Guidance for setting up a Virtual Supported Discharge Service for Covid 19

National Clinical

Programme Respiratory

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Glossary of Terms and Definitions

Covid 19: Covid-19 is an illness caused by the virus Sars-Cov-2 which is rapidly spreading internationally through a virus naïve population.

Virtual SD: Virtual Supported Discharge (SD) is a service based on the hospital at home model of care and provides a supported discharge service for selected patients with a diagnosis of Covid-19. This patient would otherwise require acute in-patient care. This is performed through both virtual technology and phone calls.

COPD: Chronic Obstructive Pulmonary Disease is a preventable and treatable disease which is characterised by airflow limitation that is not fully reversible. This airflow limitation is usually progressive and associated with increased breathlessness (GOLD, 2014). COPD can be described as an illness that makes it hard to empty air out of your lungs. This can lead to shortness of breath and feeling tired because you are working harder to breathe.

SpO_2: The peripheral capillary oxygen saturation, an estimate of the amount of oxygen in the blood

1. Introduction

This document is intended for use by health care professionals involved in the care of Covid 19 patients.

Virtual Supported Discharge provides supported discharge options for patients who present with uncomplicated Covid 19 or who stabilise during their hospital admission and are deemed suitable for discharge but require additional monitoring. This is achieved by increasing integration between acute and community services and enabling care closer to home through virtual methods.

This service has fast track access to the Respiratory team. The benefits to the patient include being able to recuperate in their own environment with both family support and the Virtual COPD Outreach Team's support.

The impact of Covid 19 on healthcare facilities is profound, but it also has wider social and economic effects. With this increased demand on acute beds, a shift in the model of care from acute hospital to primary care is essential. The ability to discharge patients in a safe manner to the community will improve access to acute hospital beds for those in need and reduce overall length of patient stay. The opportunity to treat suitable patients at home instead of in hospital is attractive not just for patients but from an economic and organisation perspective.

The care pathway of those with diagnosed Covid 19 may differ depending on the location where care will be delivered as the patient moves through the stages of transmission. This will not be a unidirectional pathway, in that it will be influenced by the patient's clinical condition, their environment and the psychosocial circumstances of individual patients and their immediate carers.

This virtual supported discharge model describes the pathway for Covid-19 patients to facilitate and support care at home.

Virtual supported discharge is a dynamic process where the patient can be assessed and accepted into the programme under the on-going care of trained health care professionals for a condition that would otherwise require acute inpatient care or on-going inpatient monitoring.

Virtual supported discharge facilitates early discharge from hospital and potentially reduce length of stay.

Each patient will be provided with an active customised discharge package comprising information on virtual monitoring via an Mpower app and personalised review calls as clinically indicated over a two week period.

In general, the introduction of a virtual outreach service to a hospital would be expected to reduce the length of stay by two days. In addition, it is estimated that approximately 1 in 4 patients would be suitable for early supported discharge resulting in a reduction in bed day usage.

2. Aims

The aims of the VSD service is to manage confirmed Covid-19 inpatients nearing discharge home or patients tested in hospital/Emergency department deemed suitable for management at home with the backup support of the COPD Outreach/SD team.

3. Objectives

The service will monitor patient's clinical observations each day in order to identify the early signs of deterioration. The team will provide a 'Supported Discharge' programme that will facilitate a safe and planned discharge through a combination of virtual monitoring and phone calls.

The following objectives are required to standardise the process:

- Put systems in place that will ensure the safe and effective delivery of the service.
- Identify outcome measures which are safe and easy to collect via virtual technology.
- Outline the role of each key stakeholder in the programme.
- Ensure standards of practice are maintained in line with national and international guidelines.
- Ensure evidence based practice.
- Facilitate the sharing of information for future service development
- Comply with GDPR (technology and information sharing and consent).

4. Scope

This policy applies to:

- Medical Teams referring patients to the COVID-19 Supported Discharge programme.

- COPD Outreach teams or Supported Discharge Teams involved in screening & monitoring COVID 19 patients for this programme.
- Patients referred into the Covid-19 SD programme.
- Relevant stakeholders of monitoring equipment such a patient Mpower.

This policy serves to ensure that the most appropriate patients are selected for the programme. There should be a clear pathway of referral, process for selection and communication of same. There are clear pathways for discharge from the programme.

