which named team member will respond to an alarm?</td>
<td></td>
</tr>
<tr>
<td>Can this team member stay within earshot of machine/pulse oximeter alarm at all times?</td>
<td></td>
</tr>
<tr>
<td>Do you know the location of the nearest fire extinguisher? Do you know how to use it to attack an oxygen fire?</td>
<td></td>
</tr>
<tr>
<td>Which named BLS trained team member will respond in an emergency?</td>
<td></td>
</tr>
<tr>
<td>Can this team member remain close to the patient at all times?</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 5
### CORE CARE STRATEGIES FOR THE WHOLE BODY REHABILITATION AND WEANING PATHWAY

<table>
<thead>
<tr>
<th>Core Strategies</th>
<th>Areas to consider within strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Daily routine panned and established</td>
<td>• Active rehabilitation times&lt;br&gt;• Time patient sits out of bed&lt;br&gt;• Rest period agreed&lt;br&gt;• Getting patient dressed in own clothes&lt;br&gt;• Personal time (e.g. listening to music, family visits)&lt;br&gt;• Off unit visits</td>
</tr>
<tr>
<td>B. Communication strategies trialled and established</td>
<td>• Cuff deflation (Above Cuff Vocalisation if cuff inflated)&lt;br&gt;• Speaking valve – PMV or other one way valve&lt;br&gt;• Pen and paper&lt;br&gt;• Alphabet / picture boards&lt;br&gt;• Other AAC tools&lt;br&gt;• Rehabilitation and weaning plan written up on patients write and wipe board</td>
</tr>
<tr>
<td>C. Effective wake and sleep cycle established</td>
<td>• Usual sleep pattern / routine at home&lt;br&gt;• Night sedation&lt;br&gt;• Assessment and treatment for delirium / agitation&lt;br&gt;• Change into night clothes at night time</td>
</tr>
<tr>
<td>D. Rehabilitation interventions</td>
<td>• Short term and long term goals agreed&lt;br&gt;• Strength and endurance&lt;br&gt;• Active and passive&lt;br&gt;• Planned rest days</td>
</tr>
<tr>
<td>E. Weaning strategies</td>
<td>• Developed on an individual basis&lt;br&gt;• Weaning and rehabilitation may not be able to be carried out in the same day&lt;br&gt;• Wean during the day&lt;br&gt;• Effective And supportive ventilation following weaning episode&lt;br&gt;• Stop weaning for 24 hours if:&lt;o Frequent diarrhoea&lt;br&gt;o Septic shower&lt;br&gt;o Clinical judgement&lt;br&gt;• Ventilator CPAP should not be used as a prolonged strategy for weaning unless needed.</td>
</tr>
<tr>
<td>F. Nutrition optimised and established</td>
<td>• Fine bore tube&lt;br&gt;• Swallow test for oral diet&lt;br&gt;• PEG&lt;br&gt;• Supplements</td>
</tr>
<tr>
<td>G. Comfort strategies</td>
<td>• Regular analgesia&lt;br&gt;• Bowel care&lt;br&gt;• Massage therapy&lt;br&gt;• Music and TV&lt;br&gt;• Reading material&lt;br&gt;• Outside visits</td>
</tr>
<tr>
<td>H. Psychological strategies</td>
<td>• Patient diary&lt;br&gt;• Days off&lt;br&gt;• Pet therapy</td>
</tr>
<tr>
<td>I. Reduce invasive monitoring</td>
<td>• Urinary catheter&lt;br&gt;• Central line&lt;br&gt;• Cardiac monitor</td>
</tr>
</tbody>
</table>
Patient not currently suitable for weaning/LTTV
*patient will be reviewed again if needing PMV
Referral commenced, details entered onto Teleologic
Patient from ICU needing PMV
Referral reviewed by on-call LFU consultant
Referring consultant informs LFU via phone call
LFU consultant discusses with Referring consultant regarding patient’s condition over the phone, documented on Teleologic
Decision to wean patient
Decision to do LTTV
Trial of de-cannulation successful?
Patient decannulated
Discharge home or to appropriate community facility
No
Yes
Need and availability of bed for transfer?
No
Yes
Decision to be made (this is always a yes/no question)
Terminator - The final action in the process
Linked process - the occurrence or action which triggers the start of the process
Process flow direction - indicates the direction of the process
Optional process flow - the flow of the process is optional
Subprocess - process step with sub processes
Denotes exchange of information through email
Denotes Letters or Documents are created and handled manually/printed
Denotes exchange of information through a call
Denotes a process where client information is stored on a clinical system
Glossary of terms:
Teleologic - Referral website
LFU – Lane Fox Unit
LTTV – Long term Tracheostomy Ventilation
PMV – Passir Muir Valve (speaking valve)
Notes:
Home NIV and Discharge pathway the same regardless of site.
Glossary of terms:

