The Administration of Oxygen Policy
<table>
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<th>Clinical Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Purpose:</td>
<td>Best practice guidance</td>
</tr>
<tr>
<td>Unique identifier:</td>
<td>CP0082</td>
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<td>The Administration of Oxygen Policy</td>
</tr>
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<td>Target Audience:</td>
<td>Clinical staff who administer oxygen</td>
</tr>
<tr>
<td>Description:</td>
<td>Outlines the administration and use of oxygen within the Trust and the clinical steps which should be taken by Registered Nursing staff before administering oxygen to patients. Also outlines equipment which should be used to administer oxygen therapy and the roles and responsibilities of staff caring for patients receiving oxygen</td>
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<td>Ratified by:</td>
<td>Quality Committee</td>
</tr>
<tr>
<td>Ratification date:</td>
<td>03/09/2010 (Virtual)</td>
</tr>
<tr>
<td>Implementation date:</td>
<td>03/09/2010</td>
</tr>
<tr>
<td>Review period:</td>
<td>Always 3 years unless statutory timeframe</td>
</tr>
<tr>
<td>Version update date:</td>
<td>February 2011</td>
</tr>
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<td>Review date:</td>
<td>03/09/2013</td>
</tr>
<tr>
<td>Owner:</td>
<td>Chief Pharmacist</td>
</tr>
<tr>
<td>Responsible group:</td>
<td>Medicines Management Working Group</td>
</tr>
</tbody>
</table>
| Contact Details:    | Chief Pharmacist  
Woodside, Perry Wood Walk  
Worcester  
WR5 1ES |
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Appendix 1 Oxygen Flowchart
Appendix 2 Equality Impact Assessment
Appendix 3 Oxygen checklist
Appendix 4 Oxygen Prescription Sheet
1. Introduction
   a. Oxygen has been used in clinical practice for many years and is one of the most commonly used medicines in hospital environments. If appropriately used, oxygen is life saving. In general use oxygen is safe however there is potential for serious harm if it is not administered and handled properly.
   b. Oxygen is a colourless, odourless and tasteless gas which makes up 21% of the atmosphere. Within the Trust there are Patient Group Directions (PGDs) for the use of oxygen in emergency situations. Within all inpatient hospital wards there are portable cylinders. The Electroconvulsive Therapy (ECT) Department has both piped oxygen and cylinders.
   c. See Appendix 1 for arrangements detailing supply and replacement of oxygen cylinders across the Trust.

2. Aims and Objectives
   a. The use of supplementary oxygen within the Trust is considered to be a medicine and is managed by the Medicines Management Working Group.
   b. This policy outlines the administration and use of oxygen within the Trust and the clinical steps which should be taken by Registered Nursing staff before administering oxygen to patients. The policy also outlines equipment which should be used to administer oxygen therapy and the roles and responsibilities of staff caring for patients receiving oxygen.
   c. In addition the aim is to produce a unified clinical approach to the administration and care of patients requiring oxygen therapy.

3. Scope and Competencies
   a. This policy applies to all areas within the Trust where oxygen is administered and responsibility lies with qualified healthcare professionals who in order to administer oxygen safely must understand:
      i. The indications for oxygen
      ii. The hazards associated with oxygen therapy
      iii. Oxygen and humidification systems in use
      iv. Potential side effects of usage.
   b. In an emergency situation staff should follow the relevant Patient Group Direction (PGD).

4. Indications for Prescribed (Non Emergency) Oxygen Therapy
   a. Oxygen therapy is used for a variety of clinical conditions but primarily where the patient is unable to maintain their own oxygen levels. Patients requiring oxygen may fall into the following clinical groups:
      i. Cardiac failure
      ii. Respiratory failure/distress
      iii. Palliative care
      iv. Other medical conditions

5. Assessing and Monitoring Patients Requiring Oxygen Therapy
   a. On admission patients should have baseline observations of temperature, pulse, respirations, blood pressure and oxygen saturation levels recorded using a pulse oximeter. The normal range for peripheral saturation (SpO2) levels is 94 - 98%.
Where patient’s oxygen saturations are lower than this, check any recent recordings and undertake a further assessment of their physical health.

b. Apart from in an emergency it is not acceptable that the first response is the application of oxygen as in the case of a patient with Chronic Obstructive Pulmonary Disease (COPD) as this may be very harmful.

c. 10 - 15% of patients with COPD have type II respiratory failure (Bateman and Leach 1998) and for these patients a falling oxygen level is their drive to breath. These patients need to have their hypoxia corrected but the dose of oxygen given needs to be carefully administered and monitored. As this is a small number it should be reviewed as a potential issue when oxygen therapy is considered.

d. Clinical signs of inadequate oxygenation to consider when making an assessment are:

   i. Is their SpO2 below 94%?
   ii. Does the patient have a raised pulse rate?
   iii. Does the patient have a raised respiratory rate?
   iv. Does the patients have altered skin colour? Is there cyanosis?
   v. Are there signs of agitation, confusion or an altered level of consciousness?
   vi. Are they using their accessory muscles when breathing?