5. Roles and Responsibilities

Where COPD Outreach teams are already established, they are in a position to expand their services to support those patients both newly diagnosed and recovering from COVID-19.
In some localities this may be performed by a supported discharge team from acute care or community care.
As the clinical path of Covid 19 patients can be extremely unpredictable and patients may deteriorate rapidly, all team members will need to have experience of dealing with such unpredictable events and escalating care when indicated.

Lead Consultant Respiratory Physician

- Maintain clinical responsibility and support to the virtual programme and COPD Outreach/SD teams.
- Responsible for governance of the COPD Outreach team/ SD team and for the performance of the service.
- Provide relevant clinical information to the Outreach team/SD team to affect safe and timely discharge to the team.
- All patients enrolled on the virtual SD Programme will be under the care of the lead Respiratory Consultants for a period of up to two weeks until discharge back into the care of the patient's General Practitioner (GP).

Clinical Nurse Specialist

- To work within the hospital or other relevant settings as part of the multidisciplinary team. Remote work may be an option, depending on arrangements locally.
- To develop the structure, processes and functions of the virtual SD programme.
- Responsible for patient well-being.
- Keeping management informed of progress.
- Delivering care as per the SD programme guidelines.
- Recording datasets for patients, reporting on agreed targets and managing and mitigating risks.

- Escalate any issues of patient care and safety to the lead consultant.
- If they are a nurse prescriber, they may make alterations to patient's medication regime under the guidance of the lead consultant.

Senior Physiotherapist

- To work within the hospital or other relevant settings as part of the multidisciplinary team. Remote work may be an option.
- To develop the structure, processes and functions of the SD programme.
- Responsible for patient well-being and keeping management informed of progress.
- Delivering care as per the SD programme guidelines.

- Recording datasets for patients, reporting on agreed targets and managing and mitigating risks.
- Assess patient suitability for onward referral to virtual Pulmonary Rehabilitation programme if available.
- Provision of respiratory physiotherapy as clinically indicated.
- Escalate any issues of patient care and safety to the lead consultant.

Director of Nursing /Assistant Director of Nursing.

- To be the direct line manager of the Virtual COPD Outreach/SD Clinical Nurse Specialist.
- To support both the Outreach team /SD team and the SD programme.

Physiotherapy Manager.

- To be the direct line manager for the Outreach /SD Senior Physiotherapist.
- To support both the Outreach /SD team and the SD programme.

All Staff Referring to the SD Programme

- Identify and refer patients who are appropriate for SD to be assessed by a member of the COPD Outreach Team /SD team
- Be familiar with the referral process.
- Be familiar with the specific inclusion/exclusion criteria.
- Refer patients to the SD service in a timely manner.

Patient MPower –The data processor

- Complete an extensive review of data protection with the HSE in relation to the early discharge programme for COVID19.
- Complete a Protection Impact Assessment for HSE.
- Complete a Data Processing Agreement with HSE.
- Complete a Data Protection Impact Assessment information for the HSE
- MPower data protection processes to be reviewed by an external consultant and their report shared with the Data Protection Commissioner.
- Mpower in-app consent statements to be reviewed and agreed by the HSE and external legal advisers. See Appendix 1 for details of completed tasks by Mpower.

HSE- Data Controller

- Work with Data processor to ensure all GDPR standards are adhered to

6. Procedure

6.1 Supported discharge patients are assessed as per the inclusion/exclusion criteria. They may be discharged following a period of in-hospital treatment with a specific virtual home care package, or they may be admitted to the programme to prevent hospital admission with confirmed Covid-19. These patients remain under the care of the Respiratory Consultant for the two weeks of the programme. They are discharged back to the care of their GP two weeks after their discharge from hospital.

6.2 Patients who are enrolled in the programme to prevent hospital admission will be under the care of the Respiratory Consultant for the first two weeks of the programme and are then discharged back to the care of their GP.

6.3 Inclusion/Exclusion Criteria for Supported Discharge for Covid-19 Patients

6.3.1Inclusion Criteria:

- Age over 18.
- COVID positive (confirmation from positive swab).
- Access to a smart device.
- Access to telephone is essential.
- Adequate social support.
- Fully alert and consented.
- Deemed stable and suitable for discharge home by treating physician.
- Deemed stable and not requiring hospital admission by treating Physician.
- SpO_2 ≥94% on RA (if COPD SpO2 ≥90%) (In keeping with ITS/HSE Covid-19 pathway).
- RR <20 (in keeping with ITS/HSE Covid-19 pathway).

