Royal Cornwall Hospitals
NHS Trust

Oxygen Policy Child Health

V4.0

July 2023

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. The administration of supplemental oxygen is an essential element of appropriate management for a wide range of clinical conditions; however, oxygen is a drug and therefore requires prescribing in all but emergency situations. Failure to administer oxygen appropriately can result in serious harm to the patient. The safe implementation of oxygen therapy with appropriate monitoring is an integral component of the Healthcare Professional's role.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

The purpose of this policy is to ensure that:

- All in-patients who require supplementary oxygen therapy receive therapy that is appropriate to their clinical condition and in line with national guidance.
- Oxygen is prescribed according to a target saturation range. The system of prescribing target saturation aims to achieve a specified outcome, rather than specifying the oxygen delivery method alone.
- The multidisciplinary team administer and monitor the patient in keeping with the target saturation rate.

3. Scope

3.1. This policy applies to and is implemented by all health care staff who are involved in the prescribing and delivery of Oxygen therapy.

3.2. All patients in Child Health who are receiving Oxygen Therapy will be affected.

4. Definitions / Glossary

O2- Oxygen.

Spo2- Peripheral capillary oxygen saturations.

Co2- Carbon Dioxide.

FiO2- Fractional inspired oxygen.

NNU – Neonatal Unit.

CPAP – continuous positive airway pressure.

BIPAP – Bi-level positive airway pressure.

5. Ownership and Responsibilities

5.1. **Line managers are responsible for:**

Disseminating policy to all relevant staff, ensuring they have appropriate

resources including equipment, documentation to allow staff to comply with this policy. All staff members are responsible for reading and complying with Trust Policy.

5.2. It is the responsibility of each ward/ unit manager to ensure that:

- Qualified nurses, student nurses & healthcare assistants are familiar with and follow the current Clinical Practice Guidelines – Patient Assessment and Monitoring and the Paediatric Early Warning tool guidelines.

- All nurses, students, and healthcare assistants (who undertake observation and monitoring) are trained and competent in the accurate recording of all vital signs: blood pressure, pulse rate, respiratory rate and temperature and must have completed online EObservation training where necessary.

- Health Care Support Workers must attend an Observations and monitoring /Pews teaching session with Child Health Practice Development team and complete the Infant and Child Observations sections and tests on Clinicalskills.net. Following this, 'The Assessment and Recording of Patient Observations and PEWS supervised practice and assessment workbook.' Must be completed and signed off in the ward setting.

- Staff who use continuous ECG and/or pulse oximetry are trained in the use of this equipment and appreciate the equipment's limitations.

- Varying sizes of age appropriate equipment (including disposables) are readily available for the above to be undertaken with ease.

- Monitors and equipment are kept in good condition, with regular planned servicing by the medical physics department.

- Defective equipment is withdrawn immediately from patient use and sent to medical physics. (Trusts Medical Device Policy).

- Appropriate observation recording device or charts incorporating the Paediatric Early Warning tool are readily available to record the observations on paediatric wards.

- An appropriate level of staffing is in place to ensure that an adequate level of observation is facilitated (determined by the child's clinical status). In children requiring higher frequency of observations, the patient caseload of the nurse caring for this child/ children may need to be reorganised to enable him/her to undertake this level of monitoring effectively.

- If staffing is not adequate to meet this need, the matron/senior nurse bleep-holder must be notified immediately, and the escalation policy followed.

5.3. It is the responsibility of all ward staff to inform and educate the child/young person, parents, family, and carers about the hazards of oxygen. Oxygen is highly combustible Fuel/O2/Heat/Ignition; there is always the risk of fire. RCHT is a smoke free site, and this should be made clear to all patients and their families.

Please also refer to The Child Health Observation and Monitoring Policy.

6. Standards and Practice

6.1. Safety and Storage

All equipment should be clean, safe, working and in good repair which includes medical gas pipeline installations.