6. **Administration and Equipment**

   a. All staff involved in the provision and administration of oxygen should be able to demonstrate competency with the equipment in use within their clinical area of work. Where cylinders are in use staff should be able to demonstrate how to change the flow meters. All equipment should be regularly checked and stocks of masks readily available and accessible. Within mental health, where only oxygen cylinders are used, systems are in place to ensure that supplies are readily available and accessible. Staff should be aware of cylinder capacities, supply duration and the point of needing to change. (see Appendix 2) In addition there needs to be clear segregation of full and empty cylinder supplies.

   b. Any patient requiring oxygen therapy should be reviewed by a doctor at the earliest opportunity and a prescription for oxygen together with the desired oxygen saturation range clearly documented on the Trust oxygen prescription chart. The correct oxygen administration device can then be selected. In ECT there is a separate prescription chart for oxygen.

   c. Oxygen administration devices are many and variable. For emergency situations where high percentage oxygen is required the mask of choice, for those who will tolerate a mask, is a non re-breathe mask. This can be connected directly to 15 litres per minute or more and deliver 60 - 80% oxygen. This product is only licensed for emergency situations and once stabilised an alternative mask should be used. Guidance from the British Thoracic Society (BTS) is that in an emergency oxygen should always be given immediately and documented later.

   d. Nasal Specs deliver a low range of oxygen between 24 – 35% and are connected directly to the oxygen with an oxygen flow rate of up to 4 litres per minute. These are safe, easy to use, are comfortable and allow the patient to eat drink and talk.

   e. Medium concentration (MC) masks (NB these are also known as Simple Masks by the BTS) deliver a medium range of oxygen, generally considered to be 35 - 60%. The mask is connected directly to the oxygen flow meter with a flow of 5 – 10 litres per minute. The oxygen flow should be adjusted according to the flow rate or the desired SpO2 range stated clearly. This mask is ideal for people who are suffering with asthma, pulmonary embolism, myocardial infection, pneumonia or other forms
of type I respiratory failure. When using this type of mask flow rates should be maintained at 5 litres per minute or more as lower rates may result in re-breathing of exhaled air. This makes it difficult to achieve a low inspired oxygen concentration and so these masks are generally unsuitable for patients with type II respiratory failure.

7. **Nebulised Medication**
   
a. The regular in-patient treatment card is used and, unless prescribed otherwise, all nebulisers should be administered via a portable nebuliser/compressor system (e.g. Portaneb).

8. **Prescribing and Monitoring**
   
a. A medic is required to prescribe oxygen and this should be done at the earliest opportunity with guidance on the range of oxygen saturation levels required.
   
b. Oxygen therapy will be adjusted to achieve target saturations rather than giving a fixed dose to all patients with the same disease. Nursing staff will be able to adjust the dose delivered without requiring a prescription change on every occasion.
   
c. The patient’s requirement for oxygen should be monitored every hour and their oxygen saturation levels recorded. If oxygen is no longer required and/or the prescription needs to change the nurse should sign the prescription chart.

9. **Step Down and Discontinuation**
   
a. Oxygen therapy should be reduced in stable patients with satisfactory Spo2 levels. Once oxygen has been discontinued the prescription should be reviewed by the patient’s doctor and discontinued on the oxygen prescription sheet. An entry should also be made in the medical notes.

