Contents

1. Introduction and Who Guideline applies to

1.1 Objective and background

The objective of this guideline is to ensure appropriate and timely admission and discharge of adult patients (>16 years old) to the Respiratory Support Unit (RSU), and to facilitate the proper utilization of limited resources. The SOP covers the admission and discharge criteria for the unit, the daily medical running of the unit, and the governance involved in safely managing these complex patients. This RSU has been designed with the national specification in mind, and the guidelines will be adhered to where possible.[1] The clinical management within the unit also relies on guidance from other national guidelines.[2][3]

1.2 Purpose of an RSU

- Provide a safe and effective environment to manage patients with complex respiratory disease or patients at risk of deterioration with acute respiratory disease.
- Allow patients with complex respiratory disease or at risk of deterioration to be co-located to concentrate multi-professional management.
- Bring multi-professional skills and experience together to bridge the gap between ward level care and critical care for patients with significant disease respiratory disease. This is defined as level 1.5 care.
- Facilitate robust governance processes for such patients, with the overarching aim that improved infrastructure, staffing and monitoring may result in improved patient outcomes.

1.3 Location, rooms and beds

The RSU is located on ward 20 at Glenfield Hospital. Ward 20 has 28 beds and of these 16 beds will be RSU specific bed spaces located in Bays A, B, and C and side rooms 1-4, with centralised cardiac monitoring and a higher nurse to patient ratio. The bariatric patients will be nursed closer to the fire doors in Bays A and B and SR 1-3, as per the recent fire officer's risk assessment. The remaining 12 beds are considered to be step down beds where the nursing ratio will be adjusted accordingly, taking into account the overall level of acuity of the patients and the ward at the time. Each of the 28 higher acuity beds has a wall-mounted cardio-respiratory monitor thereby ensuring there is sufficient capacity to expand the number of RSU level 1.5 beds during 'winter pressure' months should this be required, subject to having appropriate nursing staffing to provide the correct nurse to patient ratio.

1.4 Opening Times

The RSU operates 24 hours a day, 7 days a week. Patients can be admitted at any time of day or night but should not be discharged after 22.00hrs. Visiting hours for patient relatives are 2pm to 8 pm. Exceptions will apply in certain circumstances at the discretion of the Consultant and Nurse in charge. Access to the unit is via the Bay B area of CDU. Visitors are restricted to two per bed space.

1.5 Contact numbers

The main unit can be reached on:
Extension 12562

[1] Respiratory Support Units: Guidance on development and implementation. Intensive Care Society and British Thoracic Society, 2021
[2] BTS/ICS Guidelines for the Ventilatory Management of Acute Hypercapnic Respiratory Failure in Adults, Thorax, 2016
[3] NCEPOD, Acute Non-Invasive Ventilation: Inspiring Change (2017)

Extension 10422
Direct line 0116 250 2562/0422

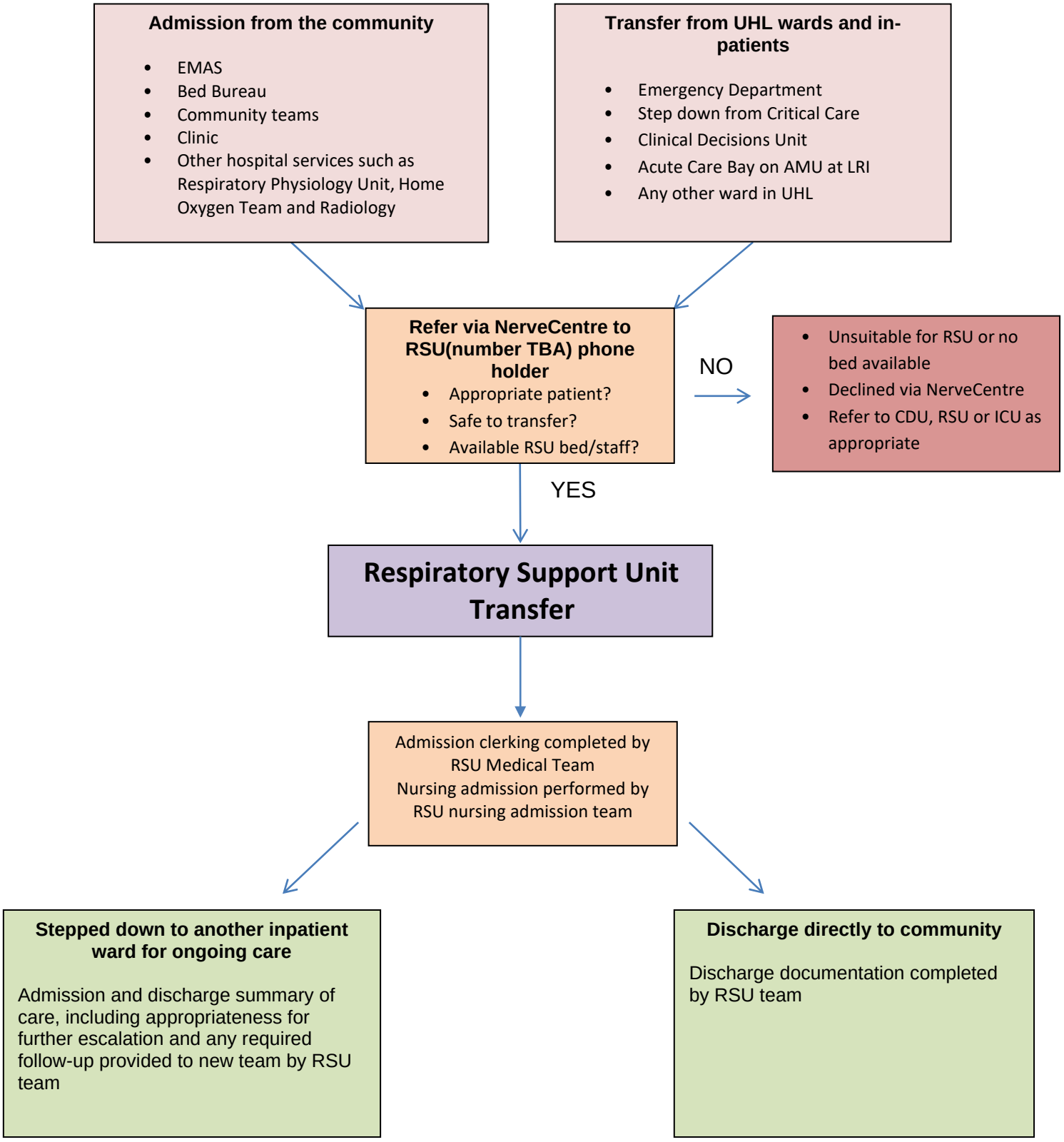
Doctor's office:
Extension 10421
Extension 12802

