Utilisation of AIRVO in Palliative Care

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Background

AIRVO has revolutionised provision of high flow Oxygen to patients with advanced respiratory illness.

AIRVO delivers humidified, conditioned air at high concentrations of oxygen via soft, flexible nasal prongs.

AIRVO can be administered in the ICU, on general wards and in the community.

Use of AIRVO is becoming more prevalent in Palliative Care.

Aim

To describe the population of Palliative Care patients receiving AIRVO in GUH.

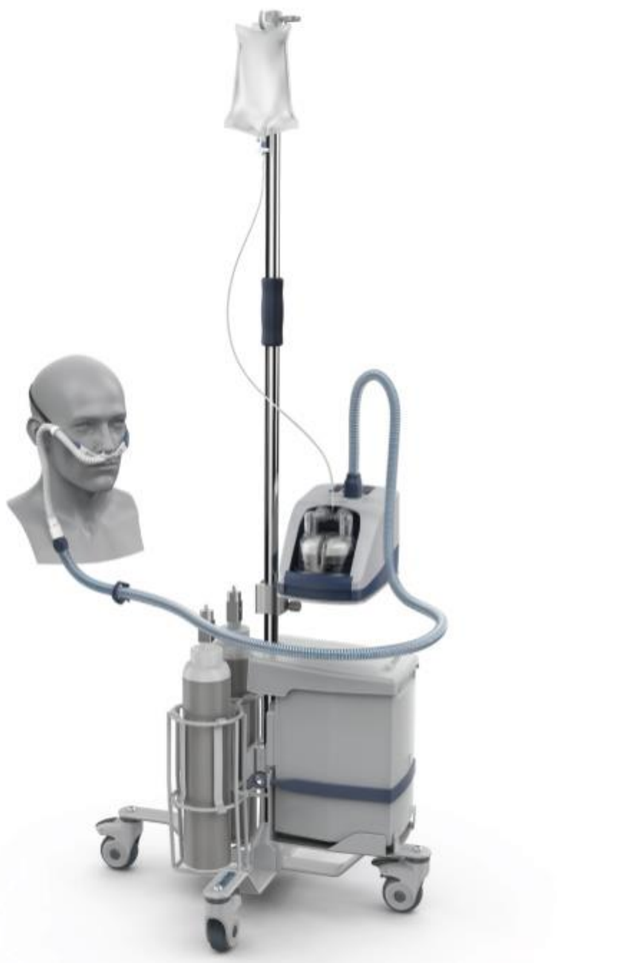
To establish whether the use of AIRVO results in:

(a) An objective improvement in symptom control.

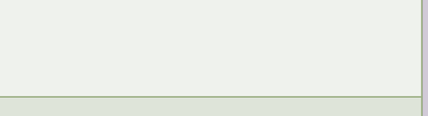
(b) A reduction or avoidance of ICU admissions.

Methods

A retrospective chart review on 22 Palliative Care patients commenced on AIRVO between January and September 2017.



Results



N=22 charts reviewed.

Indications for commencing AIRVO:

- 19/22 applied for a decrease in Sp02 below 90%.
- 2/22 patients were weaned from non-invasive ventilation.
- 1/22 patient was commenced on AIRVO for relief of respiratory distress.

Days from commencement of AIRVO to discharge or death: ranged from 2-50

Question:	Response A	Response B
Background Diagnosis?	Malignant 41%	Non-Malignant 59%
AIRVO Started?	Ward 86%	ICU 14%
Resus Documented before AIRVO	Resus Clarified 55%	Resus not Clarified 45%
Dyspnoea Severity Score recorded	Yes 0%	No 100%
Opiate / Benzodiazepine for Dyspnoea	Yes 32%	No 68%
AIRVO well tolerated (documented)	Yes 86%	No/ Data not complete 14%
Place of death	GUH 91%	Community 9% (off AIRVO)

Discussion

59% of patient cohort had a non-malignant diagnosis.
54% had a documented resus status prior to a trial of AIRVO.
The treatment was well tolerated in 86% of patients with a documented objective reduction in symptom burden with the commencement of AIRVO.

All patients admitted to ICU were discharged to a ward.
188 days were spent on AIRVO out of ICU, an average of 8.54 days per patient.
There were no discharges to the community on AIRVO.

4.5% of our sample had documented difficulty with AIRVO tolerance, attributed to co-existing delirium.
Increasing availability of AIRVO devices in acute hospitals, hospices and communities will contribute toward alleviation of symptom burden in a cost-effective manner.

Conclusion

AIRVO is a well-tolerated intervention providing improved symptom control.
Implementation of AIRVO may provide cost savings by ICU admission avoidance while providing high-flow oxygen in a general ward or community setting.