6.3.2 Exclusion Criteria:

- Unconfirmed Covid 19 diagnosis.
- No telephone access.
- Requires full time care.
- Unable to mobilise across the room at their baseline mobility level.
- Significant co-morbidity including clotting abnormality, HTN, malignancy, ↑↑ BMI, cardiovascular disease, Diabetes, Chronic respiratory disease, obesity.
- SpO2< 94% or RR>20.
- Increased oxygen requirement from baseline if no clinic available for follow up

These above criteria serve as guidelines, and clinical judgement should be used in making appropriate referrals. Individual Referrals should be discussed with the COPD Outreach/SD Team for suitability.

6.4 Referrals to the Covid 19 Supported Discharge Programme:

Referrals to the Virtual SD programme can be made through the Respiratory team or other relevant local teams.
Referrals can be made by completing a referral form and contacting the COPD Outreach team/SD team directly to discuss a patient's suitability for inclusion on the supported discharge programme.

6.5 Patient selection for Supported Discharge:

All patients must meet the inclusion/exclusion criteria detailed above and must consent to the referral to the team and also to the remote monitoring. An information sheet on remote monitoring and the use of data will be provided to the patient so that they can give informed consent. See Appendix 2
Each patient will be screened by the COPD Outreach Team/SD Team for suitability for the recruitment onto the programme.

All patients must have a level of mobility that will enable them to function independently or with family support in their home environment.
All patients will receive the contact details for the COPD Outreach Team/ SD Team, currently implementing the supported discharge service.

6.6 Hours of Operation:

The COPD Outreach Team/SD Team that will be managing the SD programme for Covid-19 patient's hours will be decided locally. The service will be staffed by a Clinical Nurse Specialist and a Senior Respiratory Physiotherapist.
On occasion, in consultation with the Respiratory Consultant where possible, a patient may be discharged over the weekend with a plan to commence the SD programme on the following Monday (Tuesday if a bank holiday weekend).
If monitoring out of hours or over the weekend is deemed necessary then local arrangements will need to be put in place to facilitate this. Options at local level may include an on call allowance for relevant staff for weekends/bank holidays.

Outside of normal service hours there needs to be clearly identified and communicated local arrangements agreed with the patient in the event of deterioration in their condition.

6.7 Procedure:

Following patient consent for referral to the service and if the patient is deemed to meet the criteria for acceptance on the programme, the referrer discusses the patients' suitability with the COPD Outreach/SD team and emails a completed referral form to the team. Appendix 3

On initial assessment by a member of the COPD Outreach/SD team all patients accepted to the service will be provided with an information sheet on the Mpower app and the use of their data for the purpose of monitoring. This will allow the patient to give informed consent to use the monitoring app (Appendix 2). This includes the details that will be used for the app both in the hospital and at home.

Written informed consent will be required to proceed with the app. This will be placed in the patients' medical file with a copy to the patient.

Following written informed consent patient details are entered on the patient Mpower portal by the COPD Outreach/ SD team member.

When patient details are uploaded onto the Mpower portal, this triggers an e-mail to be sent to the patient prompting them to download the Mpower app to their smart device.

The patient is advised to input clinical data into the app four times per day. This data will include SpO_2, HR and breathlessness. If the oximeter has Bluetooth connectivity this data will upload automatically when Bluetooth is connected and devices sync. This can be inputted manually by the patient if Bluetooth enabled device is not available.

The Mpower dashboard monitoring and daily phone calls then begin and are tailored to each individual.

The dashboard is accessed twice daily by the COPD Outreach/SD team member and patient data is reviewed.

Once accepted on the service the patient is provided with a pulse oximeter before discharge for use over the 14 day period, this may be extended on individual case by case assessment.

The patient will also be provided with a patient information leaflet and a facemask to be used in the event readmission is required. Appendix 4

If a patient has not input any data over the previous 8 hours they will receive a phone call to prompt data input.

If a patient has not input data in the previous 8 hours and the (monitor) COPD outreach/SD team member cannot contact the patient, NOK or nominated carer, they (monitor) should inform the emergency services, following discussion with the respiratory consultant. If a patient does not have the means to input the data, the assessor will manually input the data during a phone call review.

