CASE STUDY
Difficulties in withdrawal of home oxygen therapy

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Background

Mrs Puffa-lot is a 68 year old retired nurse with a 62 pack year history.

Mrs Puffa-lot smoked 30 plus cigarettes a day and had COPD. She was under the care of the long term conditions team and has refused smoking cessation advice / support.

Long term oxygen therapy was prescribed from the outreach team in Manchester 6 months ago and a concentrator and ambulatory oxygen was present at home when she came to Hull.

The community matron and Air Products technician contacted the Oxygen Team with concerns
Issues presented to the Home Oxygen Team:

• Patient continued to smoke refusing to have smoking cessation input or to quit

• Witnessed smoking with oxygen therapy by Community Matron and Air Products technician – Patient ignored advice

• Patient required oxygen long term- if removed profoundly hypoxic

• She looked after her Grandchildren 5yrs and 7yrs three nights a week

• Family also smoked – witnessed smoking near oxygen provision
Advice and Support given

- Smoking cessation advice offered by the RNS/community matron - Refused
- Risk assessments completed by the Team/Community Matron/ fire safety officer and Air Products – considered high risk of fire
- Patient informed of high risk – opportunity – advised to smoke outside - advice ignored
Further Issues

- Patient able to have capacity to understand the health and safety issues
- Patient ignored advice given and refused to smoke outside away from her oxygen
- Patient continued to smoke with her oxygen therapy attached
- High risk of fire and danger apparent to anyone entering the home, her family and grandchildren
- Removal of oxygen therapy would result in rapid health deterioration and hypoxia
- No national /local policy for withdrawal of oxygen therapy
What would you have done?

To remove or not remove?
What actually happened

The oxygen provision was removed, the patient’s health deteriorated and she was admitted to hospital with hypoxia.

The chest consultant had been informed verbally/ a written letter had been faxed explaining why the oxygen had been removed.

The consultant reinstated the oxygen and Mrs Puffalot was discharged home in 24 hours.
Mrs Puffa-lot died at home 48 hours later – found on the floor with facial burns and a burnt out cigarette in her hand with her oxygen still on.
Overcoming challenges!

**Smoking and oxygen**
Worked with the National lung improvement project to develop a MDT approach:
- Health and safety and use of oxygen policy
- Home oxygen risk assessment pathway
- Worked with local fire and safety officer, HOS lead and smoking cessation services

**Withdrawal of oxygen**
- Draft policy for safe withdrawal and removal
- Staged approach /optimise treatments
- Education /training on HOOF prescriptions
- MDT support inclusive of Consultants and GP’s
Withdrawal protocol

Two Types of Scenarios:

Pts **amenable** to having to oxygen withdrawn & no clinical need
Pts **not willing** to have oxygen withdrawn.

Protocol will have to be adapted for both scenarios.
If Pts SPO2 >94% breathing room air then it is considered safe for oxygen to be withdrawn.
Our Protocol

• Look at concordance data to establish if the use matches the express want /need

• **Visit one** Full review, if Spo2 is >94% after 15 minutes without oxygen the patient will require further assessment in 1-2 weeks.

**Visit two 1-2/52:** Pts remove oxygen one hour prior to the home /clinic visit. If Spo2 remains>94% after one hour blood gas /ambulatory assessment given.

**Visit three 1-2/52** The patient will be asked to refrain from using oxygen for one whole week SPO2 monitoring and LTCT support.

• HOS number to contact for advice/concerns.

• If there is agreement with the patient their oxygen will be withdrawn based on SPO2. GP and Consultant informed
If the patient has concerns/refuse oxygen removal, MDT meeting with GP /LTCT/DN etc will be arranged to discuss way forward.

Referral to Pulmonary rehabilitation to address psychological issues related to breathlessness, calming techniques and attempts made to withdraw during the programme.

In some cases it is impossible to remove but minimising cost of provision should be looked at and HOOF amended
How good are your powers of observation?