Sleep and Ventilation Service Provision

Exit this survey

We would be very grateful if you could complete this survey regarding sleep and ventilation service provision. It should only take 10 minutes.
Thank you.

***1. Please state your institution.**

***2. Does your unit initiate patients with chronic hypercapnic respiratory failure on domicilliary non-invasive ventilation?**

- Yes
- No

Other (please specify)

***3. Which of the following equipment for the assessment and diagnosis of sleep disordered breathing do you have access to in your unit?**

	Yes	No	Don't know	Not applicable
Full polysomnography				
Respiratory sleep study e.g Embletta, Alice				
Overnight Oximetry				
Transcutaneous capnography				
CPAP autotitration				

Other (please specify)

4. If you do not have access to all of the above, please state to whom patients are referred and which patient groups are referred.

***5. Do you admit patients to perform the following?**

	Yes	No	Unsure	Not applicable
Respiratory sleep study				
Overnight oximetry				
Overnight transcutaneous capnography				
CPAP autotitration				

Other (please specify)

***6. Who reports your monitoring/diagnostic studies?**

	Doctor	Nurse	Technician	External company	Not Applicable
Full polysomnography					
Respiratory sleep study					
Overnight oximetry					
Overnight transcutaneous capnography					
CPAP autotitration					

Other (please specify)

7. Who advises patients regarding the following:

	Doctor	Nurse	HCA	Technician	Ventilator provider	Don't know	Not applicable
Mask issues							
Ventilator faults							
Ventilator maintainance							

Other (please specify)

***8. Does your hospital specifically charge the PCT for the following services?**

	Yes	No	Unsure	Not applicable
Fully polysomnography				
Respiratory sleep study				
Overnight oximetry				
Overnight transcutaneous capnography				
Domiciliary non-invasive ventilation				

Other (please specify)

***9. Please estimate the number of the following groups of patients initiated on domiciliary non-invasive ventilation per annum.**

- Obesity related respiratory failure
- Chronic obstructive pulmonary disease
- Neuromuscular weaknes
- Restrictive chest wall defect

***10. Please provide an estimate of what you feel is an appropriate level of concordance with nocturnal ventilation (hours per night) for each of the following patient groups.**

- Obesity related respiratory failure
- Chronic obstructive pulmonary disease
- Neuromuscular weakness
- Restrictive chest wall defect