6.2. General Principles

6.2.1. Ensure equipment is serviced regularly by the manufacturer.

6.2.2. Follow manufacturer's maintenance/cleaning instructions of all equipment.

6.2.3. Liquid oxygen cylinders should always be stored upright.

6.2.4. Gas oxygen cylinders may be stored on their sides.

6.2.5. Oxygen cylinders should be fixed or placed in a holding device to prevent movement and damage to the cylinder.

6.2.6. Where possible keep oxygen equipment out of the reach of children.

6.2.7. Take care when moving oxygen equipment and handle oxygen cylinders with care, especially at the collar.

6.2.8. Never use oxygen near a naked flame i.e., birthday cake candles.

6.2.9. Avoid grease or oil coming into contact with oxygen equipment.

6.2.10. Never use paraffin based products such as Vaseline, aerosols, sprays or oil based makeup/sun creams as they are flammable with oxygen. Use water based creams instead.

6.2.11. Keep masks and nasal cannulae as clean as possible, change regularly when the child has lots of secretions or a respiratory infection.

6.2.12. Check expiry date on collar of the oxygen cylinder before use.

6.2.13. Check for leaks, especially at attachment sites.

6.2.14. Check oxygen tubing each shift for signs of damage, kinking, flattening, and splitting replace immediately.

6.2.15. Take care that oxygen tubing does not become trapped in cots, highchairs, pushchairs, wheelchairs, furniture etc.

6.2.16. Thread oxygen tubing through the child's clothing to avoid the tubing wrapping itself around the child.

6.2.17. Have spare equipment - oxygen cylinders, masks, nasal cannulae, tubing etc.

6.2.18. Check oxygen cylinder contents gauge, red usually indicates empty.

6.2.19. Turn off oxygen when not in use.

6.2.20. Report incidences and near misses via the Trust Incident Reporting system and to the manufacturer/supplier.

6.3. Infection Control

6.3.1. Equipment used in delivering oxygen can contribute towards the child/young person developing a respiratory infection by acting as a reservoir for the growth of micro-organisms.

6.3.2. Keep oxygen equipment clean, dust free, safe, working and in good repair.

6.3.3. Follow manufacturer's instructions regarding cleaning and disinfecting equipment.

6.3.4. Wash hands prior to handling oxygen equipment.

6.3.5. Wear Personal Protective Equipment where appropriate/according to Manufacturers and NHS Trust Policy.

6.3.6. Check at initial assessment and in line with the pressure ulcer risk assessment scale in Child Health Risk assessment Pack CHA2957 the condition of the skin of vulnerable areas, behind the ears, face, nose, lips and the mouth. Protect these areas with suitable dressings, tape. Seek advice from tissue viability team where score dictates.

6.3.7. Keep patient lips and mouth moist and maintain good oral and dental hygiene.

6.3.8. Check oxygen equipment daily for damage, discoloration, soiling, tampering, (note expiry dates).

6.3.9. Drain condensation inside oxygen equipment.

6.3.10. Change humidification apparatus, oxygen masks, oxygen nasal cannulae, oxygen tubing and oxygen filters as instructed by the manufacturer.

6.4. **Cautions and Hazards**

Oxygen administration and carbon dioxide retention

In patients with chronic carbon dioxide retention, oxygen administration may cause further increases in carbon dioxide and respiratory acidosis. This may occur in patients with the following conditions.

- Neuromuscular disorders.
- Cystic Fibrosis.
- Morbid obesity.
- Musculoskeletal disorders.

There are several factors which lead to the rise in CO2 with oxygen therapy in patients with hypercapnoeic respiratory failure. Details are in the BTS guideline. These patients should have their target saturations prescribed as per table in 6.2.1

- In certain cardiac conditions oxygen (due to its pulmonary vasodilating effect) can increase left to right shunting and increase pulmonary blood flow leading to gradual increased breathlessness.
- Examples of such left to right shunts would primarily be young infants with large unrestrictive VSDs awaiting surgical repair. Other more complex congenital cardiac conditions involving large VSDs may have similar concerns but would need to be discussed with medical staff and a plan for oxygen put in the care plan.

Contra-indications

There are no absolute contraindications to oxygen therapy. The goal of oxygen therapy is to achieve adequate tissue oxygenation using the lowest possible FiO2. Supplemental oxygen should be administered with caution in patients suffering from chemical poisoning (BNF 2005) and with acid inhalation or previous bleomycin lung injury.