RSU SpR Mobile:
07931867929

Ward Sister's office:
Extension 10420

2. Guideline Standards and Procedures

Figure 1: Overview of admissions and discharges



2.1 Admissions

2.11 Sources of admissions and the referral process

Admissions to the RSU are to be agreed between the referring team and the senior decision maker on duty for the RSU. The senior decision maker is primarily the designated RSU registrar, contactable via dedicated mobile on number 07931867929 or by contacting the ward directly, with other senior decision makers including the RSU Consultant (during working hours) and the on-call Respiratory Consultant out of hours. For patients in ED the referral will be made electronically to the dedicated RSU mobile held by the SpR (or consultant during working hours) who will then call ED to discuss the referral, or accept the referral electronically. The referral should also be tagged to the RST mobile in addition. If there is a free bed available and the patient meets the criteria for admission then the bed status will be made "green" on NerveCentre and the patient can be transferred. The ward may need to make a bed move in order to make a free bed. If there is no possibility of a free bed in a timely manner the admission would be declined stating no bed was available on the RSU and an admission via CDU would be suggested. The referral process through CDU would be as it currently stands. Other referrals from CDU, other Glenfield wards or ACB at LRI can be made to the RSU SpR in person or via mobile (or RSU Consultant during working hours).

ITU step-down patients

- The RSU will also accept step-down patients from ICU with ongoing single organ failure, ideally requiring ongoing CPAP, HFO_2, BiPAP or additional monitoring. Verbal handover is required with the RSU SpR or consultant.
- Patients with new tracheostomy ventilation who are weaning from invasive ventilation on ITU should be emailed or phoned through to the RSU consultant for discussion with the wider ventilation team as review on ITU and more specific discharge planning will likely to be required.
- If the patient does not require any additional respiratory support the patient could be stepped down from ICU to a base respiratory ward.
- ICU patients should not be stepped down after 10pm in order to prioritise patient rest.

It is not acceptable for any non-clinical management team member to make a decision regarding admissions and allocation of beds within the unit.

2.12 Appropriate patient cohort

The RSU will provide cardiac and respiratory monitoring to patients with single organ failure requiring level 1.5 care. Prior to discussing the patient with RSU team, the referring clinician should consider the appropriateness of the level of care given the patients current conditions and the treatment escalation wishes of the patient. The decision to admit to the RSU should be based on the concept of potential benefit. Patients who are "too well" to benefit or those with no hope of recovery to an acceptable quality of life ("too ill to benefit") should not be admitted. This is a clinical decision based on individual circumstances. Equally those whose care exceeds or is likely to imminently exceed the care which is able to be provided within the RSU should be discussed and care for within the Critical Care Services. Patient autonomy should always be respected including any advanced care wishes and discussions around this (RESPECT forms) should be documented prior to referral to RSU. All admissions to RSU must be discussed and accepted by the RSU Respiratory registrar or Consultant.