Any data that is outside set parameters is noted and the patient is contacted by the team member to repeat data collection. If data remains outside set parameters the respiratory consultant is informed and care will be escalated appropriately. If readmission is required, during SD service hours of operation, the rapid access pathway is followed. Appendix 5

The data is monitored during hours of operation outlined above only.

The patient is discharged from the SD programme following a maximum of 14 days, (this may be extended or shortened on a case by case basis).

A summary will be sent to the patient's GP and referring consultant at the end of the 14 day monitoring period and filled in the patients clinical notes.

6.8 Deterioration at home, outside SD service hours of operation:

All patients are provided with the contact numbers of the COPD Outreach/SD team managing the SD programme, to be contacted should they have any concerns regarding their respiratory condition during the service hours.

The Emergency Department National Ambulance Service (NAS) response car can be arranged to visit and assess a deteriorating patient if deemed appropriate by the primary consultant and COPD Outreach/SD team. If using this please have the local NAS number available to all team members.

Outside the service hours the patient will contact GP out of hour's service, or will ring 999/112 and state they are Covid positive and attend the Emergency Department if they deteriorate.

Should a patient, being monitored through the SD programme during working hours, be identified as too unwell to be safely managed at home, the patient is advised to attend the emergency department wearing a facemask.

6.9 Pathway with the GP

A clear pathway with the GP is required with real time discharge information at the start and end of the two week period. There will be a clearly identified contact person (monitor) during the two week period should the patient make contact with the GP service during the time period as they are still deemed to be under the care of their GP.

6.10 Follow Up

Following their discharge from the supported discharge programme, patients may be invited to participate in a virtual pulmonary rehabilitation programme. The provision of this programme will depend on staffing levels locally.

All patients requiring further treatment intervention, or having difficulty managing at home will be referred for a Consultants Clinic review with timeframes on a case by case basis, or will be referred to the appropriate community services.
A summary of this assessment, including results of any outcome measures completed, will be provided in a letter to the consultant. This will then be filed in the correspondence section of the patient's medical records. A copy will be sent to the patient's GP.

6.11 Patient Confidentiality:

The COPD Outreach/SD team will adhere to the standard GDPR guidelines. All documentation that is in digital format will be encrypted and password protected. The virtual data on the third party app remains the property of the HSE.
The patient will however be asked, through the app, if they consent to their data being used by the third party company. The patient is entitled to decline same. Appendix2

6.12 Documentation:

Once a patient has informed consent and is accepted onto the SD programme most documentation will be in digital format through a database and encrypted and password protected. The referring member of the MDT will write a note in the patient's medical notes documenting the patients' inclusion in the SD programme. A summary letter to the consultant will be completed and filed in the correspondence section of the patient's medical records chart.

7.0 Service monitoring audit and evaluation

Health care professionals have a clear responsibility to the patients in their care and should ensure the standard and delivery of that care is adequately meeting the need of patients. Health care professionals have responsibilities not only in planning care but also in re- evaluating patient outcomes, and demonstrating the ability to change current practices and interventions to effectively respond to the identified need of the individual patient. This service will be monitored and audited at a local level through reports to the Physiotherapy and Nursing Managers and Respiratory Consultant Lead, analysing the performance of the programme.

8.0 References/Bibliography

NCP Respiratory Guidance document for COPD Outreach.

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This document was written by

- Des Murphy Clinical Lead NCP Respiratory
- Susan Curtis Programme Manager NCP Respiratory
- Members of NCP contributed including
- Mark O Kelly ICGP HSE Primary Care Lead for Integrated Care Programmes (COPD)
- Peter O' Toole Advanced Nurse Practitioner
- Brenda Deering Senior Physiotherapist
- Anne Lanigan Senior Physiotherapist
- Rosie Hassett Clinical Nurse Specialist

Approved by Dr. Orlaith O' Reilly National Clinical Advisor and Programme Group Lead for Health and Wellbeing, Strategic Planning and Transformation.

Appendix 1 :Mpower GDPR information

An extensive review of data protection has been completed with the HSE in relation to the early discharge programme for COVID19.