10. **Infection Control**
   
a. All oxygen administration devices should be used in accordance with the manufacturer’s guidance and will generally be for single patient use, so they can be re-used for the same patient unless specifically stated on the packaging.
   
b. At all times administration devices should be kept visibly clean and protected from contamination. Prior to use, devices should be stored in a clean area, off the floor and protected from contamination. When in use they should be checked as part of ongoing hygiene needs to ensure they remain visibly clean and uncontaminated, devices should be cleansed or replaced as indicated by the manufacturer.
   
c. During intermittent use care should be taken to ensure they are visibly clean and dry before putting into a designated container ready for its next use. For hospital patients this container should be clearly labelled with the patient’s name.
   
d. In addition to oxygen administration sets, all nebuliser masks, mouthpieces and tubing can be re-used for the same patient unless specifically stated on the packaging. All administration equipment except the tubing should be washed after each use with general purpose detergent and warm water. They should then be thoroughly dried using a disposable soft paper towel. The tubing should be attached to the gas delivery device and turned on for a few seconds, which will remove any dampness from inside the tubing. Ensure all the equipment is dry before putting it in a designated container ready for its next use. For hospital patients this container should be clearly labelled with the patient’s name.
   
e. With regard to nebulisers, if a compressor is used, when unplugged it will need to be wiped over with a multi-surface detergent wipe. This should be part of routine cleaning schedules (daily/weekly) and in addition should be undertaken between uses with different patients. If the medical device becomes contaminated seek advice from infection control and Electro-Biomedical Engineering (EBME - hospital
equipment technicians). The compressor should be stored clean and dry without nebuliser equipment attached.

f. Routinely, oxygen devices should **not** remain connected to the oxygen source. The exception is “emergency use” oxygen where it is important that the device remains connected and ready for use. In the interests of good hygiene the mask and tubing should be protected from contamination by retaining within original packaging and this should be included in regular cleaning schedules.

g. At all times healthcare staff should comply with standard infection control practices including the World Health Organisation (2009) 5 moments of hand hygiene as detailed within the infection control policies and procedures.

11. Training

a. Clinical staff should be able to demonstrate the knowledge of the use of equipment when administering oxygen.

b. Competency in recording the patient’s oxygen saturation and taking the appropriate action required should be assessed.

c. Facilities staff involved in oxygen logistics should complete Trust identified training which may include e-learning courses.

12. Monitoring of Policy

a. This policy will be audited and the following outcomes measured

<table>
<thead>
<tr>
<th>Standard</th>
<th>Percentage Compliance</th>
<th>Clinical Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients requiring oxygen will be assessed and a clear clinical indication and end point identified.</td>
<td>1 to 5 - 100%</td>
<td>1 to 5 None</td>
</tr>
<tr>
<td>2. Patients will receive oxygen in accordance to a current prescription.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Staff will be able to demonstrate their knowledge of the use of equipment in place to administer oxygen.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Where cylinders are in use staff will be able to change flow meters if required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Empty and full oxygen cylinders are stored separately</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. References

- British Thoracic Society (October 2008): Guidelines for emergency oxygen use in adult patients

Oxygen flowchart

Wards
Berkeley
Size E Resus Trolley
Size F Ward Supply
Hadley Unit
Size E Resus Trolley
Size F Ward Supply
136 assessment unit
CD in resuscitation grab Bag
Grafton Treatment centre
See other block
Athelion
Size E Resus Trolley
Size F Ward Supply
Occupational therapy
CD in resuscitation grab Bag
Clifton
Size E Resus Trolley
Size F Ward Supply
Abberley
Size F Ward Supply
Wustan unit
CD in resuscitation grab Bag

Notes
Size F to be replaced with HX

Service contact for
Grafton TC piped system
Wall outlets
Regulators & flow meter on all Size E

Stores rooms and delivery points
Newtown
Hill Crest

Grafton Treatment centre
Size J X 6 Piped system
Size E Resus Trolley
Size E Recovery Trolley
Size F Back up Supply
CD in resuscitation grab Bag

Training
CD in resuscitation grab Bag
Replacement stock
CD
Size J X 2 Piped system

CD LIST
Worcester
CD in resuscitation grab Bag
CD Replacement stock
136 assessment unit
Occupational therapy
Wustan unit
Cromwell House
Community Drug Team Castle House
Turning point 6 Shaw Street
Malvern
Rowan House
Touchstone (to be redeployed)
Turning point 12 priory Road
Kidderminster
Community Drug Team New Road
Evesham
Waterside Day Hospital
Turning point 64 high street
Redditch
Community Drug Team Church Green East
Rowan Day Hospital (to be issued this week)
Bromsgrove
Keith Winter Close

Cromwell House
CD in resuscitation grab Bag

Turning point
6 Shaw Street
CD in resuscitation grab Bag

Community Drug Team
Castle House
CD in resuscitation grab Bag

Cromwell House
CD in resuscitation grab Bag

Appendix 1
Kidderminster

Witley Ward
Size E Resus Trolley
Size F Ward Supply?
Harvington Ward
Size E Resus Trolley
Size F Ward Supply?
Lucy Baldwin DH
Size E Resus Trolley
Size F Ward Supply?
Replacement stock
Via Acute Trust

Community Drug Team
New Road
CD in resuscitation grab Bag

Bromsgrove

Keith Winter Close
CD in resuscitation grab Bag

Brook Haven
Size E Resus Trolley
Under review might be replaced with Grab Bag.

Church view and Harley
Under review might be requiring CD size oxygen

Redditch

Hill Crest
Reception
CD in resuscitation grab Bag
Ward
Size E Resus Trolley
Size F Ward Supply
Replacement stock
Size E x 4
Size F x 4

Smallwood
Rowan Day Hospital
CD in resuscitation grab Bag

Community Drug Team
Church green east
CD in resuscitation grab Bag

Witley Ward
Size E Resus Trolley
Size F Ward Supply?
Harvington Ward
Size E Resus Trolley
Size F Ward Supply?
Lucy Baldwin DH
Size E Resus Trolley
Size F Ward Supply?
Replacement stock
Via Acute Trust

Community Drug Team
New Road
CD in resuscitation grab Bag

Bromsgrove

Keith Winter Close
CD in resuscitation grab Bag

Brook Haven
Size E Resus Trolley
Under review might be replaced with Grab Bag.

Church view and Harley
Under review might be requiring CD size oxygen

Malvern

Rowan House Bag

Osborn Court
CD in resuscitation grab Bag
CD in resuscitation grab Bag

Touchstone
CD in resuscitation grab Bag
To be redeployed

Turning point
12 Priory Road
CD in resuscitation grab Bag

Evesham

Waterside Day Hospital
CD in resuscitation grab bag

Turning point
64 high street
CD in resuscitation grab Bag

Appendix 1

Shaded areas:
Replacement cylinders are obtained from Grafton Treatment Centre
# EQUALITY IMPACT ASSESSMENT FORM (EIAF)

## SECTION ONE: SCREENING / PRIORITISING FOR FULL IMPACT ASSESSMENT

<table>
<thead>
<tr>
<th>Name of the Function/Policy/Procedure</th>
<th>Which of the 3 parts does it apply to (if any)</th>
<th>Is there evidence or reason to believe that some groups could be differently affected?</th>
<th>Which groups are affected?</th>
<th>How much evidence do you have?</th>
<th>Is there any public concern that the function or policy is being carried out in a discriminatory way?</th>
<th>Priority (add columns 3 &amp; 4)</th>
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<tr>
<td></td>
<td>1. Eliminating discrimination</td>
<td>2. promoting equal opportunities</td>
<td>3. Promoting good community relations</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>RACE</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>RELIGION/BELIEF</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<td>DISABILITY</td>
<td>x</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>GENDER</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>AGE</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<td>SEXUAL ORIENTATION</td>
<td>x</td>
<td>x</td>
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<td>x</td>
<td>x</td>
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<td>x</td>
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<td>HUMAN RIGHTS</td>
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<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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**Section 2: ACTION PLAN – No action plan required 1st September 2010**
Medical instruction
For staff prescribing oxygen: What can YOU do?

Because of the risks from poor oxygen management, medical staff should satisfy the following points

- A clear rationale for prescribed oxygen is evident
- The target saturation on the oxygen prescription chart is indicated
- **How can I recognise inadequate tissue oxygenation?**
- Due consideration has been given to how the oxygen is best delivered and whether humidification is necessary.
- When review of oxygen therapy is due it is clearly stated

Nursing instructions
For staff administering oxygen: What can YOU do?

Because of the risks from poor oxygen management, staff should ask:

- The patient’s diagnosis and target saturation has been recorded
- The flow rate may need adjusting to achieve that patient’s target saturation
- The oximetry results have been recorded (saturation levels)
- The tube is connected to the right outlet/cylinder ie oxygen not air
- The systems checklist has been fully completed
- My competency and training needs have been met

<table>
<thead>
<tr>
<th>Mask Colour</th>
<th>Flow rate litres/min</th>
<th>O₂ concentration delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue</td>
<td>2 litres</td>
<td>24%</td>
</tr>
<tr>
<td>White</td>
<td>4 litres</td>
<td>28%</td>
</tr>
<tr>
<td>Orange</td>
<td>6 litres</td>
<td>31%</td>
</tr>
<tr>
<td>Yellow</td>
<td>8 litres</td>
<td>35%</td>
</tr>
<tr>
<td>Red</td>
<td>10 litres</td>
<td>40%</td>
</tr>
<tr>
<td>Green</td>
<td>15 litres</td>
<td>60%</td>
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Venturi System Details

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<tr>
<th>Amount of Oxygen</th>
<th>Full</th>
<th>¾ Full</th>
<th>½ Full</th>
<th>¼ Full</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size CD</td>
<td>460 litres</td>
<td>30 minutes</td>
<td>22.5 minutes</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Size E</td>
<td>680 litres</td>
<td>45 minutes</td>
<td>34 minutes</td>
<td>22.5 minutes</td>
</tr>
<tr>
<td>Size DX</td>
<td>2300 litres</td>
<td>153 minutes</td>
<td>115 minutes</td>
<td>76 minutes</td>
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</tbody>
</table>

These figures are based on usage at 15 litre per minute

Documentary Evidence Checklist

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<tr>
<th>When Should I replace Cylinder</th>
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<tbody>
<tr>
<td>Size CD</td>
</tr>
<tr>
<td>Full</td>
</tr>
<tr>
<td>¾</td>
</tr>
<tr>
<td>½</td>
</tr>
<tr>
<td>¼</td>
</tr>
</tbody>
</table>

When Should I replace Cylinder

- Initial SATS recorded in medical notes and on prescription sheet
- The clinical indications for oxygen are stated in the medical notes
- A treatment plan for the oxygen therapy documented in the medical notes
- If humidification is required it has been documented in the ‘other systems’ column overleaf
- If something has gone wrong, a Sentinel incident report must be completed by the senior nurse on duty

- Amount of Oxygen | Full | ¾ Full | ½ Full | ¼ Full |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td>2300 litres</td>
<td>153 minutes</td>
<td>115 minutes</td>
<td>76 minutes</td>
</tr>
</tbody>
</table>

These figures are based on usage at 15 litre per minute
## Oxygen Prescription Sheet

### Step 1
initiation

| Patient's name…………………………NHS no………………DOB……………… |
|-----------------|-----------------|-----------------|-----------------|
| SATS Target range (tick): 88-92% [ ] 94-98% [ ] Other……..[ ] |

### Step 2
Treatment duration and end point(tick relevant box)

<table>
<thead>
<tr>
<th>A fixed flow rate is already in place to maintain appropriate SATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent oxygen only to maintain SATS at level identified above</td>
</tr>
<tr>
<td>Patient self manages their oxygen</td>
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<tr>
<td>Other as identified below</td>
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</tbody>
</table>

### Step 3
Prescription (complete initial flow rate and review criteria)

<table>
<thead>
<tr>
<th>Signature or continued</th>
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<tbody>
<tr>
<td>Initial Oxygen flow rate</td>
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**Review Criteria**

- Monitor SATS every………………

### Step 4
Oxygen delivery method

<table>
<thead>
<tr>
<th>Nasal [ ] (0-4 litres/min)</th>
</tr>
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<tbody>
<tr>
<td>Simple face mask [ ] (5-10 litres/min)</td>
</tr>
<tr>
<td>Venturi Mask [ ] (2-15 litres/min) - specify colour/rate-see Appendix 3</td>
</tr>
</tbody>
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### Step 5
Initial Observations

<table>
<thead>
<tr>
<th>SATS on room Air………………%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiration rate………………../min</td>
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</tbody>
</table>

### Step 6
Monitoring

**NB Always re-check SATS once oxygen has stopped**

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>O₂ Rate</th>
<th>SATS</th>
<th>Resps</th>
<th>Cylinder reading</th>
<th>Action Taken</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Oxygen Prescription Sheet (Continued Monitoring)

When full a new oxygen prescription sheet must be written. If a continuing episode of care then endorse as continued. **See original prescription for**

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>O₂ Rate</th>
<th>SATS</th>
<th>Resps</th>
<th>Cylinder reading</th>
<th>Action Taken</th>
<th>Initials</th>
</tr>
</thead>
</table>

**Step 6**

Monitoring

*NB Always re-check SATS once oxygen has stopped*

**Step 7**

Discontinuation

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date:</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>Print Name</td>
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</table>

<table>
<thead>
<tr>
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<th></th>
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