British Thoracic Society Guideline for oxygen use in adults in healthcare and emergency settings

Public consultation/Stakeholder comment form

Name: Dr Deepak Dwarakanath, Secretary and Vice President

Organisation: Royal College of Physicians of Edinburgh

Please indicate if you are responding as an individual or on behalf of the organisation noted above:

Individual response: ☐

Organisation response: x

Please add comments to the following table noting the section number and page number to which your comment refers.

Note 'general' in the section column if your comments relate to the whole document.

You will notice that there are 2 versions of the Guideline - full and concise. Please indicate which version each of your comments refers to.

Document Full Guideline or Concise version	**Page**	**Line #**	**Comment**
General comments	General comments		The document represents a very important contribution to patient care in an area that is often poorly understood and subject to complacency. The key aim of these guidelines is to improve the assessment and management of acutely unwell breathless and hypoxaemic patients and should be welcomed across a broad range of specialty groups to promote safe and effective oxygen prescribing. However, as it is currently written, the document contains a significant amount of repetition and would greatly benefit from further editing.
Concise	8		The aim of the document is to promote simple, safe and effective oxygen prescribing. It would be helpful to clarify some key terms that will be used in the document; for example, definitions of hypoxia and hypoxaemia.
Concise	11	414	A1 and A2 could be combined with little loss of impact e.g. "Oxygen should be administered to all acutely ill patients with the aim of achieving a target saturation of 94-98% (with the exception of those individuals judged to be risk of hypercapnia)".
Concise		420	A4 could be shortened to state "a sudden change in oxygen saturation e.g. ≥ 3% may be the first sign of acute illness and should prompt clinical assessment".

Concise		430	This could be shortened to “Encourage fully conscious hypoxaemic patients to maintain an upright posture to promote best oxygenation”.
Concise	11	437	Is it necessary for a clinician to undertake the assessment? Many hospitals will use nurses in triage. “The assessment of all acutely ill patients should include …..”
Concise		B3	It may be preferable to encourage recording of oxygen concentration rather than flow rate.
Concise		475 f	Wording in this section could be improved to facilitate ease of reading.
Concise	12	C3	Again, this would be improved by being more concise.
Concise		498	Insert space between “)or…..” , i.e. “) or”.
Concise	13		We would suggest inserting a comment regarding the role of humidification. The College notes this does appear later in the document, however this can often be omitted when it would be helpful.
Concise	14	546f	This section could be made more concise as much of the text is repetition of similar advice.
Concise	16	576 F1-F11	This could be improved by editing, to communicate that conditions for which a target oxygen saturation of 94-98% is appropriate include most cases of: • Acute asthma • Pneumonia • etc Annotation may be easier to read than the succession of paragraphs that contain similar text.
Concise	17	F16	F16 is an important point and the text in this section could be edited to add emphasis to this.
Concise	18	Table 2	The wording of the first text box could be made easier to read.
Concise	19	Table 3	This is a very helpful table.
Concise	20	676F	This would benefit from editing.
Concise		693	This is an over-simplification – suggest omitting as this is not really the intention of the guideline.
Concise		697f	We suggest changing the order of the paragraphs to commence with pre-hospital assessment moving towards A&E and then obtaining arterial blood gases

Concise	21	726	The identification of chronic type II RF may also be assisted by referring to the bicarbonate.
Concise		743f	As above, much of this is repetition of the same message.
Concise		767	As above, much of this is repetition of the same message.
Concise		860	The College suggests stating the known indication first, followed by a statement to the effect that there is no role for Heliox in asthma or COPD outside a clinical trial.
Concise	25	Q	Comments on humidification earlier in the document would be helpful as mentioned previously.
Concise	27	T2	Should encourage recording of concentration rather than (or as well as) flow rate.
Concise	32	Chart 1	Text in box dealing with risk factors for hypercapnic RF could be edited. 6th box on left hand side suggests seek 'immediate senior review and consider NIV' although, in reality, for patients with COPD it is more common to administer bronchodilators and reassess before NIV or invasive ventilation. May be sufficient to suggest senior medical review, which will follow guidelines appropriate to the condition in question. 8th box in 2nd column from left. If the decision has been made that the condition is not COPD, it is more important to be certain whether or not any rise in PaC02 reflects worsening V/Q mismatch or exhaustion and represents an indication for senior assessment re: HDU/ITU rather than reduction in Fi02. We would appreciate clarification if this section is suggesting use of NIV for acute asthma, pneumonia, etc. Again, may be better to suggest senior review and the clinician would make judgement. This could also include use of bicarbonate when interpreting gases.
Concise	33	Chart 2	Signs of C02 retention – "tremor" should be changed to "flapping or coarse tremor" to avoid confusion with the tremor associated with beta-2 agonists. Should include comment re: humidification particularly when higher concentrations are used. Suggest including a reminder that a change in 02 Saturation $\geq$ 3% should trigger review.

Please add rows to this table as required.

Please return the completed form to:

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Deadline: 5pm Monday 18th January 2016