- Protection Impact Assessment for HSE done on 31 March 2020.
- Data Processing Agreement with HSE signed on 31 March 2020.
- Data Protection Impact Assessment information provided to HSE
- Patient Mpower is the Data Processor not the Data Controller (HSE is Data Controller)
- Our data protection processes were reviewed by an external consultant and their report shared with the Data Protection Commissioner.
- The in-app consent statements were reviewed and agreed by the HSE and external legal advisers

For further information contact the NCP Programme manager

Use of your data for the supported discharge monitoring service

You have been deemed eligible for the supported discharge programme.
This programme will allow you to go home and continue to be monitored for a 2 week period at home .
This monitoring is done through a small finger device which measures your heart rate and oxygen levels and is connected by Bluetooth to a computer in the hospital. This monitoring system on the computer in the hospital can only be accessed by the COPD Outreach/SD team.
By allowing us to continue to monitor you in this way we will be able to ensure you have the most appropriate, individual medical care at home.

Your personal and health information will only be shared with trained personnel at the hospital for the purpose of your own individual medical care.

<u>There are two parts to the consent we require from you of this service</u>

Part 1 is consent to use your details on the Mpower app.
This will included your personal details- name address, date of birth.

Part 2 is consent to receive your data daily through the monitor that you will wear at home. This is collected 4 times a day and will be sent back to the hospital via Bluetooth for our records.

This information will be kept on the computer system and access will be limited to the COPD Outreach/SD team. The computer system will have passwords for added security.

All information shared will be treated in strict confidence as it would if you were admitted to a hospital.

The monitoring app is provided by MPower and great importance is placed on protecting your data and employ strict security measures.

For further information and the complete statement on patient device policy on storage, use and protection of data for any of its services.
See:

https://info.patientmpower.com/privacy- policy

Appendix 3:

Covid-19 Early Supported Discharge Referral Form

Name: **Date:**
Address + Eircode

Consultant:
DOB: **MRN:**
Phone No. **Hospital Location:**
Email: **Carers Contact Number:**

Diagnosis	**Tick and DATE appropriate box**
Covid-19 positive (specify date of diagnosis)	
Awaiting Covid-19 swab result (specify date swab taken)	

Inclusion Criteria	**Please tick or specify**
Access to a smart device or telephone	
Fully alert and consented	
Deemed stable and suitable for discharge home by treating physician	
SpO_2 >94% on RA (if COPD SpO2 >90%) (Please specify)	
HR 51-90 (Please specify)	
BORG ≤ 2 (light/easy) at rest (Please specify)	
RR <20 (Please specify)_	
Adequate social support	

Exclusion Criteria
• No telephone access. • Requires full time care. • Unable to mobilise across the room at their baseline mobility level. • Insufficient home care. • Living outside the catchment area. • Significant co-morbidity including clotting abnormality, HTN, malignancy, ↑↑ BMI • SpO2<94% or RR>20.

Past Medical History-please list	
Medications-please list	
Other relevant information	

Referring Doctors Name: **Referring Doctors Signature:**

When referral form is complete please email it to.....to complete referral process.
If you want to discuss the referral please contact the outreach team on ……

Appendix 4

Covid-19 Early Discharge Remote Monitoring
Patient Information

You have been deemed appropriate for home monitoring by your medical team. You will be monitored remotely for up to 14 days using the patient monitor Mpower App.

You will receive an email with a link to the patient monitor App. You should then start to download this App.

You will receive a pulse oximeter monitor device before you are discharged from hospital. You will use this daily and input the readings from it into the app. The return of this oximeter will be arranged after the 14 day period.

You will also receive a facemask on discharge home. This mask should be kept by you to use should you need to come back into the hospital.

You will be prompted to input figures 4 times daily. You will need to input your oxygen saturation %, breathlessness and heart rate, other information is optional.

Your information will be monitored remotely during daytime working hours 8.00-4.30 Monday to Friday.

If your readings are not satisfactory, a member of the monitoring team will contact you. The team will phone you 1-2 times daily Monday – Friday to check in with you.

Outside these hours, if your condition has deteriorated, you should attend the emergency department. During daytime working hours you can contact the monitoring team on ..... if you have any concerns

Appendix 5

Rapid Access Pathway (8am-4.30pm Mon-Fri)
Covid-19 Supported Discharge (SD)

(Outside of above working hours the patient attends the ED)
Note: The patient may be appropriate for review by the NAS response car ….phone….