Hazards/ Complications of oxygen therapy

- Drying of nasal and pharyngeal mucosa.
- Oxygen toxicity.
- Absorption atelectasis.
- Reduced respiratory drive in patients with chronic respiratory failure.
- Skin irritation or Pressure Sores – all oxygen equipment used on patients must be documented and scored on the Pressure Ulcer Risk Assessment Scale in the Child Health Risk Assessment Pack. CHA2957.
- Fire hazard.
- Potentially inadequate flow resulting in lower FiO2 than intended due to high inspiratory demand or inappropriate oxygen delivery device or equipment faults.
- Retinopathy of Prematurity.

6.5. Prescribing

6.5.1. Oxygen is a drug and must be prescribed in all situations other than in an emergency where its use must be documented in the patient's medical notes. See section 6.8 Emergency situations.

6.5.2. Oxygen must be prescribed on EPMA and signed for by the prescriber as a PRN drug. It must include target oxygen saturations and route of administration i.e., Inhaled.

6.5.3. EPMA must be signed at each nursing handover by the nurse taking over care of the child or supervising untrained staff for administration of oxygen.

6.6. Identifying appropriate target saturations

6.6.1. When prescribing oxygen, it should be to achieve target saturations for the following patient groups. Choose from the following categories on EPMA:

PAED- Acutely unwell patients	94-98%
PAED- Patients at risk of hypercapnoeic respiratory failure	93-95%
ED Asthma < 5 years	94-98%
ED Asthma 5-18 years	94-98%
ED Anaphylaxis 6 months-6 years	94-98%
ED Anaphylaxis 5 -12 years	94-98%

Please see separate neonatal Oxygen policy for guidance for neonatal patient groups:

http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Neonatal/OxygenTherapyAndSaturationMonitoringOfTheNeonate.pdf

6.6.2. Variations to the usual targets must be discussed at the time of prescription with medical staff.

Management of Bronchiolitis: (as per NICE guidance 2021) – ref: 1 Recommendations | Bronchiolitis in children: diagnosis and management | Guidance | NICE

- Oxygen supplementation should be given to babies and children with bronchiolitis if their **oxygen saturation is either persistently less than 90% (age 6 weeks or over) or persistently less than 92% for babies under 6 weeks** (or children of any age with underlying health conditions.

6.6.3. The oxygen flow rate should be increased if the saturation is below the desired range and decreased if the saturation is above the desired range and eventually discontinued as the patient recovers. Any sudden fall in oxygen saturation levels in an acutely unwell child should lead to the clinical evaluation of the patient and consideration of the measurement of blood gases.

6.6.4. Unexpectedly persistent oxygen saturation levels of less than 90% should be reported immediately to the medical team.