Table 1: The patient cohort accepted for level 1.5 care on the RSU

	Patients suitable for transfer to the RSU
1	**Acute hypercapnic respiratory failure** • Exacerbation of COPD, or strongly suspected COPD, with acidosis persist (pH <7.35) after usual medical management of COPD • Neuromuscular disease (e.g. MND, muscular dystrophy, spinal injury) • Restrictive lung diseases (e.g. Kyphoscoliosis presenting with new acute respiratory issue with PCO2 > 6.5 , even without acidosis • Obesity hypoventilation +/- OSA (confirmed or suspected)
2	**Life threatening asthma as defined by BTS guidelines** • Aminophylline infusion with cardiac monitoring • Patients with normal/raised pCO_2 ± acidosis should be *simultaneously* referred to critical care
3	**Type 1 respiratory failure requiring >FiO_2 60% / 10l to maintain PaO_2>8kPa /sats >94%** • DART and respiratory support team should be made aware of the patient before transferring to RSU if for escalation • High flow oxygen, high flow nasal oxygen and CPAP can be started on the RSU. If the patient is for escalation to ICU then a consultant to consultant ICU referral should be made, or SpR to SpR with consultant discussion outside of working hours, unless a plan for escalation has already been made. • Patients who are for palliative care only could potentially be managed on a ward on 60% venture mask
4	**Massive Haemoptysis** • >100mL of haemoptysis in 24 hours not requiring airway protection on ITU
5	**Pulmonary embolism meeting criteria for thrombolysis or thrombectomy** • Patients with right heart strain requiring 24 hours observation prior to discharge can remain on CDU
6	**Complex home ventilation patients requiring admission** • By local arrangement, depending on bed pressures
7	**Patients with a tracheostomy +/- ventilation, laryngectomy, or with chest clearance requirements** • Patients who are self-caring with their tracheostomy / laryngectomy who don't have chest clearance or ventilation needs could be managed on any respiratory ward
8	**Patients not fitting any of the above criteria but deemed by a Respiratory physician (SpR/Consultant) as benefitting from closer respiratory monitoring on RSU** • Such as patients requiring frequent suctioning or respiratory physiotherapy input

Table 2: Patients who would not be suitable for care on the RSU

	Patients not suitable for care on the RSU
1	Patients in multi-organ failure where another location is more suitable, such as ITU for level 2or 3 care, CCU for inotropes, or for care of CVP or arterial lines
2	Patients receiving ventilatory support via an endotracheal tube, or <24 hours after extubation
3	Patients receiving **new** ventilatory support via a tracheostomy or laryngectomy unless usually invasively ventilated in the community

4	Tracheostomy or laryngectomy patients who either have no respiratory issues, or are self-caring and not ventilated
5	Patients requiring a CVP or arterial line
6	Patients with monitoring requirements for non-respiratory causes
7	Patients receiving **acute** renal replacement therapy

2.13 Critical care involvement

If a patient is felt to be for escalation to critical care and is deteriorating on the RSU then ITU consultant involvement should be sought early in the day. In the event of hypoxic respiratory failure increasing respiratory support through high flow oxygen, high flow nasal oxygen and up to CPAP can be provided out on the unit but close contact with ICU must be maintained as intubation and ventilation may be required. Such patients must have been reviewed by the respiratory consultant prior to ITU review. The RSU will be covered by a dedicated consultant Monday to Friday 9am to 5pm, and Saturday and Sunday 9am to 1pm. Outside of these hours, the CDU consultant should be contacted. If the deterioration occurs out of hours and the patient has not been seen by a respiratory consultant then a discussion over the phone between the on call SpR and on call consultant can be held prior to an SpR-led phone call to the ICU team. If a respiratory consultant has already reviewed the patient and made plans in the event of deterioration earlier in the day, and the ICU team have already provisionally agreed for escalation to ICU in the event of deterioration, then a call can be made straight to the ICU team.

2.2 Safety of inter-site transfer

Where an inter-site transfer is required for admission the safety of the transfer needs to be considered when deciding on the appropriateness of the admission to the RSU. The agreed safety standard for inter-site transfers can be found within the Adult Patient Transfer policy: http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Transfer%20and%20Escort%20-%20Adult%20Patients%20UHL%20Policy.pdf

The transfer for patients on non-invasive ventilation in the Emergency Department is covered in this policy: http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Hypercapnic%20Respiratory%20Failure%20UHL%20Emergency%20Department%20Guideline.pdf

Where the patient is not safe for transfer, the referring team should discuss the patient with the on-site Critical Care Services and teams providing high acuity care (including the Acute Care Bay) to stabilise the patient ahead of further consideration of transfer.

From the above guidelines and policies, the table below summarises the parameters that are **not** safe for inter-site transfer **without further discussion** with the RSU SpR or consultant.

Table 3: Patients not suitable for inter-site transfer to the RSU without further discussion

Patients requiring non-invasive ventilation	Patients on non-invasive ventilation and one of the following: • Agitated or uncooperative patient with non-invasive ventilation • pH <7.25 or falling despite treatment • Oxygen saturations <88% despite 60% or 15l oxygen via NIV • Respiratory rate >29/min or <11/min • Heart rate >130 bpm or <50 bpm • Systolic blood pressure <90mmHg or >180mmHg

Supplemental oxygen	Patients requiring >60% oxygen, especially if suitable for escalation to ITU EMAS / AMVALE cannot transfer patients on CPAP or high flow oxygen (see below)
High-flow oxygen or CPAP	Please note that currently UHL does not have any HFO_2 or HFNO devices that are suitable for transferring patients as they do not have batteries. Thus these patients are not safe for inter-site transfer
Heart rate and blood pressure	Heart rate >130 bpm or <50bpm Systolic blood pressure <90mmHg or >180mmHg
EWS ≥7 or rapidly increasing	The transferring team should also anticipate the care needs required at the receiving site and if necessary ensure that the DART team or intensive care team on that site are made aware of the transfer if the patient has an EWS of 7 or greater or if the EWS is rapidly increasing

2.3 Available resources

The required resources for successful transfer of a patient to the RSU includes:

- Available appropriate bed space dependent on infection status (as defined by standard Infection Prevention Protocols regarding admission to ward)
- A senior member of the nursing team (band 6 or above) with appropriate competencies, to provide leadership and co-ordination will be available on each shift
- Available appropriate staffing levels which will be dependent on the number of beds within the unit and the complexity of each patient, and needs to include the competencies and the skill mix of the ward staff on both day and night shift. The minimum nursing requirement is 1:4, but this varies for example increases to 1:2 for differing respiratory conditions including the use of HFO, CPAP and acute NIV usage and 1:1 for long term ventilation via tracheotomy. These staffing ratios must be maintained at night and during weekends.

2.31 Rapid Assessment Beds

To facilitate timely urgent admissions to the unit, two beds will be nominated as the rapid assessment beds for the RSU in order to maintain patient flow into the unit. These beds will remain empty unless there are extreme bed pressures such as Operational Pressure Escalation Level 3 or above. The RSU senior decision maker will aim to facilitate patient flow by way of daily ward rounds and identification of patients for step down from the RSU utilising the RSU Capacity flow chart included appendix 1.

2.4 Refusals of admissions

If a patient is refused admission for clinical reasons or lack of critical care capacity, and the referring team feels that this is inappropriate they can escalate their concerns to the on-call respiratory or RSU Consultant (during working hours).

2.5 Admissions, ward rounds & reviews

All new admissions must be clerked within 30 min of arrival to the RSU and must have a senior (Respiratory SpR or Consultant) review within an hour, and by a consultant within 14 hours. Patients who meet evidence-based criteria for acute NIV should start NIV within 60 min of the blood gas result associated with the clinical decision to provide NIV and

within 120 min of hospital arrival for patients who present acutely.[4] Clinical progress should be reviewed by a healthcare professional with appropriate training and competence. All patients treated with acute NIV should have ABG or CBG performed within 2 hours of starting acute NIV.
All RSU level patients must have a daily ward round and a second senior review, which may be in the form of a board round. There will be a morning handover each day where all patients will be discussed and the following will be highlighted:

- Any patient requiring urgent review
- Any patient on EOL care
- Any staffing related or other concerns
- Any planned discharges/step downs

A post ward round huddle should be carried out in an MDT meeting with the Nurse in charge, Respiratory Support Team, Physiotherapists and other allied health professionals present.

[4] BTS/ICS Guidelines for the Ventilatory Management of Acute Hypercapnic Respiratory Failure in Adults, Thorax, 2016

2.6 Discharges

The decision to discharge a patient from the RSU will be a clinical decision based made by the designated senior decision maker (RSU registrar or during working hours the RSU consultant). It is not appropriate for decision regarding discharge from the RSU to be made by non-clinical teams.

In order to maintain efficient patient flow through the RSU, patients deemed ready for discharge should be prioritised by bed managers for ward level beds, in a similar manner to patients fit for step down from critical care. Although most patients will be transferred to a lower acuity setting prior to discharge, some patients will be discharged home straight from an RSU.

Discharge planning normally would occur following MDT discussion and clinical ward round. However, where capacity is challenged, whilst every effort will be taken not to move patients overnight, discharges (in particular stepping down to other wards) may take place at any time. Where this is required, the RSU senior decision maker will assess all competing needs for resources and can utilise the capacity tool attached in appendix 1.

Where a patient is stepped down to another clinical ward, a discharge summary of the care including appropriateness for further trials of high acuity care will be given to the receiving team. If a patient is being discharged home, any discharge paperwork and follow up will be completed by the RSU team.

2.7 Workforce Model

Medical staff

- Daily consultant ward round for RSU level patients, 7 days a week
- Twice daily board rounds by senior decision maker (Consultant or SpR)
- There will be 24 hour SpR and junior doctor presence, 7 days a week. The RSU SpR will be the RSU senior decision maker and will be in charge of accepting referrals to the unit
- The doctors roles and responsibilities are the same as per respiratory base wards

Nursing

Matron

For a full description, please refer to UHL Matron Job description.

- Maintain clinical credibility/skills and have a visible presence on the RSU
- Ensure that RSU interests and concerns are represented at appropriate meetings
- Ensure equal focus on RSU (commensurate with nurse and medical staffing) in decision making within the CMG
- Provide leadership and support to the nursing team during change management to integrate new specialities and different ways of working
- Evaluate the design and monitor the implemented processes to ensure they are fit for purpose and audit quality and risk during change management
- Maintain oversight of the strategic development of the service

Ward Sister/Charge Nurse (Band 7)

- Maintaining safe staffing levels on a daily basis
- Actively engaging with the Consultant/SpR to with regards to patient plans, destinations and discharge decisions
- Provide leadership support to the RSU team
- Have an operational overview at all times
- Support and manage incidents and complaints
- Be available for patient/family consultations when required
- To be visible and provide leadership at all times

- Consult with Nurse in charge on the wards and Intensive Care Unit to ensure that patient flow is maintained in and out of the RSU
- Ensure any delays, patient issues and staffing shortages are escalated to the Matron, or in their absence the Matron of the Day
- To escalate to Gold /Tactical command, Service Managers and bed coordinators as needed in the event of delayed transfers of care

Nurse in Charge (Band 6/7)

- Leads on handover at beginning and end of shift and is responsible for nurse allocation.
- Liaison with the Matron/Band 7 for staffing issues or for any other advice or guidance
- The NIC role will be a supernumerary role to enable bed flow management and coordination of the ward
- Attend every senior ward/board round. Nerve Centre to be kept up to date with information patient in/outflow and escalation status
- Monitoring to ensure care is delivered and measured against key performance indicators
- Actively engage with the Consultant/ Registrar to advise re: patient plans, destinations and discharge decisions
- Ensure discharge plans are completed
- Provide source isolation care for infected patients
- Allocate breaks ensuring adequate staffing at all times. Making sure breaks start and finish on time
- Ensure efficient in/out flow of the RSU
- Assist and support patient concerns or complaints, and escalate appropriately
- Ensure all staff maintain a professional image, which includes ensuring the Uniform Policy is adhered to. Ensure that all staff have an ID badge
- Ensure safe storage of medicines in line with the Trust Medicines Management Policy
- Provide education and training

Deputy Sisters/Charge Nurses/Registered Nurse (Band 5/6/7)

- Provision of timely and appropriate nursing care to their named patients
- Responsible for updating their patients' location and level of dependency on Nerve Centre in a timely manner, including new arrivals
- Complete essential nursing risk assessments
- Escalation of any concerns regarding patient's condition or changes to the NIC
- Consulting with the doctors and team leaders in order to deliver patient care
- Complete treatments and give prescribed medication
- Ensuring patients are transferred to allocated wards or discharged in a timely manner
- Support unqualified team members, students, inexperienced staff, and post registration students
- Support patient relatives – providing them with advice and information pertinent to the patient's condition
- Provide palliative care to patients at end of life. Provide support to relatives, including involving them in care as appropriate and in accordance with patient's wishes
- Responsible for own education / development.
- Responsible for maintaining contractual obligations - sickness reporting, off duty, FWA

Registered Nursing Associates (Band 4)

- To provide bedside care for an allocated patient, under the supervision of a registered nurse
- Escalation of any concerns regarding patient's condition or changes to the NIC
- Liaising with the doctors and team leaders in order to deliver patient care
- Complete treatments and give prescribed medication, within the sphere of competency
- Ensuring patients are transferred to allocated wards or discharged in a timely manner
- Support patient relatives – providing them with advice and information pertinent to the patient's condition

- Provide palliative care to patients at end of life. Provide support to relatives, including involving them in care as appropriate and in accordance with patient's wishes

Health Care Assistant (HCA) Band 2

- Provision of timely and appropriate care to support the bedside nurse
- Support the provision of hygiene care
- Toileting as appropriate
- Cleaning and restocking bed spaces
- Talking to patients and their companions and making them comfortable
- Ensure patients have drinks and food as appropriate
- Support Ward Clerk with administration duties
- Order specialist beds and mattresses
- Infection prevention awareness
- Monitor and manage consumables
- Maintaining a safe and effective workspace
- Assist with internal hospital patient transfers both to wards and other departments such as imaging
- Communicate with NIC/nursing staff to prioritise workload and tasks to be completed

Housekeepers (Band 2)

- Restocking of the unit and bed spaces
- Making up clean bed spaces
- Ensure patients have drinks and food as appropriate
- Support Ward Clerk with administration duties
- Following health and safety guidelines
- Reporting lost or found items
- Auditing of kitchen areas inclusive of fridge temperatures
- Monitoring of water supplies
- Maintaining a safe and effective workspace

Ward Clerk (Band 2)

- Answering telephones and dealing with/escalating any issue to the appropriate person
- Ensuring that filing in the medical notes is up to date
- Ensure medical notes are stored safely
- Keep Patient Centre up to date to reflect which patients are on the unit
- Ensuring that the Critical Care Period Data is collected and inputted onto the system
- Ordering of stationery/paperwork for use on the RSU

<u>Respiratory Support Team</u>

The team consists of

- 1WTE 8b
- 1 WTE 8a
- 3.5 WTE B7
- 4.5 WTE B6

- 7 day service 8am to 8pm 365 days a year
- Contactable via bleep 2716 or mobile 07966 556715 or ext 12960
- Facilitating patient flow into and out of the RSU
- Assisting the senior decision makers with patient admissions to the RSU
- Supporting the Consultant to assess the suitability for transfer of patients invasively ventilated via a tracheostomy on the Intensive Care Unit to the RSU for long term ventilation and/or weaning
- Daily reviews of all patients requiring respiratory support on the RSU, CDU and other wards at Glenfield
- Remote outreach support will be provided to ACB, ED or any other wards as required for advice on optimising respiratory support but ultimately the aim will be to highlight patients

to the RSU senior decision maker for admission to the RSU. A face to face review on other sites would require additional funding
- Setting up, monitoring, weaning and titrating acute and long term ventilation (BiPAP)
- Setting up acute CPAP and high flow nasal oxygen (Or supporting other health professionals with appropriate competency)
- Providing teaching and training to the multi-disciplinary team
- Providing teaching and training to patients and both informal and formal carers as appropriate taking responsibility for the delegated health task and signposting to the long-term ventilation team for on-going access to training and competency as required

Physiotherapy

The RSU will be staffed by the following physio grades:

- 1WTE Band 7
- 1.68 WTE Band 6
- 1 WTE Band 6 (rotational)
- 1 WTE B5 (rotational)
- 1 WTE B3

Service is currently provided:

- Monday to Thursday 08:00am–20:00pm
- Friday 08:00am - 18:00pm
- Weekend/Bank holiday service is 08:30am–16:30pm during which time a physiotherapist will be available to see the priority patients
- The Physiotherapy Emergency On-call Service is an out of hours emergency respiratory service available 7 days a week, for patients who require emergency respiratory intervention (treatment response time within 45 minutes) between the hours of 16:30pm and 08:30am the following day. Referral is made via Switchboard by the doctor on call or nurse in charge.