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PMV – Passiv Muir Valve (speaking valve)
CHC – Continuing healthcare (package of care provided outside of hospital)
CCG – Clinical commissioning group
NIV – Non-invasive ventilation

Notes:

1. Reappplication of funding may be needed, however the majority of times clarification is sufficient for funding to be approved.
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NIV – Non invasive ventilation
CVIS/TOMCAT – Echocardiogram/Cathlab procedure storage
EPR – Electronic patient record
PACS – Imaging viewer
STH – St Thomas Hospital

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Notes:

1. Access database acts as a repository for patients receiving home NIV. Used by technical services to ensure that servicing of machine is maintained. Also contains data regarding device settings and can be used as reference for troubleshooting. Limited access because of limited login. Database is maintained by technical services within LFU.
Notes:

Discharge criteria decided on preceding process
Dear Colleague

We are pleased to announce that the Ventilation Service at University Hospital Aintree has completed the establishment of its dedicated ventilation facility known as the "Ventilation Inpatient Centre" which includes dedicated weaning beds. The unit is now fully operational and is able to accept referrals. The Ventilation Service would be pleased to receive referrals for possible transfer of "slow to wean" patients. A brief guide to aid patient selection is outlined below.

Suggested criteria for referral are:

1) Patient deemed to have weaning potential by parent ICU team
2) Delayed wean after 21 days of attempted weaning by the ICU team
3) Transfer acceptable to patient and/or relatives
4) No immediate further acute treatment planned e.g. surgery
5) Haemodynamically stable (pulse <140 bpm; BP < 180 and >90 systolic) and no requirement for pressor agents/inotropes
6) Neurologically and cognitively stable
7) All sedation/neuromuscular relaxants withdrawn
8) No instability involving other organ systems requiring organ support other than long term renal replacement i.e. dialysis
9) No evidence of acute sepsis

The Ventilation Service would also be able to assist with establishment of a long term Ventilation package for those deemed non- weanable and therefore not suitable for transfer. The Ventilation Business Manager and/or the Ventilation Secretary may be contacted for this purpose.

A referral letter should be faxed to the Ventilation Business Manager or the Ventilation Secretary containing patient details, NHS number, original diagnosis at presentation, any active problems and whether the referral is for weaning assessment and potential transfer or for support with establishment of a home ventilator package.

Patients who are referred as a potential "weaning" candidate will be reviewed in the referring unit by the duty "Weaning" Respiratory Consultant. If deemed suitable for transfer after formal nursing liaison and agreement with patient and/or next of kin, the referring hospital will be invited to arrange transfer. Liaison between all the paramedical disciplines i.e. between the Physiotherapists, Speech and Language therapists, Occupational therapists and Dieticians is recommended prior to transfer.

The Ventilator Business Manager (Marie Pearce; Tel 0151 529 3504; Fax: 0151 529 3129) will facilitate the transfer process. In her absence, the Ventilation secretary (Tel: 0151 529 8944; Fax 0151 529 2873) may be contacted.

Ventilation Manager - Fax: 0151 529 3129 or Ventilation Secretary - Fax 0151 529 2873
The rota for the ventilation consultant is held by the Ventilation Secretary and Marie and they can be contacted for discussion via them or the Ventilation Inpatient Unit on 0151 529 3602.

Visits to the Ventilation Inpatient Centre would be welcome and may be arranged by contacting the Ward Manager Julie Cheney on 0151 529 3625.

Yours sincerely

_________________________  ________________________
Dr Robert M. Angus        Dr Biswajit Chakrabarti

_________________________  ________________________
Dr John F. O’Reilly       Dr Nick Duffy
Ventilation Service Referral

Referrer: ...........................................................

Unit: .....................................................................

Contact number: ................................................

Name of Patient: ..................................................

Date of Birth ....................................................... 

NHS Number: ....................................................

Address: ................................................................

...........................................................................

Contact Number: ................................................

Next of Kin: ..........................................................

GP details: ..........................................................

...........................................................................

Weaning assessment and potential transfer or for support with establishment of a home ventilator package (please delete appropriately)

Diagnosis: ..........................................................

...........................................................................

Active problems: ................................................

...........................................................................
Appendix 8: Referral flow diagram

Specialist Weaning Unit (SWU)

Start

- Patient on Critical Care (intubated Regionally)
- Invasive mechanical ventilation (3 wks resolution of multi-organ failure)

Flag to local Specialist Weaning Unit (SWU)

Advice & guidance given to facilitate weaning

Has weaning been successful?

- Liberated from mechanical ventilation
- No benefit from admission to SWU

Liberated from mechanical ventilation

Referral accepted?

- No benefit from admission to SWU
- Patient admitted to SWU - Treatment & discharge planning

Outcome?