6.7. **Administration**

Oxygen administration

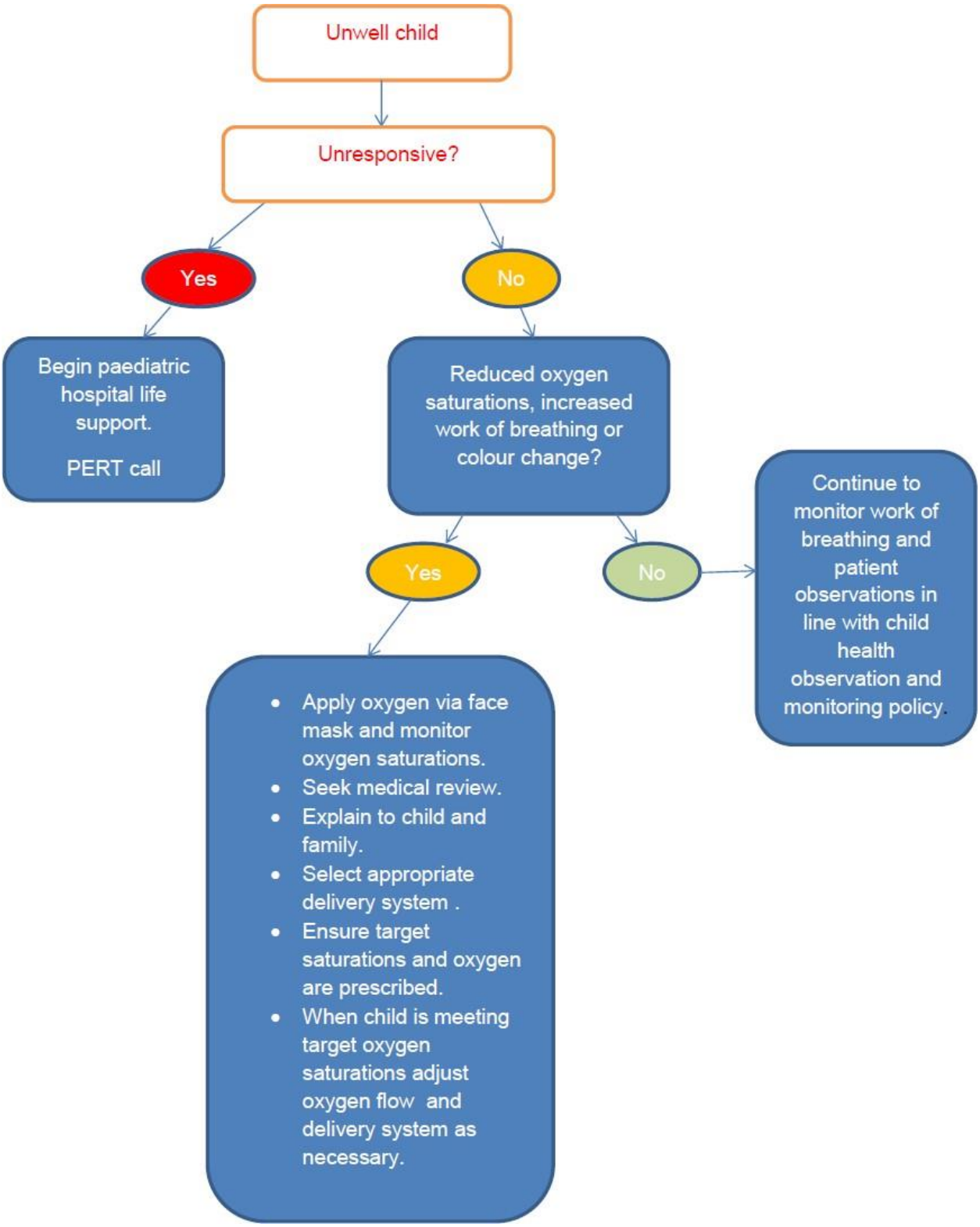
6.7.1. The method of oxygen administration will depend on the amount of oxygen required by the child.

6.7.2. Please follow the guidance to select the correct method of oxygen administration to achieve target saturations as prescribed. When possible/ appropriate deliver oxygen to paediatric in-patients though a heated and humidified circuit.

6.7.3. Prior to applying the delivery system for the oxygen fully explain the process to both the child and family.

6.7.4. Oxygen administration flow chart and table- see administration flow chart and table on next pages:

Oxygen Administration Flow Chart



Oxygen Administration Table

Method of Administration	Age of Child/ Size Guide	Situation to Use Administration Method	Rate of Running Oxygen	Checks	Equipment
Non re-breath mask (single patient use only).	Adult, child, and neonatal sizes available. To fit from the bridge of the child's nose to below their bottom lip.	When a child is requiring high concentration of oxygen.	15 litres of oxygen per min.	That the bag fits correctly. That the reservoir is full prior to placing on the child's face. Ensure a seal around the child's face adjust the elastic straps if needed. Monitor pressure areas from the mask.	Oxygen tubing. Appropriate size rebreath mask. Continuous monitor for heart rate and sao2.
Face masks (single patient use only) .	Adult, child, and neonatal sizes available. To fit from the bridge of the child's nose to below their bottom lip.	If the child is not tolerating nasal cannula oxygen. If requiring over 5 litres of oxygen per min.	Above 5 litres. Heated and humidified.	That the mask fits the child appropriately. Ensure a seal around the child's face adjust the elastic straps if needed. Monitor pressure areas from mask.	Oxygen tubing. Appropriate size face mask. Continuous monitor of heart rate and oxygen saturation.