COPD Outreach/SD team identifies patient requiring admission

↓

COPD Outreach/SD team member discusses case with Respiratory Consultant

↓ If admission is indicated

COPD Outreach/SD team informs bed management that return patient needs urgent admission under discharging/primary consultant

↓

Bed management inform COPD Outreach/SD team where patient is to be admitted. If no suitable ward/side rooms are available the patient will attend the ED.

↓

The Patient is contacted by COPD Outreach/SD team member, informed to attend hospital, main entrance, wearing facemask. The patient is given the phone number of the ward identified. The patient will let the ward know time of arrival.

↓

The designated ward will arrange for a porter, in full PPE, to meet the patient at the main entrance of the hospital and bring them to the admitting ward.

↓

Patient admitted and managed appropriately as per hospital Covid-19 Pathway

Appendix 6

COVID VIRTUAL CLINIC DAILY SCHEDULE

#	ACTION ITEMS	ROLE	WHEN	COMMENT
1	LOG INTO HSE COVID-19 APP PATIENT MONITORING PORTAL	MONITOR	AM	
2	CHECK EMAILS FOR ONLINE REFERRALS	MONITOR	AM	
3	CONTACT CO-MONITOR AND DISCUSS CASELOAD ALLOCATION AND PLAN FOR DAY	MONITOR	AM	
4	1. REVIEW PATIENTS ALREADY ON MONITORING ON PORTAL FOR 1ST 02 SAT READING 2. CALL PATIENTS WHO ARE NOT INTERNET CAPABLE FOR 1ST 02 SAT READING	MONITOR	AM	
5	RING ANY PATIENTS WHO HAVE: 1. HAD THE DEVICE FOR 24H BUT HAVE NOT REGISTERED 2. REGISTERED BUT NOT RECORDED ANY READINGS 3. HAVE O2 SATURATION NOT WITHIN PARAMETERS AND ASK THEM TO TAKE A REPEAT READING 4. ANY REMAINING PATIENTS	MONITOR	AM	
6	IN THE CASE OF REPEAT READING STILL NOT BEING WITHIN PARAMETERS, ADVISE THE PATIENT A DOCTOR WILL RING THEM BACK, AND CONTACT THE RESP REGISTRAR.	MONITOR	AM	To escalate to Respiratory team Consultant/designated Reg.
7	RECORD ANY PATIENT CONVERSATION	MONITOR	AM	Log into Patient Centre Enter Mark as reviewed and document detail of conversation
8	INPUT NEWLY REFERRED PATIENT DATA TO THE MONITORING PORTAL	MONITOR	AM	Capture the following information: 1.Patients who will be eligible for virtual clinic 2.Patient MRN, email 3.Pulse oximeter serial number (If available).

				4.Other
9	PROVIDE NEWLY REFERRED PATIENTS WITH PULSE OXIMETER OR ARRANGE FOR DELIVERY OF SAME	MONITOR	AM	Note oximeter serial number and whether Bluetooth enabled
10	LOG ONTOPORTAL TO REVIEW PM PATIENT DATA 1. REVIEW PATIENTS ALREADY ON MONITORING ON PORTAL FOR 2ND 02SAT READING 2. CALL PATIENTS WHO ARE NOT INTERNET CAPABLE FOR 2ND 02 SAT READING	MONITOR	PM	
11	RING ANY PATIENTS WHO HAVE: 1. NOT RECORDED ANY PM READINGS 2. HAVE O2 SATURATION NOT WITHIN PARAMETERS AND ASK THEM TO TAKE A REPEAT READING	MONITOR	PM	Prompt repeat readings and Input data manually if necessary
12	IN THE CASE OF REPEAT READING STILL NOT BEING WITHIN PARAMETERS,ESCALATE TO MEDICAL TEAM	MONITOR	PM	To escalate to Respiratory team Consultant/designated Reg.
13	RECORD ANY PATIENT CONVERSATION	MONITOR	PM	-Log into Patient Centre Enter Mark as reviewed and document detail of conversation
14	TELEPHONE CONTACT ANY PATIENT REQUIRING SAME	MONITOR	PM	
15	LIAISE WITH CO-MONITOR TO REVIEW DAY AND DISCUSS ANY ISSUES ARISING	MONITOR	PM	
16	ACT ON ANY ISSUES FROM POINT 15. THAT REQUIRE ACTION	MONITOR	PM	