- Liberated from mechanical ventilation
- Weaned to non-invasive ventilation
- Long-term tracheostomy tube ventilation
- Palliative discharge on long term ventilation
- Patient died
- Repatriation

Discharge to Follow up

Refer to Long Term Ventilation Service
WHOLE BODY REHABILITATION PATHWAY
DAILY MDT REVIEWS AND PLANNING

Development of an individual wholistic rehabilitation / weaning programme

Weaning Plan
Communication Strategies established
Rehabilitation Programme / Nutrition optimisation / Energy management
Psychological profile

Possible Weaning Strategies
• Supportive settings
• Pause weaning to establish rehabilitation and energy management
• Ventilator Free Time (VFT)
• Wean in the day using VFT
• Supportive ventilation at night until can wean off

Communication Strategies
• Cuff down
• Use of Passy Muir Valve (PMV)
• Pen and paper / iPAD
• Daily goals

Rehab / Nutrition / Energy Strategies
• Exercise plan supported with effective ventilation
• Eat and drink
• ?PEG/RIG
• Rest periods / days
• Sunshine therapy

Psychological strategies
• Likes / dislikes
• Plan for the day
• Night time and day time wear
• Active listening / diaries
• Comfort strategies

Proactive Discharge Planning

One-way Wean / Palliation
Successful Wean from Invasive / non-invasive Ventilation
• Decannulated
• May require NIV
• Off NIV completely

Transfer to Specialist Extended Facility or Home with an appropriate care package
• Still requiring TIV / NIV ventilation after 21 days
• Long term tracheostomy tube
Appendix 10 – EQUIPMENT LIST