Method of Administration	Age of Child/ Size Guide	Situation to Use Administration Method	Rate of Running Oxygen	Checks	Equipment
Nasal cannulae.	Adult, child, and neonatal sizes available. In paediatric and neonatal patients, the tips of the nasal cannulae should not sit any further than 0.75cm into their nose.	When a child requires oxygen from 0.1- 6 litres to maintain target saturations.	0.1 to 6 litres of oxygen. Please ensure that a high flow oxygen point remains available when delivering low flow oxygen. Heated and humidified.	The nasal cannulae are an appropriate size. Secure in the correct place with tape when appropriate. To check pressure areas on the child from the tubing.	Oxygen tubing. Correct size nasal cannulae. Tape and barrier cream if required to secure. Continuous monitor of heart rate and oxygen saturations.
Tracheostomy mask.	Adult, child, and neonatal sizes available. To fit comfortably over the child's tracheotomy.	If the child has an oxygen requirement.	To run at an appropriate oxygen flow depending on the target saturations prescribed. To heat and humidify. If not heated and humidified to give regular saline nebulisers to prevent drying of any secretions.	To ensure the correct size of oxygen mask is selected. That it is securely fitted. That pressure areas are checked regularly.	Oxygen tubing. Heated and humidified oxygen circuit. When using low flow delivery point ensure high flow oxygen point available at all times. Appropriately sized mask. Continuous monitoring of heart rate and saturations.

Method of Administration	Age of Child/ Size Guide	Situation to Use Administration Method	Rate of Running Oxygen	Checks	Equipment
Nebulisers.	Adult, child, and neonatal sizes available. To fit from the bridge of the child's nose to below their bottom lip.	When the child required a nebulised drug.	6-8 litres of oxygen. Portable oxygen cylinders are not to be used to deliver the nebulised drug in these situations use an electrical compressor wall oxygen with meter.	That the mask fits the child appropriately. Ensure a seal around the child's face adjust the elastic straps if needed. Monitor pressure areas from mask.	Oxygen tubing. Appropriate size face mask. An acorn nebuliser. Continuous monitor of heart rate and oxygen saturation. To be aware of drugs that need to be vented to the outside when delivered and the need to use a suitable compressor for nebulising antibiotics.
Wafting oxygen.	Adult, child, and neonatal sizes available. To have the face mask placed approx. 35cm from the child's face.	**For short term temporary use only:** If the child is feeding. When the child does not tolerate the face mask or nasal cannula.	A rate of 10 litres of oxygen provides the child with approx. 30-40% oxygen	That the face mask is fitted safely to the child's top. Parent and child both aware this it is not the long term chosen method of administration.	Green oxygen tubing. Face mask of the appropriate size. Tape to secure mask to the child's top. Continuous monitor of heart rate

Method of Administration	Age of Child/ Size Guide	Situation to Use Administration Method	Rate of Running Oxygen	Checks	Equipment
					and oxygen saturations.
Heated Humidified High Flow Nasal Cannula Oxygen.	Please refer to Bristol Royal Hospital for Children High Flow Oxygen Guideline – link in Appendix 1.				
CPAP/BIPAP.	Please refer to Bristol Royal Hospital for Children Acute Non-invasive Ventilation Guideline – link in Appendix 1.				

6.8. **Emergency Situations**

6.8.1. In the emergency situation an oxygen prescription is not required. Oxygen should be given to the patient immediately without a formal prescription or drug order but documented later in the patient's record.

6.8.2. All peri-arrest and critically ill paediatric patients should be given 100% oxygen (15 l/m using a non re breathing mask with a reservoir bag) whilst awaiting immediate medical review.

6.8.3. Patients with Cystic Fibrosis and other risk factors for hypercapnia who develop critical illness should have the same initial target saturations as other critically ill patients pending the results of urgent blood gas results after which these patients may need controlled oxygen therapy or supported ventilation if there is severe hypoxemia and/or hypercapnia with respiratory acidosis.

6.8.4. In Neonatal emergencies Oxygen should be administered according to Newborn Life Support and Neonatal guidelines.

6.8.5. All patients who have had a cardiac or respiratory arrest should have 100% Oxygen provided along with basic/advanced life support.

6.8.6. A subsequent written record must be made of what oxygen therapy has been given to every patient alongside the recording of all other emergency treatment.

6.8.7. Any qualified nurse/ health professional can commence oxygen therapy in an emergency situation. This will be in line with local policies within the relevant clinical area.