The physiotherapy team will support with:

- airway clearance
- tracheostomy management
- lung volume recruitment
- breathlessness management
- rehabilitation and discharge planning

- The physiotherapists will also have an active role in oxygen therapy and patients with respiratory failure including high flow/CPAP/ NIV
- Referrals will be via daily MDT board round and face to face referrals on the ward
- The physiotherapy team will also fully self-screen the ward in the morning prior to board round

Occupational therapy

The RSU will be staffed by the following Occupational Therapy grades:

- 1 WTE Band 7
- 1 WTE Band 6

Service is provided:

- Monday - Friday 08:00am-16:00pm
- Weekend / Holiday 08:00am - 16:00pm

-Access to Occupational Therapy is a prioritised service on weekends and bank holidays
-Referrals will be via daily MDT board round and face to face referrals on the ward

-The team will also fully self-screen the ward in the morning prior to board round

The occupational therapy team will support with:

- Early rehabilitation of patients
- Seating and positing of patients
- Completing physical, cognitive and daily living assessment
- In order to maintain efficient patient flow through the RSU the occupational therapy team will be involved in the discharge planning of patients, completing assessment and refer onto the community services and social services team in order to facilitate and support with discharge

Dietetics

The dietetics team will consist of:

- 1.2 WTE band 7
- 0.13 WTE band 6

The post will also look to set up metrics and dietetic outcomes for unit
-The Dietetic and Nutrition Service is open Monday to Fridays between 8am and 4pm and can be contacted on telephone 0116 2255280
-All inpatients should be referred electronically on ICE
-The team will provide Nutrition Support including nutritional screening, nutritional assessment and interventions such as oral nutritional support and enteral tube feeding
- Support of RSU staff with nutritional care eg: implementing first line oral nutritional support pathways
- Specialist diet interventions used to control diseases include renal, liver, gastro & diabetes therapeutic diets
- Complex enteral nutrition, including those patients being considered for or with an established enteral feeding tube
- Contribute to discharge planning especially patients going home on enteral tube feeds
- Participation in the RSU MDT meetings
- Involvement with education/teaching/audit/guideline and policy development as relevant
- For inpatient menus standard and support menus see Ward Catering Folder
- For starter protocols e.g. enteral tube feeding see Guidelines on Insite
- For enteral feeding system e.g. enteral giving sets, syringes provided by Materials Handling please speak to Materials Management

Speech and language therapy (SALT)

The SALT team will consist of:

- 1 WTE Band 7

-RSU will have access to a speech and language therapist five days a week during working hours
-All patients with a tracheostomy must have communication and swallowing impairment assessed by a competent tracheostomy trained Speech and Language Therapist
-All critically ill patients who have communication and/or swallowing difficulties (dysphagia) will have timely access to an SLT service
-
Patients should have access to a communication aid according to individual need to facilit ate patient interaction and rehabilitation
-
Swallowing and communication recommendations and treatment plans should be include d in both the medical and nursing handover when the patient is transferred to differing wards or discharged home

-Patients should have access to instrumental swallow assessment such as Videofluoroscopy or Fibreoptic Endoscopic Evaluation of Swallowing (FEES)

Pharmacy

The RSU Pharmacy Team will comprise the following:

- Band 8A Advanced Specialist Pharmacist – 1.23 WTE
- Band 5 Medicines Management Technician (MMT) – 0.6 WTE

Monday-Friday (9am-5pm)

-The pharmacist will work in collaboration with the MMT to ensure timely completion of medicines reconciliation

- Daily clinical pharmacy check and review of the inpatient drug charts ensuring availability of supplies of prescribed medicines to minimise missed doses of critical and high risk medicines
- Attendance at board / ward round
- Involvement in daily MDT meetings post morning ward round
- Involvement in all matters relating to medicines optimisation i.e. medicines management, safety and governance
- Support safe and timely discharge via involvement in discharge planning, patient counselling, medication reviews and processing TTOs prior to discharge either to a lower acuity setting/ward or straight home (depending on the discharge pathway)
- Provide specialist prescribing and medication advice
- Support in the development of relevant clinical policies and guidelines for the RSU
- To work in close collaboration with the critical care pharmacy team and provide specialist pharmacist advice as appropriate for patients discharged from the RSU to a lower acuity ward
- Attendance at relevant meetings as a pharmacy representative of the RSU
- Work closely with RSU staff and the wider MDT in the provision of a specialist clinical pharmacy service for the RSU patients

Saturday, Sunday and Bank Holidays

-Pharmacist and MMT visits to wards do not occur at weekends

-Glenfield Pharmacy Department's core opening hours are:

- Monday to Friday 9:00am to 6:00pm
- Saturday 9:00am to 12:30pm
- Sunday and Bank Holidays 10:00am to 12:30pm

-Outside of these hours the on-call pharmacist is available 24/7 via Switchboard for urgent medicines information and medicines supplies

TTO process

-The Pharmacy department works to a 2-hour turnaround time for TTO medication (2 hours from the time an authorised TTO is received into the department)

-All inpatient requests and TTOs will be prescribed via the Trust supported electronic prescribing system

-TTO requests will be recorded on the Pharmacy Prescription Tracking System (PTS) and their progress will be available to view on-line via individual ward log-in

Stock management

Weekly top-ups will be provided by the pharmacy replenishment team

Controlled drugs

-Supplied via the main dispensary

-Requests for controlled drugs will only be processed upon receipt of an appropriately written and signed TTO prescription or controlled drug order book

The Trust is working towards the implementation of the Optimed system of closed loop medication supply and has started the roll-out process at the Leicester Royal Infirmary.

Specialist Palliative Care

-Patients on the Respiratory Support Unit will be referred, triaged, assessed and managed in keeping with the UHL Specialist Palliative Care SOP
-After recruitment there will an annualised average of 6 hours/week Specialist Palliative Care Consultant time dedicated to the RSU, delivered within Monday-Friday 9-5pm. The role of this consultant will include:

- Weekly specialist palliative care input into an RSU board round
- Patient and family reviews and multidisciplinary meetings relating to assessment and planning of complex palliative care needs during their inpatient stay or for key transition points in their care
- Examples of this will include a shared role with the wider MDT about ethical decision making, advanced care planning and liaising about specific community or hospice specialist palliative care interventions

Critical Care

- The Critical Care Team can be accessed via DART (bleep 2808), via bleep 2710
- Daily ward rounds are not required but the RSU will have close links to the critical care team for patient's suitable for, and requiring, escalation to ITU
- The ICU team will communicate with the RSU team regarding patients who are suitable for step down to the ward, and a verbal and written handover will be provided

Tracheostomy Nurse Support Team

- The Tracheostomy service
    - 1.0 WTE Band 7
    - 1.0 WTE Band 6
- Work Monday-Friday (8am-4pm)
- Referrals can be made via phone: 07984235993
- Currently provide 2 ward rounds a week at Glenfield
- Review all tracheostomy patients and support with anything tracheostomy related from routine tube changes, upsizing, downsizing, trouble shooting, weaning plans, decannulation and discharge planning

Respiratory Physiology Team

- Service is provided Monday–Friday 08:30–16:30
- Weekends / Bank Holidays –currently not supported
- Highly Specialised Respiratory Physiologist will be the lead for Service Delivery and responsible for training
- Senior Respiratory Physiologist to provide support, ensure continuity of service and personal development

The physiologist will:

- Provide support in setting-up and monitoring patients on non-invasive ventilation
- Provide an essential link for those patients transitioning from acute to chronic ventilation
- Demonstrate in depth specialist knowledge, skills and innovative practice

- Support the multi-disciplinary team in resolving complex patient problems, by the provision of new innovative models of case management
- Review long-term NIV and CPAP users on the RSU, demonstrating appropriate expert practice and specialist advice in the assessment, planning and implementation of care
- Perform blood gas analysis to assess patients respiratory status and titration of oxygen or NIV requirements
- Initiate, review and adjust treatment for patients on NIV based on patients individualised requirements
- Transition patients from acute to long-term NIV and provide appropriate education to patients and/or carers prior to discharge
- Provide inpatient sleep studies and/or CPAP setups where appropriate
- Provide inpatient respiratory tests where appropriate
- Provide specialist physiologist support in partnership with the multi-professional team to enhance standards and best practice of care across the acute and LTV service
- Ensure appropriate outpatient follow up for those discharged with LTV
- Ensure quality of the physiology service provision within the acute setting
- Provide support and training to the wider team to ensure they are competent with the different devices/interfaces we use

Research

A culture of research will be embedded within the RSU and on-going research will form part of the daily morning briefing.

Safety

A twice daily safety briefing, using the available checklists, will be done at the morning briefing and at the huddle.

MDT Mortality review

There will be a monthly morbidity and mortality (M&M) process in place to provide a rapid case review of inpatient death of patients treated with (or considered for) acute NIV/CPAP/HFNO/HFO_2. This process will be carried by the medical ward team and RSU leads and the case review will be held monthly for the whole ward. Learning points, processes and pathways will be reviewed as well as case reviews, and escalation to the departments quarterly M&M will be made as required.

3. Education and Training

All new nursing staff appointed to RSU must be allocated a period of supernumerary practice to allow adequate time for Registered Nurses to develop basic skills and competencies assessed to ensure they can safely care for a respiratory requiring enhanced care. Where direct care is augmented using non-registered support staff, appropriate training and competence assessment must be provided. The skill set of Registered Nursing staff working in this environment will have common ground to some of the Critical Care nursing competencies.

An appropriate competency document will be developed by combining existing competency packages to support and monitor the development of competency of all staff working on RSU. To support this, a rolling teaching programme will be developed for staff working on RSU. Over time it will be expected that competencies and skills will develop to allow nurses to care for any patient within the RSU no matter their care requirements.

The RSU team must have the necessary competencies relevant to managing patients requiring enhanced care. All junior and middle grade medical staff will have access to appropriate clinical support from the RSU SpR or Consultant on call.

4. Monitoring Compliance

The Respiratory Support Unit will sit within and be accountable to the Renal, Respiratory, Cardiac and Vascular Clinical Management Group. However, it is recognised that like, Critical Care, the RSU will look after a subset of patients with higher acuity than the general wards, and may share some common issues of gatekeeping, staffing, skills and quality management. As such, the RSU should engage as fully as possible with Trust-wide mechanisms for higher care areas such as the Trust Critical Care Delivery Group. There may be some aspects of these groups that may not be relevant to an Enhanced Care area, but in general, service delivery and governance will benefit from engagement and shared planning and learning in areas of commonality.

The leadership governance of the GH RSU service will be led by the appointed RSU lead, a respiratory consultant with some clinical oversight, and the RSU Matron. This leadership team will collectively manage the following for their service:

- Activity
- Performance
- Workforce
- Clinical and Service Development
- Finance – each speciality will retain the budget and associated income for their respective services

Local outcomes will be continuously monitored. The RSU will participate in national audit and data collection, such as the British Thoracic Society RSU Audit and the BTS NIV Audit. This will allow for comparison of local vs national data and will be important for outcome evaluation, mortality predication and research.

5. Supporting References (maximum of 3)

http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Transfer%20and%20Escort%20-%20Adult%20Patients%20UHL%20Policy.pdf

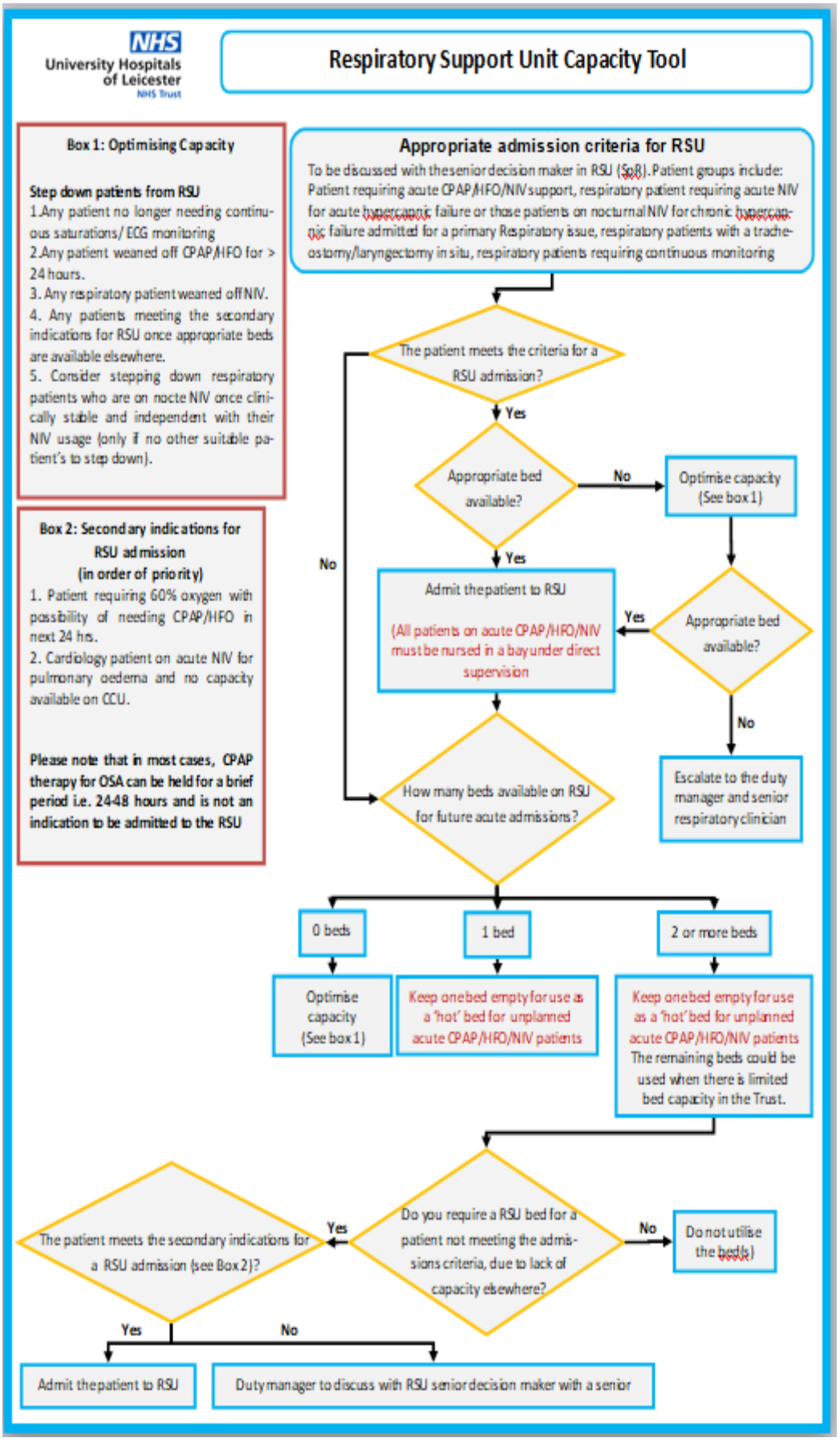
http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Hypercapnic%20Respiratory%20Failure%20UHL%20Emergency%20Department%20Guideline.pdf

6. Key Words

- Respiratory Support Unit
- RSU

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) **Dr Charlotte Swales – Head of Service for Respiratory and Allergy**	**Executive Lead** **Karen Jones – Head of Operations RRCV**
Details of Changes made during review: **N/A**	

APPENDIX 1: RESPIRATORY SUPPORT UNIT CAPACITY TOOL



APPENDIX 2: FIRE OFFICER ASSESSMENT 2023

fire risk assessment RSU Aug 23.pdf