- Mixture of ventilators for Non-invasive and invasive ventilation
  - Internal battery
  - Access to external battery
  - Single limb
- MI-E devices
- Bronchoscopy
- FEES equipment and nasendoscopy
- Expiratory Muscle Strength Training equipment
- sEMG biofeedback and Pharyngeal Electrical Stimulation (Phagenyx) equipment
- Blood gas machine
- Ultrasound for the purposes of pleural procedures and intravascular access
- Transcutaneous CO2 monitors
- Sleep study equipment
- iSTAT machines
- ABG static machine
- Respiratory vests
- Active heated humidifiers
- Lung volume recruitment bags
- Aerogen Nebuliser
- Spirometry and muscle strength measurement
- ECG machine
- Mobile USS
- Portable airway scope
- Rehabilitation equipment
  - Seating
  - Wheelchair
  - Therapy bikes
  - Resistive bands
  - Weights
  - IMT / EMT
  - Walking frames
- Mixture of tracheostomy tubes
- Tracheostomy cuff manometers
- One-Way Valves for tracheostomies
- Mixture of NIV masks
  - Full face
- Nasal
- Total
- Hybrid
- AAC equipment
- Ceiling hoists
- Standing hoists
- Communication aids
- iPads
- Headphones
- Eye shades
- Ear plugs
- Entertainment
  - Board games
  - Cards
  - Art material
  - Audio books
- Hairdryers
- Electric toothbrushes
- Mirrors
- In bed hair wash bowels
- Foot spas
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<thead>
<tr>
<th>PRODUCT</th>
<th>SUPPLIED BY:</th>
<th>MODEL</th>
<th>SUPPLIER</th>
<th>NUMBER REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator and filters</td>
<td>weaning centre</td>
<td>B&amp;D Electromedical NIPPY 3+ x 2</td>
<td>Lane Fox Unit</td>
<td>X2</td>
</tr>
<tr>
<td>Battery and charger</td>
<td>weaning centre</td>
<td>B&amp;D Electromedical 1 x portable</td>
<td>Lane Fox unit</td>
<td>1 each</td>
</tr>
<tr>
<td>Humidification unit</td>
<td>weaning centre</td>
<td>Fisher &amp; Paykel</td>
<td>Lane Fox Unit</td>
<td>X1</td>
</tr>
<tr>
<td>Suction Unit</td>
<td>CCG</td>
<td>Local policy</td>
<td>Local policy</td>
<td>X2 (at least 1 portable)</td>
</tr>
<tr>
<td>Nebuliser Compressor unit</td>
<td>Lung function, local hospital</td>
<td>Local Policy</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Cough assist machine</td>
<td>weaning centre</td>
<td>NIPPV Clearway Cough assistor B&amp;D Electromedical</td>
<td>Lane Fox Unit</td>
<td>X1</td>
</tr>
<tr>
<td>Heated wire vent/humidifier circuits</td>
<td>District Nurses/CCG</td>
<td>Fisher &amp; Paykel Healthcare RT202 including MR290 chamber (box of 10)</td>
<td>NHS supplies FDC205</td>
<td>One circuit per fortnight</td>
</tr>
<tr>
<td>Whisper swivel valve</td>
<td>District Nurses/CCG</td>
<td>Respironics 332113</td>
<td>NHS supplies FDE078</td>
<td>X1 per month</td>
</tr>
<tr>
<td>Clearway Disposable 2mm circuit</td>
<td>District Nurses/CCG</td>
<td>B&amp;D Electromedical 0960.101</td>
<td>NHS supplies FAG2243</td>
<td>X1 per month</td>
</tr>
<tr>
<td>Smooth bore breathing system limb 1.8m</td>
<td>District Nurses/CCG</td>
<td>Intersurgical 5018000</td>
<td>Intersurgical</td>
<td>x1 per fortnight</td>
</tr>
<tr>
<td>Water for inhalation (sterile)</td>
<td>District Nurses/CCG or Prescription</td>
<td>Aquilant Critical Carefusion Airlife 2D0737</td>
<td>NHS supplies FDD2093</td>
<td>1 2L bag per 24-48 hours</td>
</tr>
<tr>
<td>Catheter mount</td>
<td>District nurses/CCG</td>
<td>Intersurgical 3521</td>
<td>NHS supplies FDE148</td>
<td>1 per week</td>
</tr>
<tr>
<td>HME (Heat moisture exchange)</td>
<td>District Nurses/CCG</td>
<td>Intersurgical 1942</td>
<td>Intersurgical / NHS supplies FTC048</td>
<td>2x weekly</td>
</tr>
<tr>
<td>Hard Ambu bag and mask</td>
<td>On discharge from Lane Fox</td>
<td>Intersurgical 7152</td>
<td>NHS supplies FDE658</td>
<td>1x yearly or PRN</td>
</tr>
<tr>
<td>Suction catheters Size 10</td>
<td>District Nurses/CCG</td>
<td>GBUK Healthcare Tender tip TTO1-10-060</td>
<td>NHS supplies FSQ580</td>
<td>1-2x box of 100/week</td>
</tr>
<tr>
<td>Suction tubing</td>
<td>District Nurses/CCG</td>
<td>Universal Hospital Supplies Ltd UN30026FFM</td>
<td>NHS Supplies FWP204</td>
<td>X7 per week</td>
</tr>
<tr>
<td>Yankauer sucker</td>
<td>District Nurses/CCG</td>
<td>Medtronic MITG Argyle (Covidien)</td>
<td>NHS supplies FWP501</td>
<td>3 per week</td>
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<tr>
<td>Item Description</td>
<td>Supplier Details</td>
<td>Description</td>
<td>Leadtime</td>
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<td>------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Trache tube with Innertubes</td>
<td>District Nurses/CCG</td>
<td>Smiths Medical International Blue Line Portex size 7.0 cuffed suctionaid</td>
<td>1 per month</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>100/860/070</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>NHS supplies FDG181</td>
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<tr>
<td>Spare trache tubes</td>
<td>District Nurses/CCG</td>
<td>Smiths Medical International Blue Line Portex Size 6.0 cuffed suctionaid</td>
<td>As emergency and spares</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>100/860/060</td>
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<td>NHS supplies FDG926</td>
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<tr>
<td>Spare inner tubes for trache</td>
<td>District Nurses/CCG</td>
<td>Smiths Medical International Blue Line Ultra Size 7.0</td>
<td>2 per month</td>
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<tr>
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<td>100/850/070</td>
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<td>NHS supplies FDG341</td>
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<tr>
<td>Nebuliser acorn and T piece</td>
<td>District Nurses/CCG</td>
<td>Intersurgical kits. Code 2505</td>
<td>1 per fortnight</td>
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<td>NHS supplies FDE083</td>
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<tr>
<td>Trache dressings</td>
<td>District Nurses/CCG</td>
<td>Activa Healthcare Lahmann metalline 23094 8x9cm</td>
<td>1 per day</td>
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<td>NHS supplies EJI191</td>
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<td>Trache holders</td>
<td>District Nurses/CCG</td>
<td>Insight Medical Products Ltd TH/100</td>
<td>2 per week</td>
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<td>NHS supplies FTH000</td>
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<tr>
<td>Gauze Swabs to clean trache site</td>
<td>District Nurses/CCG</td>
<td>Any brand</td>
<td>7 packs per week</td>
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<td></td>
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<td>NHS supplies ENK004</td>
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<tr>
<td>Saline Ampoules 10mls</td>
<td>GP/CCG</td>
<td>Any brand</td>
<td>7 ampoules per week</td>
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<td></td>
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<td>Prescription</td>
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<tr>
<td>Gloves</td>
<td>District Nurses/CCG</td>
<td>Any brand</td>
<td>DNs to assess</td>
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<tr>
<td></td>
<td></td>
<td>NHS supplies</td>
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