6.9. **Exclusions**

- Patients admitted to specialist areas with a specialised oxygen prescribing policy.
- Patients receiving oxygen as part of palliative care or patients on the end of life care pathway (in which case, the prescriber should note 'target saturations not indicated' on EPMA system).
- Patients admitted for Long Term Oxygen Therapy or non-invasive ventilation assessment.

6.10. **Monitoring and Documentation**

6.10.1. The method of oxygen administration and the amount of oxygen delivered must be recorded along with an oxygen saturation reading and the child's respiratory rate on E observations or PEWS chart.

6.10.2. Children who are requiring oxygen must be on a continuous saturation, monitor, the probe site should be changed 2-4 hourly to prevent marking. Probe changes must be documented, including the position of the probe. A saturations probe must be documented as hospital equipment on the Pressure Area Risk Assessment and core care plan commenced.

6.10.3. When discontinuing oxygen therapy or weaning a child from oxygen, continuous saturation monitoring must continue, followed by frequent observations as indicated by the patient's condition and in line with the Child Health Observation and Monitoring Policy. If a child is trialing discontinuation of oxygen, monitoring when asleep is essential as this is when desaturation most often occurs.

6.11. **Respirations**

6.11.1. Variations in respiratory rate and patterns of breathing in a child or young person can be a marker for a wide range of changes in a child or young person's condition, from increasing oxygen requirements to increased pain and anxiety. Simply observing the breaths per minute is not sufficient. The pattern, effort and rate of breathing should be observed. Skin colour and any traumatic petechiae around the eyelids, face and neck should be observed.

6.11.2. Observe abdominal movements in infants and children of less than seven years of age because they are predominantly abdominal breathers.

6.11.3. Due to often irregular patterns, effort and rate of breathing, count respirations for a full minute for accuracy.

6.11.4. Signs of respiratory distress e.g., nasal flaring, grunting, wheezing, dyspnoea, recession, and use of accessory and intercostal muscles, chest shape and movement should be noted by looking and listening and documented.

6.11.5. Normal Respiratory Rates

Age (years)	Respiratory Rate (breaths/min)
<1	30-40
1-2	25-35
2-5	25-30
5-12	20-25
>12	15-20

6.12. **Oxygen Saturation monitoring**

6.12.1. To ensure equipment is suitable for use, make sure the probe and monitoring equipment /module is clean and in good working order.

6.12.2. Ensure monitor performs self-calibration checks prior to patient connection plug in monitor and probe.

6.12.3. The practitioner must wash hands and use appropriate PPE prior to patient contact.

6.12.4. Ensure correct type and size of probe is selected for the infant or child.

6.12.5. Using wrong site and/or type of probe may result in inability of the sensor to track the pulse thus giving inaccurate readings.

6.12.6. The sensor should be placed on the extremity opposite arterial lines and non- invasive blood pressure devices so that pulsatile blood flow is not impeded. In neonates preferred site is the foot or hand. In older children/adults preferred site is the index finger. If sensor-site (skin) is too thick or thin, pigmented, dirty or coloured - e.g., dark nail polish or gel nails - appropriate light transmission may be affected and errors in measurement may occur.

6.12.7. Attach sensor probe as per manufacturers' instructions. After a few seconds ensure adequate waveform displayed and that pulse corresponds to that of the infant/child. Pulse strength is equal to the fullness of the waveform. This waveform is vital in determining if the saturation recording is reliable.

6.12.8. Avoid using tape to secure to secure sensor to skin. Sensors attached too tightly may cause erroneously low readings. Using additional tape can restrict blood flow.

7. Dissemination and Implementation

This policy will be disseminated to all relevant ward and medical staff. Compliance sheets will be signed by all relevant staff on completion of reading this document. If any equipment or other training needs are highlighted when reading this document, staff must complete the tick box on the compliance sheet and obtain relevant training if appropriate.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with all elements of the policy.
Lead	Child Health Audit and Guidelines Lead.
Tool	Documentation audit, sign off sheets.
Frequency	Safety audit rota. Annual documentation audit.
Reporting arrangements	Child health business and guidelines meeting. Ward managers and lead nurse/Matron. Practice Development Forum- Child Health.
Acting on recommendations and Lead(s)	Ward managers and Lead nurse/Matron. Practice Development Forum- Child Health.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned and a lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

