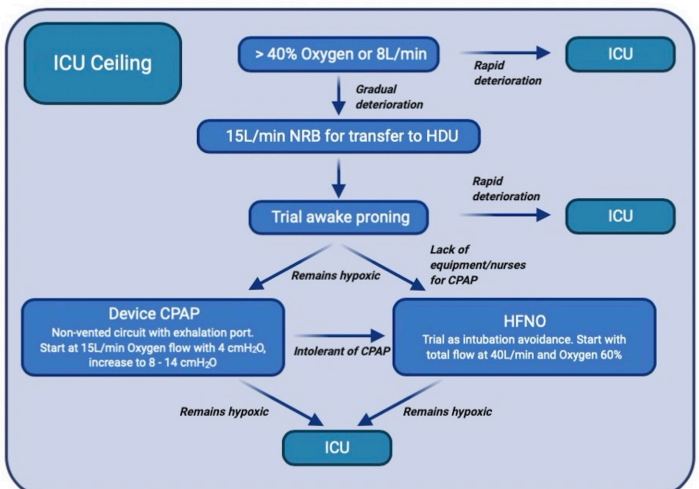
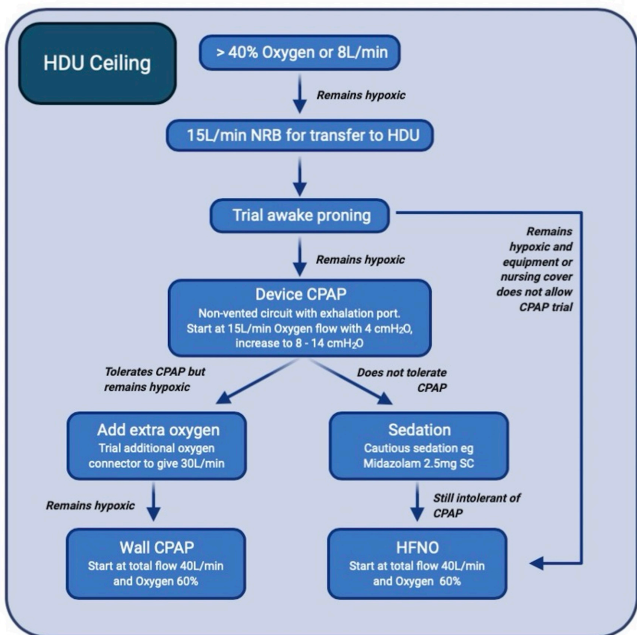


### Respiratory High Dependency Unit Admission and Oxygen Escalation Policy



**Target Oxygen Saturations: 92-96%**

**COPD: 88-92%**

**Decision-Making on HDU Admissions**

The decision to commence level 2 treatment will be made by the respiratory consultant or registrar in conjunction with the ICU acute respiratory failure (ARF) consultant and home medical team.

**Rationale:**  
Level 2 oxygen therapies are all aerosol generating procedures (AGPs) and need to be performed in single rooms with staff in OUH level 2 PPE. They require a high degree of technical skill, which is best achieved in cohorted areas. They have high oxygen demand, which must be monitored and managed to preserve the hospital oxygen pressure

*Covid-19 Respiratory HDU Admission and Level 2 Oxygen Policy v1.GH.HB.6April2020*

**Respiratory HDU Admission Criteria**

- Oxygen sats < 93% despite Oxygen > 40% or respiratory acidosis
- Patients for full escalation with gradual escalation of oxygen requirement over several hours to days as intubation avoidance
- Patients with ceilings of care at HDU (NIV/CPAP/HFNO)
- ICU Stepdown

**Choosing Modes of Oxygen Support**

Once the patient requires more than 40% oxygen or 8L/min, switch to NRB 15L/min to enable safe transfer to destination ward

1. Consider trial of awake proning if possible. Oxygenation can improve significantly without needing further oxygen therapy
2. Machine CPAP 8 - 15 cmH2O with 15L/min entrained oxygen using non-vented mask circuit. The application of CPAP can improve oxygenation by recruitment of functional alveoli. If remains hypoxic and is not for ICU, consider adding further oxygen connector and running up to an additional 15L/min (total 30L/min) oxygen.
3. Consider HFNO if there is insufficient equipment to deliver a non-vented circuit set-up, insufficient trained nursing staff, or if the patient is unable to tolerate mask despite cautious sedation. Start with total flow of 40 L/min and Oxygen 60% (this will use ~ 20L/min oxygen). Titrate up Oxygen first rather than flow.
4. Consider high flow wall CPAP if the patient is tolerant of CPAP but remains hypoxic. Start at total flow of 40L/min, 60% Oxygen.
5. If unable to achieve sufficient oxygenation on machine CPAP or high flow nasal oxygen refer urgently to ICU if appropriate.