9. Updating and Review

This document will be reviewed in three years unless change in best practice becomes apparent and the policy will then be amended accordingly.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Oxygen Policy Child Health V4.0
This document replaces (exact title of previous version):	Oxygen Policy Child Health V3.0
Date Issued / Approved:	July 2023
Date Valid From:	July 2023
Date Valid To:	July 2026
Author / Owner:	Dr. K. Thomas; Paediatric Respiratory Team
Contact details:	01872 252463
Brief summary of contents:	Administration, prescription, and delivery of oxygen therapy
Suggested Keywords:	Oxygen Child health
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Child Health Audit and Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Caroline Amukusana
Links to key external standards:	None required

Information Category	Detailed Information
Related Documents:	Kelsey and McEwing 2008 clinical skills in child health practice Elsevier pg 210. Husband and Trigg 2000 practices in children's nursing guidelines for hospital and community. Churchill and Livingstone pg 190. McQueen et al 2012 The Great Ormond Street Hospital manual of children's nursing practices. Wiley Blackwell pg 643. Guidelines for assessing and measuring vital signs in a child or young person in a community setting (Joan Gowans - Jan 2010) RCHT. Policy For Patient Observation and Monitoring in Child Health (May 2016) Nursing Procedure: Monitoring SpO2 in the Highly Dependent or Critically Ill Infant or Child. Paediatric Intensive Care Guideline (Greater Glasgow & Clyde Nov 2010) Emergency Oxygen Policy, Royal Cornwall Hospitals NHS Trust (2009) Oxygen Therapy Protocol Long Term O2 Therapy for Adults in the Community Setting NHS Gloucestershire, Gloucestershire Care Services. Oxygen Therapy Administration in a Non Emergency Situation. Oxford handbook of Children's and young people's Nursing. Second Edition 2016 **Bristol Royal Hospital for Children guidelines:** High Flow Oxygen: http://nww.avon.nhs.uk/dms/download.aspx?did=17640 Non Invasive Ventilation Guideline: http://nww.avon.nhs.uk/dms/download.aspx?did=22644 RCHT Neonatal Oxygen Guideline – see link in 6.6.1. NICE Guidance updated 2021– 1 Recommendations | Bronchiolitis in children: diagnosis and management | Guidance | NICE
Training Need Identified:	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Paediatrics/ Prescribing

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
Sep 2012	V1.0	Initial Issue	Dr. A.Prendeville Maria Coppin Sophie Crosby Tabitha Fergus Carly Hamilton Ann Mckay
November 2016	V2.0	Re design of flow chart and contraindications section	Dr. Prendeville Dr. Srikantaiah Tabi Fergus
June 2020	V3.0	Changed to new trust format. Summary flowchart completed. Glossary updated. Administration table at 6.7.3. updated: headbox removed, links to Vapotherm/ BIPAP guidance added, Wafting Oxygen stated as temporary method of administration only. Neonatal guidance removed throughout document. Link to neonatal O2 guideline added.	Tabi Fergus, Practice Development Nurse Dr K Thomas, Paediatric Consultant
June 2023	V4.0	Additional information for use of oxygen in bronchiolitis added in section 6.6.2 (ref. NICE Guidance 2021- link in main body and reference section). Update to section 5.2 on training. Vapotherm amended to Heated Humidified High Flow Nasal Cannula Oxygen.	Dr K Thomas, Paediatric Consultant Tabi Fergus, Practice Development Nurse

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Oxygen Policy Child Health V4.0
Department and Service Area:	Child Health
Is this a new or existing document?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Child Health Audit and Guidelines Group
Contact details:	01872 252463

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Standardisation of oxygen therapy in child health.
2. Policy Objectives	Safe administration, prescription, and delivery of oxygen.
3. Policy Intended Outcomes	Safe administration, prescription, and delivery of oxygen.
4. How will you measure each outcome?	See section 3.
5. Who is intended to benefit from the policy?	Children and families.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Child Health Audit and Guidelines Group
6c. What was the outcome of the consultation?	Approved- 03 July 2023
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/ carer/ patient's needs- i.e., available in different languages if required/ access to an interpreter if required.

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/ carer/ patients with any identified additional needs will be referred for additional support as appropriate - i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact a treatment decision.
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Child Health Audit and Guidelines Group

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis