Appendix 1 / Document 1 - Cardiac Arrest Procedure

Cardiac arrest procedure within Derriford Hospital (adult or paediatric)

In the event of a cardiac arrest those present should organise themselves to ensure points 1-5 are instigated.

1. **DIAL 2222**
   
   clearly state
   
   Adult OR Paediatric “CARDIAC ARREST”
   
   and the LOCATION

   *(NB assign someone to keep open ‘swipe access’ doors for the team)*

2. Start Cardiopulmonary Resuscitation (CPR) in accordance with training received.

3. Fetch the nearest emergency trolley (or backpack depending on location).

4. Use the equipment for which they have been trained e.g. pocket mask or BVM with oxygen, automated external or manual defibrillator.

5. Ensure a suction device is set up ready to be used, if required.

A handover should be given to the most senior member of the cardiac arrest team. The leader will allocate roles and manage the arrest in accordance with current UK Resuscitation Guidelines (RCUK)

**NB:** If no one from the arrest team has arrived within 3 minutes ring 2222 to have the call repeated.

An incident form should be completed for all unanticipated cardiac arrest calls.
Cardiac arrest procedure within Derriford Hospital grounds (adult or paediatric)

In the event of a cardiac arrest occurring within the hospital grounds those present should organise themselves to ensure at least points 1& 2 are instigated and where possible points 3-5 also.

1. 
DIAL 2222

clearly state

Adult OR Paediatric “CARDIAC ARREST”

and the LOCATION

The operator will also call for an ambulance.

(NB: If the arrest is too far from an internal phone to make this practical call 999 on the nearest phone, stating cardiac arrest)

2. Start Cardiopulmonary Resuscitation (CPR) in accordance with training received.

3. If a 2222 call has been made a porter will bring equipment but if possible, fetch the nearest emergency trolley or backpack

4. Use any available equipment for which they have been trained e.g. pocket mask or BVM with oxygen, automated external defibrillator.

5. Ensure a suction device is set up ready to be used if required.

A handover should be given to the most senior member of the cardiac arrest team. The leader will allocate roles and manage the arrest in accordance with current UK resuscitation guidelines (RCUK)

NB: If no one from the arrest team has arrived within 3 minutes ring 2222 to have the call repeated.

An incident form should be completed for all cardiac arrest calls occurring within the grounds.
Obstetric cardiac arrest procedure at Derriford Hospital

In the event of an obstetric cardiac arrest those present should organise themselves to ensure points 1-5 are instigated.

1.

**DIAL 2222**

clearly state

“OBSTETRIC CARDIAC ARREST”

and the **LOCATION**

(both the adult cardiac arrest and obstetric emergency team will be alerted, clearly stating the location. Consider whether the neonatal team may also be required.

(NB assign someone to keep open ‘swipe access’ doors for the team)

2. Start Cardiopulmonary Resuscitation (CPR) with the woman firmly supported in a left lateral tilt of at least 15°- 30° or with a colleague manually displacing foetus to the left

3. Fetch the nearest emergency trolley (or backpack depending on location) and emergency Caesarean section pack.

4. Use the equipment for which they have been trained e.g. pocket mask or BVM with oxygen, automated external or manual defibrillator.

5. Ensure a suction device is set up ready to be used if required.

A handover should be given to the most senior member of the cardiac arrest team. The leader will allocate roles and manage the arrest in accordance with current UK resuscitation guidelines (RCUK) which may include perimortem caesarean section.

**NB:** If no one from the arrest teams has arrived within 3 minutes ring 2222 to have the call repeated.

An incident form should be completed for all obstetric cardiac arrest calls.
Obstetric emergency calls at Derriford Hospital

In the event of an obstetric emergency those present should organise themselves to ensure points 1-5 are instigated.

1. **DIAL 3333**
   clearly state
   “OBSTETRIC EMERGENCY”
   and the LOCATION

   *(NB: assign someone to keep open ‘swipe access’ doors for the team.)*

2. Position the woman, firmly supported, in a left lateral tilt of at least 15°-30° or with a colleague manually displacing foetus to the left

3. Fetch the nearest emergency trolley (or backpack depending on location) and emergency Caesarean section pack

4. Provide appropriate support/treatment to the patient e.g. oxygen

5. Ensure a suction device is set up ready to be used, if required.

   **NB:** If the baby is to be delivered then summon the neonatal team to attend delivery – clearly indicating the priority of the situation.

A handover should be given to the most senior member of the emergency team. The leader will allocate roles and manage the emergency in accordance with current UK guidelines.
Neonatal emergency procedure at Derriford Hospital

In the event of a neonatal emergency those present should organise themselves to ensure points 1-3 are instigated.

1. DIAL 2222
clearly state
“NEONATAL EMERGENCY”
and the LOCATION

(NB: assign someone to keep open ‘swipe access’ doors for the team.)

2. Start newborn resuscitation measures in accordance with current NLS guidance & training

3. Fetch nearest neonatal emergency equipment (and, if practical, a resuscitaire)

A handover should be given to the most senior member of the emergency team. The leader will allocate roles and manage the emergency in accordance with current UK guidelines (RCUK)

NB: If no one from the team has arrived within 3 minutes ring 2222 to have the call repeated.

Complete an incident form for all unanticipated neonatal emergencies.
Medical Emergency at Derriford Hospital (adult or paediatric)

In the event of a life threatening (peri arrest) event those present should organise themselves to ensure points 1-5 are instigated.

1. Call 3333 to request emergency medical assistance (adult or paediatric) clearly stating location.
   (NB assign someone to keep open ‘swipe access’ doors for the team)
   2. Fetch the nearest emergency trolley or backpack
   3. Provide appropriate support/treatment to the patient e.g. oxygen
   4. Ensure a suction device is set up ready to be used if required.

NB: If no one from the arrest team has arrived within 3 minutes ring 3333 to have the call repeated.

A handover should be given to the most senior member of the emergency team. The leader will allocate roles and manage the emergency in accordance with current UK guidelines (RCUK)
Cardiac arrest procedure at Child Development Centre

In the event of a cardiac arrest those present should organise themselves to ensure points 1-6 are instigated.

1. Ring (9)999 for an emergency ambulance

2. Start Cardiopulmonary Resuscitation (CPR) in accordance with training received.

3. Fetch the nearest emergency equipment.

4. Use the equipment for which they have been trained e.g. pocket mask, BVM oxygen

5. Ensure a suction device is set up ready to be used if required.

6. Ensure the paramedics have access to the building and are directed where to go.

An incident form should be completed for all cardiac arrest calls at Child Development Centre.
Cardiac arrest procedure at the Satellite Haemodialysis Unit

In the event of a cardiac arrest those present should organise themselves to ensure points 1-6 are instigated.

1. Ring (9)999 for an emergency ambulance

2. Start Cardiopulmonary Resuscitation (CPR) in accordance with training received.

3. Fetch the nearest emergency equipment.

4. Use the equipment for which they have been trained e.g. pocket mask, BVM oxygen, automated defibrillator.

5. Ensure a suction device is set up ready to be used if required.

6. Ensure the paramedics have access to the building and are directed where to go.

An incident form should be completed for all cardiac arrest calls at the Satellite Haemodialysis Unit.
# Appendix 1 / Document 2 - Personnel on Arrest Team

## Pagers and groups,

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<tr>
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<tr>
<td>0690</td>
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*- core personnel
Appendix 1 / Document 3 – Intensive Care Unit (ICU) / Acute Care Team Responsibilities

Expected ICU / Acute Care Team response to cardiac arrest calls

Adult cardiac arrest calls are normally attended by the ICU F2/SHO and Acute Care Team. The acute care team member is to assist the ICU doctor with airway management. In the event of the ICU F2/SHO not available the F2/SHO on the medical take/cover will undertake the responsibility for airway management with the Acute Care Team support. Difficult airway support / tracheal intubation will be supported by the Specialist Registrar/Consultant carrying Bleep 0110.

Paediatric calls are covered by the specialist registrar/consultant carrying bleep 0110 and Paediatric ICU Nurse 0302.

The nurse covering paediatric calls from ICU is assigned by the nurse in charge.

It is the responsibility of the doctor and nurse carrying any emergency bleep to know what equipment to take to calls and where it is kept on the ICU. An immediate response is required to all cardiac arrest calls; the doctor and nurse should arrange a substitute to go if they are unable to leave immediately.

The ICU doctor or nurse attending any cardiac arrest call (adult / paediatric) must bring the small backpack as it contains equipment not readily available elsewhere in the Trust e.g. intraosseous drill, AirTraq device.

The ICU doctor or nurse attending calls, announced as paediatric, must bring, in addition to the small backpack, the larger backpack for paediatric arrest calls. This is particularly important for paediatric arrest calls to non-paediatric areas.

In addition, the ICU doctor or nurse will bring the box of anaesthetic drugs kept for this purpose in the ICU drug fridge.

NB: if the nurse carrying the arrest bleep is not based on the ICU the ICU doctor must be made aware of this by the nurse in charge. It is then the sole responsibility of the attending ICU doctor to bring the backpack(s) and drugs.

Alternatively if the doctor carrying the arrest bleep leaves the ICU s/he must inform the nurse covering the calls to ensure the backpack(s) and drugs are taken by the nurse to a cardiac arrest call.

The nurse in charge on ICU is responsible for ensuring the contents of both backpacks are checked daily and signed for. The nurse attending the call is responsible for returning and restocking the backpack(s) & drug box.

The ICU doctor attending is responsible for ensuring a cardiac arrest audit form is completed for all calls attended including ‘false alarms’. Changes to the contents of the backpacks must be agreed with the Resuscitation Dept and/or the Resuscitation Committee.
### Resuscitation Skills Training Needs Analysis

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<th>ADULT</th>
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#### Requirements for Specific Staff Groups

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<td>Requirements for Specific Staff Groups</td>
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Appendix 1 / Document 4 Training Needs Analysis (TNA)

Resuscitation Skills Training Needs Analysis

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NOTES:

* HCA= Healthcare Assistant     * NA= Nursing Auxillary     * MA= Medical Assistant
* ODP / ODA= Operating Department Practitioners / Assistants
* Therapists= Physiotherapist, Occupational Therapists, Speech and Language Therapist
* GSA= General Support Assistant

1 = Essential
1a= Essential if caring for this patient group
2= Desirable
3= Mandatory to achieve within the first year of training

# = other in house equivalent course approved by the Resuscitation Department e.g. CBALS

ALS/APLS/NLS certificates are valid for 4 years therefore an annual refresher must be attended if required.
If the patient is not ventilated administer 100% Oxygen via a bag/valve/mask with 2 breaths every 30 compressions.

For ventilated patients, turn FiO2 to 100% and switch off PEEP.

For ventilated patients when appropriately trained staff present: Disconnect from ventilator and ventilate with a bag valve mask to confirm ET tube placement and exclude a pneumothorax or haemothorax. If tension pneumothorax suspected, immediately place large bore cannula in the 2nd rib space anterior mid-clavicular line. Once ET tube placement confirmed reconnect to ventilator, set FiO2 to 100% and ventilator rate to 10 per minute.

If an IABP is in place change to pressure trigger.

If Pacing Wires in place use for asystole and severe bradycardia.

As soon as Surgical Staff available prepare for Resternotomy (if appropriate).
Adult Advanced Life Support

Unresponsive?  
Not breathing or only occasional gasps

Call resuscitation team

CPR 30:2  
Attach defibrillator / monitor  
Minimise interruptions

Assess rhythm

Shockable  
(VF / Pulseless VT)

1 Shock

Immediately resume **CPR for 2 min**  
Minimise interruptions

Non-Shockable  
(PEA / Asystole)

Return of spontaneous circulation

Immediately resume **CPR for 2 min**  
Minimise interruptions

**During CPR**
- Ensure high-quality CPR: rate, depth, recoil
- Plan actions before interrupting CPR
- Give oxygen
- Consider advanced airway and capnography
- Continuous chest compressions when advanced airway in place
- Vascular access (intravenous, intraosseous)
- Give adrenaline every 3-5 min
- Correct reversible causes

**Reversible Causes**
- Hypoxia
- Hypovolaemia
- Hypo-/hyperkalaemia / metabolic
- Hypothermia
- Thrombosis - coronary or pulmonary
- Tamponade - cardiac
- Toxins
- Tension pneumothorax
**POST CARDIAC SURGERY - OPEN CHEST ALGORITHM**

**IN THEATRE HOURS**

- Non-Cardiac Arrest Patient Requiring Review
  - Call 3333 – ask to Fast Bleep Cardiothoracic Reg 0771
  - Decision to Return Patient to Theatre
    - Notify Theatre 54516 Anaesthetist 0770 and Perfusionist if Required
      - Prepare Patient for Theatre
      - Transfer Patient to Theatre
      - Contact CICU Co-Ordinator 31784 and Inform Patient has Returned to Theatre
  - THEATRE UNAVAILABLE
    - Decision to Open Chest on Ward or Transfer to CICU
      - Prepare Environment as per Guidelines
        - Initiate Open-Chest Trolley & Supportive Equipment. Inform CICU Co-Ordinator of Open Chest. Retrieve Portable Light & Diathermy from Torrington CICU
          - Commence Open Chest Procedure

**OUT OF THEATRE HOURS**

- Call 3333 – ask to Radiopage Cardiothoracic REG 89295
  - Decision to Return Patient to Theatre
  - Ring Switch 3333
    - State Patient to Return to Theatre
      - Call On-Call Theatre Team
        - 1st On Call Nurse
        - 2nd On Call Nurse
        - GSA
        - ODA
        - *Will Need to Specify if Perfusionist is Required*
          - Prepare Patient for Theatre
          - Contact CICU Co-Ordinator 31784 and Inform Patient has Returned to Theatre

**THEATRE UNAVAILABLE**

- Decision to Return Patient to Theatre
  - Non-Cardiac Arrest Patient Requiring Review

**VARIENCE TO CONSIDER**

- Transferring patient to Torrington CICU if bed available

*OPEN CHEST WORKING PARTY*  
*Jan 2005*  
*UPDATED MARCH 2011*  
*MEDPHOTO 119656*
POST CARDIAC SURGERY - OPEN CHEST ALGORITHM

Cardiac Arrest
Commence CPR

Call 2222
State Cardiac Arrest & Area

General Arrest Team
Arrive and Manage Situation
(in Theatre hours CT REG on-site)

Anaesthetic REG
Bleep 0770

Decision by CT REG / to
Re-Open Chest

OUT OF THEATRE HOURS
CT REG OFF-SITE

Switchboard Radiopage
CT REG.
(failure to respond
call patient’s consultant)

CT REG / Consultant Contacts
Clinical Area to Discuss Case

IN THEATRE HOURS

Notify Theatre 54516
State Re-Open Chest and
Clinical Area

Prepare Environment as per Guidelines for
Theatre Team

Initiate Open Chest Equipment

Theatre Team to Bring Other Essential Equipment

OUT OF THEATRE HOURS

Clinical Area Call 3333
State Open Chest
Ask To Call The On-Call Theatre Team
1. On Call Nurse
2. 2nd On Call Nurse
3. GSA
4. ODA
5. Perfusionist

Prepare Environment as per Guidelines

Initiate Open-Chest Trolley & Supportive Equipment. Inform CICU Co-Ordinator of Open Chest 31784
Retrieve Portable Light & Diathermy from Torrington CICU

CT REG Arrives
Commence Open Chest Procedure
Anaphylaxis algorithm

**Anaphylactic reaction?**

**Airway, Breathing, Circulation, Disability, Exposure**

**Diagnosis** - look for:
- Acute onset of illness
- Life-threatening Airway and/or Breathing and/or Circulation problems
- And usually skin changes

- **Call for help**
  - Lie patient flat
  - Raise patient’s legs

**Adrenaline**

**When skills and equipment available:**

- Establish airway
- High flow oxygen
- IV fluid challenge
- Chlorphenamine
- Hydrocortisone

**Monitor:**
- Pulse oximetry
- ECG
- Blood pressure

1. **Life-threatening problems:**
   - **Airway:** swelling, hoarseness, stridor
   - **Breathing:** rapid breathing, wheeze, fatigue, cyanosis, SpO₂ < 92%, confusion
   - **Circulation:** pale, clammy, low blood pressure, faintness, drowsy/coma

2. **Adrenaline (give IM unless experienced with IV adrenaline)**
   - IM doses of 1:1000 adrenaline (repeat after 5 min if no better)
     - Adult: 500 micrograms IM (0.5 mL)
     - Child more than 12 years: 500 micrograms IM (0.5 mL)
     - Child 6 -12 years: 300 micrograms IM (0.3 mL)
     - Child less than 6 years: 150 micrograms IM (0.15 mL)
   - Adrenaline IV to be given only by experienced specialists
   - Titrate: Adults 50 micrograms; Children 1 microgram/kg

3. **IV fluid challenge:**
   - Adult: 500 – 1000 mL
   - Child: crystalloid 20 mL/kg
   - Stop IV colloid if this might be the cause of anaphylaxis

4. **Chlorphenamine**
   - Adult or child more than 12 years: 10 mg
   - Child 6 - 12 years: 5 mg
   - Child 6 months to 6 years: 2.5 mg
   - Child less than 6 months: 250 micrograms/kg

5. **Hydrocortisone**
   - Adult or child more than 12 years: 200 mg
   - Child 6 - 12 years: 100 mg
   - Child 6 months to 6 years: 50 mg
   - Child less than 6 months: 25 mg

See also: ► Anaphylactic reactions – Initial treatment
Appendix 1 / Document 8 – Emergency Trolley Checking Procedure

Emergency Trolley Important Information

At the start of each shift check that the trolley is sealed and ready for use.
Each day check the following:

- Check the defibrillator (see next page for details).
- Check the oxygen cylinder is at least ¾ full.
- Check the suction (see next page for details).
- Check the sharps bin is empty.
- Check the general cleanliness of the outside of the trolley.
- Check the seal is intact and matches the last recorded number.
- Initial the Daily Check page of the checking book.

Weekly, or after the trolley is used, or if the seal is missing, broken or not the same number as in the book:

- As per daily check above plus:
- Check the entire contents of the trolley against the list in this book.
- Check that the light works on top of Laryngoscope handle by depressing the button.
- Replace any missing, expired or inappropriately opened items.
- Remove items that are not on the list.
- Fill in and sign on a Full Check page of the checking book.

General points

- Clean, check and restock the trolley as soon as possible after it is finished with. Have a second person recheck the contents and reseal the trolley. Record the seal number.

- Phone the porters on extension 32300 to replace oxygen cylinders that are below ¾ full.

- Replace used items from ward stock where possible. Items that you do not normally stock can be supplied by Thrushel MAU level 06 and they will cross charge. Please ensure you supply Thrushel with your budget number when you collect the items.

- Check expiry dates of all consumables. Rotate stock through the ward/ED/CCU/Theatres, etc. e.g. defibrillator pads with only a few months left can be swapped with the ED.
• Generally speaking items that come in sealed packets should remain **Unopened** until used. If packets are open you cannot guarantee that their contents have not already been used and inappropriately put back in the trolley. They could also have been tampered with. Replace items in the trolley if their packets are open or damaged.

• Non disposable items should be decontaminated and returned to the trolley.

• Do not add items to the trolley that are not listed.

• Replace medications and fluids from pharmacy in hours (use your drug ordering book) or, if out of hours, from the emergency drug cupboard just outside pharmacy (keys held in porters lodge). Rotate medications with the shortest expiry date to high use areas, e.g. ED, MAU, CCU, etc.

• Note any problems in the comments box but also **do something about them!**

• If you have any queries/problems contact your Resuscitation Link person or one of the Resuscitation Officers. Out of hours, the Senior Nurse on 0355 may be able to help or offer advice.

**Daily check of an AED (Automated external defibrillator)**

• Check **inside the carry case** for:

  - 2 sets of **Unopened** and in date adult defibrillator pads.
  - **Paediatric areas only:** 1 set of **Unopened** and in date paediatric attenuated defibrillator pads.
  - An **Unopened** and in date spare defibrillator battery.
  - A pair of “Tuff Cut” scissors.
  - Skin prep razor.

• Check the status indicator (top right on the front of the AED):

  - If there is a flashing black hourglass the AED is ready for use.

  - If anything other than a flashing black hourglass is displayed, remove and then reinsert the battery. This will put the AED into a selftest that takes a few minutes.

  - If the selftest passes and the status indicator shows the flashing black hourglass, the AED is ready for use.
If the selftest fails, remove the old battery and insert the spare battery. The AED will selftest again and if this passes the AED is ready for use. Contact MEMS and the Resuscitation Department for a new spare battery. If the selftest fails contact MEMS URGENTLY.

Daily check of a manual defibrillator

- Check that next to the defibrillator there are:
  - 2 sets of Unopened and in date adult defibrillator pads.
  - **Pediatric areas only:** 1 set of Unopened and in date paediatric defibrillator pads.
  - A test load.

- Check that attached to the defibrillator there is:
  - A hands free cable.
  - An ECG cable with 3 lead attachment.

- Disconnect the defibrillator from the mains and attach the test load to the hands free cable. Turn on in test mode and follow the prompts that the defibrillator issues. If the defibrillator fails any part of this test contact MEMS URGENTLY.

- On the Phillips XL, test mode is entered by pressing and holding the print strip button (marked **Strip**) whilst turning the energy select knob to either **Manual On** or **AED On**.

- On the Phillips MRx, test mode is entered by turning the MRx on and scrolling through the menu to **Other** and then **Operational Check**.

- After the test, plug the defibrillator back into the mains and check that it is **on charge**.

Daily check of the suction unit

- Check that the unit has a clean liner, tubing and Yankauer suction catheter fitted.

- Disconnect from the mains and turn on. Occlude the tubing and make sure the gauge rises to -300 mmHg in under 3 seconds and continues to -525 mmHG.

- Reconnect to the mains and check that the unit is **on charge**.
Adult Observation Chart

Immediately inform registered nurse, re-check obs, bleep ACT on 89048, request medical review within an hour unless nurse feels clinical need is greater (use SBAR).

Immediately inform registered nurse, request medical review within 2hrs (use SBAR), re-check obs within 30 mins.

Inform registered nurse, re-check obs within 1hr.

Follow analgesic ladder, if no improvement in 30 mins bleep ACT on 0195.

Frequency Date

Time

TempºC

40

39

38

37

36

35

34

Resp rate

30

25

20

15

10

Sats %

>93

89-92

85-88

<85

O2Device

VM HM NS

Flow rate L/min or %

Heart Rate

150

130

110

90

70

50

30

BP

200

180

160

140

120

100

80

60

40

Conscious Level:

Alert

Voice

Responds to pain

Unresponsive

Blood Glucose

Weight

Bowels

For patients with severe or moderate pain, inform senior staff and manage pain as per trust analgesic ladder.

Pain

Severe

Moderate

Mild

None

Recorded by: Print initials

Nurse: Print initials when reviewed (at least once per shift)

File in the nursing records
Use SBAR when requesting medical review or calling outreach.

Pre-call preparation: Gather the following information: Patient’s name; age; obs chart, fluid chart & drug chart.

Use the checklist below to gather your thoughts and prepare.

S

Situation:
I am (name), a nurse on ward (X)
I am calling about (patient X)
I am calling because I am concerned that . . . .
(e.g. BP of low/high, pulse is XX temperature is XX, Early Warning is XX)

B

Background:
Patient (X) was admitted on (XX date) with . . . . (e.g. MI/chest infection)
They have had (X operation/procedure/investigation)
Patient (X)’s condition has changed in the last (XX mins)
Their last set of obs were (XX)
Patient (X)’s normal condition is . . . . (e.g. alert/drowsy/confused/pain free)

A

Assessment:
I think the problem is (XXX) and I have . . . (e.g. given O2/analgesia, stopped the infusion)
OR
I am not sure what the problem is but patient (X) is deteriorating
OR
I don’t know what’s wrong but I am really worried

R

Recommendation:
I need you to . . . . (e.g. come to see the patient in the next XX mins)
AND
Is there anything I need to do in the meantime? (e.g. stop the fluid/repeat the obs)
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<th>TempºC</th>
<th>Resp rate</th>
<th>Sats %</th>
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For patients with severe or moderate pain, inform senior staff and manage pain as per trust analgesic ladder.
If a patient suffers a new head injury in hospital

- Perform and record observations on a half-hourly basis until GCS = 15
- When GCS = 15, minimum frequency of observations is:
  - half hourly for 2 hours
  - then 1 hourly for 4 hours
  - then 2 hourly thereafter
- If patient deteriorates to GCS < 15 after initial 2 hr period, revert to half-hourly observations & follow original schedule
# NEWBORN EARLY WARNING

**OBSERVATION CHART FOR NEWBORN INFANTS**

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<th>DATE</th>
<th>Time</th>
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<tr>
<th>COLOUR (SpO₂)</th>
<th>PINK (&gt;94%)</th>
<th>95-94%</th>
<th>DUSKY/BLUE (&lt;95%)</th>
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<thead>
<tr>
<th>NEURO</th>
<th>ACTIVENESS TO FEED</th>
<th>UPSET/TUMMY</th>
<th>FLOPPY/DOF TO ROUGE</th>
<th>SEIZURES</th>
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<thead>
<tr>
<th>SCORE</th>
<th>RED</th>
<th>AMBER</th>
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<thead>
<tr>
<th>RESPONSE</th>
<th>ALL OBSERVATIONS IN WHITE</th>
<th>CONTINUE OBSERVATIONS 4 HOURLY OR AS REQUESTED.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ONE IN AMBER</td>
<td>CONTACT SHO/ANNIP/SENIOR MIDWIFE. VERBAL MANAGEMENT PLAN OR REVIEW. REPEAT OBSERVATIONS IN 30 MINUTES.</td>
</tr>
<tr>
<td></td>
<td>TWO IN AMBER OR ONE IN RED</td>
<td>IMMEDIATE REVIEW</td>
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</tbody>
</table>

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File alongside other observation charts

VERSION 6 - March 2010
OBSERVATION CRITERIA FOR N.E.W.

Any infant with one or more of the following risk factors may be considered ‘at risk’ and justify observation:

Prenatal
Risk Factors for infection – e.g. Maternal GBS, PROM > 18 hrs
CTG demonstrating evidence of significant fetal compromise.
Scalp pH < 7.0

Perinatal
‘Thick’ Meconium
Cord pH < 7.0
Ventilatory support for > 3 min
External cardiac massage
5 min APGAR < 8 (if < 5 requires admission to NICU)
Grunting / respiratory distress

Postnatal
Grunting
Abnormal Movements
Any other ongoing concerns
At the request of a reviewing ANNP/SHO/Registrar

Clinical common sense must be used when deciding if any other infant requires heightened observation.

Consider the following additional risk factors:

Reduced fetal movements
CTG with other non-reassuring features
Significant placental infarction or abruption
Unexpectedly small infant (< 2.5 kg)
Babies with dysmorphic features or identified congenital abnormalities

IMPORTANT

The NEW observation chart is a tool to facilitate observations and the identification of infants demonstrating signs of instability and clinical concern.

It is the responsibility of the clinical team to determine the frequency and length of time an infant is observed, based upon guidelines or clinical criteria.

IN AN EMERGENCY FOLLOW THE USUAL EMERGENCY PROCEDURE

CALL SWITCH 2222 & DECLARE
‘NEONATAL EMERGENCY’ + LOCATION

ALSO - CONTACT NNU 55057 or 53600

NEW Observation Chart

This chart is copyright of Plymouth Hospital’s NHST
### Obstetric Early Warning Chart

#### Date: [ ]

#### Time: [ ]

<table>
<thead>
<tr>
<th>Temperature</th>
<th>39</th>
<th>38</th>
<th>37</th>
<th>36</th>
<th>35</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resp. Rate</td>
<td>&gt;30</td>
<td>21-30</td>
<td>11-20</td>
<td>0-10</td>
<td></td>
</tr>
<tr>
<td>SpO2%</td>
<td>95-100%</td>
<td>&lt;95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Rate / Pulse</td>
<td>140</td>
<td>130</td>
<td>120</td>
<td>110</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>90</td>
<td>80</td>
<td>70</td>
<td>60</td>
<td>50</td>
</tr>
<tr>
<td>Systolic Blood Pressure</td>
<td>200</td>
<td>190</td>
<td>180</td>
<td>170</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td>150</td>
<td>140</td>
<td>130</td>
<td>120</td>
<td>110</td>
</tr>
<tr>
<td>Diastolic Blood Pressure</td>
<td>100</td>
<td>90</td>
<td>80</td>
<td>70</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuro Responsivity</td>
<td>Alert</td>
<td>Voice</td>
<td>Pain</td>
<td>Unresponsive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;50ml/2hrs</td>
<td>&lt;50ml/2hrs</td>
<td>&lt;100ml/4hrs</td>
<td>&lt;10ml/hr</td>
<td></td>
</tr>
<tr>
<td>Total YELLOW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See flow chart overleaf if patient triggers one red or two yellow at any one time.
Obstetric Early Warning Flowchart

x 1 red
x 2 yellow

YES

Call O&G SHO

Slow medical response/
Serious concern/
Vital signs deteriorating

NO

Patient improves with intervention

YES

Continue hourly Obs until stable

NO

No red or yellow scores for over four hours.

YES

4 hourly obs

x 1 yellow

YES

Continue to monitor,
REPEAT OBS AT LEAST HourLY.
Ensure O₂, Fluids and IV access
are adequate.
Consider PRN medication.

NO

Call O&G SpR for advice

YES

Patient improves with intervention

NO

Contact On-Call Anaesthetist
(Bleep 399) - consider
Critical Care Outreach
(Bleep 89048)

YES

Failure to improve:
Contact HDU/ICU
for advice / bed availability
(ICU Reg - Bleep 110)
DERRIFORD POST CARDIAC ARREST PROTOCOL

ADULT CARDIAC ARREST (NOT TRAUMA)

Appropriate Resuscitation Protocols

SUCCESSFUL
(Return of Spontaneous Cardiac Output)

Check ABG’s, ECG, bloods, CXR

Assisted Ventilation
Inotropes

Assisted Ventilation
Spontaneous Circulation

Spontaneous Circulation
Spontaneous Ventilation

Consider Comorbidity and Other Factors*

ICU/HDU

GCS >12 and Low Risk
GCS <12 and / or High Risk
d/w ICU

Consider induced hypothermia

CCU

ICU / HDU

FAILED

Consider after 15 mins recorded asystole unless drug overdose or temperature < 32°C

Very Poor Prognosis
Further Critical Care Management if Appropriate
Based on Clinical Condition,
(This Must Be Discussed First at a Senior Level With the ICU and if possible the admitting consultant)
Note if the patient survives and needs transfer then the Team Leader should stay with the patient until care is handed over to either the Intensive Care or Cardiology Team

*Some Factors to Consider:

- Pre-arrest morbidity - e.g. hypotension, uraemia,
- Continuing inotrope requirement
- Medication - e.g. poorer outlook if Amiodarone and Lignocaine required
- Initial rhythm - e.g. poorer outcome if PEA/Asystole
- Duration of CPR - deteriorating outlook if > 15 - 20 mins
- Number of shocks - greatest survival if < 3
- GCS - <25% survival if GCS 3,
- Better outlook if lower K and HCO3
- Delayed CPR / unwitnessed arrest
- Recurrent arrests
- Temperature
- Drug overdose

Appendix 1 / Document 12 - Procedure for testing Emergency Bleeps

Procedure for daily testing of emergency bleeps by switchboard

The switchboard manager is responsible for ensuring the emergency group bleeps are tested daily.

The groups are:
Adult cardiac arrest team
Paediatric cardiac arrest team
Neonatal emergency team
Obstetric emergency team
Adult trauma team
Paediatric trauma team

Individual emergency bleeps also tested daily:
Cardiothoracic registrar
Anaesthetic emergency cover

The manager will assign an operator to conduct the test calls. The tests are normally conducted daily- current practice is at 1400.

Procedure:
The operator should activate the each bleep group in turn and state:

“Testing your (specify which bleep) please call switchboard.
See examples:

“Testing your adult cardiac arrest bleep, please call switchboard. or
Testing your paediatric cardiac arrest bleep……
or
Testing your neonatal emergency bleep….. or
Testing your obstetric emergency bleep…… or
Testing your adult trauma call bleep…….. or
Testing your paediatric trauma call bleep……

Mark in the file responses that are received.

NB: Some bleeps are part of two or more groups hence specifying which group is being tested to ensure the bleep works for all calls.
Notes for non response:

Those marked as core members of a team must be retested if they have not responded within 20 minutes.

If there is no response to the second test the operator will inform the switchboard manager who will notify a Resuscitation Officer. In the absence of the manager the operator will notify the Resuscitation Officer. The Resuscitation Officer will then follow up non responders.

If a Resuscitation Officer is unavailable a message should be left on the departmental voice mail and/or an email sent to the resuscitation department.

Additional points:
Delay testing the bleeps if a genuine emergency call has been made to that group within the previous 30 minutes.

Responses to bleeps are recorded in the file kept in switchboard. This file is checked weekly by the Resuscitation Officers to monitor responses to the test.
Appendix 1 / Document 13

Switchboard procedure for managing cardiac arrest calls at Derriford.

Cardiac Arrest calls to 2222

- The operator should answer the 2222 phone with the words “cardiac arrest, which team do you need?”

(If the caller is uncertain ask, “is it for a child or adult?” If the casualty is an adolescent and the caller is unsure which team is required send the adult team?)

- Ask the caller for their location (i.e. where to send the team).

It is important that an accurate location is given, especially for a collapse by lifts, stairs, or within the grounds to ensure the team is sent to the right place.

- The switchboard operator should repeat the information given before disconnecting.

- The operator will immediately activate the group call for either the adult or paediatric team.

The message should state “cardiac arrest location and floor level” and be repeated.

for example

“adult cardiac arrest Honeyford ward, level 9, repeat adult cardiac arrest, Honeyford ward, level 9”

Or

“adult cardiac arrest, main entrance close to the Body shop, level 6, repeat adult cardiac arrest, main entrance close to the Body shop, level 6”

or

“paediatric cardiac arrest, Wildgoose ward level 12, repeat paediatric cardiac arrest Wildgoose ward level 12”

- After making the group call the operator will immediately notify the porters’ helpdesk by telephone (the porters are also on the group bleep)
• Record the event in the diary provided using a red ink pen.

Notes:

• For cardiac arrest calls within the grounds, in addition to the hospital team, the operator will also ring 999 to request an emergency ambulance to the location given.

• For some cardiac arrest calls additional personnel are required – e.g. obstetric cardiac arrests the obstetric emergency team are called, cardiothoracic calls the duty cardio thoracic registrar is called. See the flip chart for detail.

• Do not cancel calls once they have gone out, even if someone rings to say it was a false alarm, tell the caller the procedure is NOT to cancel calls.

• If a member of the team rings to query whether they should attend – for example to a location outside – inform them that they must always attend anywhere, any call they receive through the emergency system.
Switchboard procedure for managing emergency calls at Derriford.

(Excluding fast bleep fire & security calls)

Other emergency calls made to 3333 (or 2222)

- The operator should answer the 3333 phone with the words “emergency what help do you require?”

- Ask the caller for their location (i.e. where to send the team).

It is important that an accurate location is given, especially for a collapse by lifts, stairs, or within the grounds to ensure the team is sent to the right place.

- The switchboard operator should repeat the information given before disconnecting.

If the caller is uncertain which team is required and if they are calling from a maternity ward or maternity department the operator should send both the adult emergency team and the neonatal emergency team.

- The operator will immediately activate the group call for whichever team has been requested.

The message should state “the type of call, location and floor level” and be repeated.

see examples:

“urgent medical assistance required physio gym level 7, repeat urgent medical assistance required physio gym level 7”

“neonatal emergency central delivery suite level 4 maternity block, repeat neonatal emergency central delivery suite level 4 maternity block”

“Obstetric emergency, transitional care ward level 5 maternity block, repeat Obstetric emergency transitional care ward level 5 maternity block”

- After making the group call the operator will immediately notify the porters’ helpdesk by telephone (the porters are also on the group bleep)

- Record the event in the diary provided using a red ink pen.

Notes:
• For calls within the grounds in addition to the hospital team the operator will also ring 999 to request an emergency ambulance to the location given.

• Do not cancel calls once they have gone out, even if someone rings to say it was a false alarm, tell the caller the procedure is NOT to cancel calls.

• If a member of the team rings to query whether they should attend –for example to a location outside –inform them that they must always attend anywhere, any call they receive through the emergency system.
Appendix 1 / Document 14

Exception to standard emergency trolley

Penrose and Pencarrow (intensive care units) have alternative trolleys for managing cardiac arrests and other emergencies within the unit.

The contents are decided locally.

The trolleys are checked and signed for daily.

In the event of a collapse occurring away from a bed space, for example in the visitor waiting area or patient bathroom, there is readily available (portable) oxygen & a bag valve mask in every bed space. There are also three wall mounted portable suction units. All this equipment is checked daily.

Attending cardiac arrest calls within the Trust

It is the responsibility of the ICU nursing and medical staff, who carry the cardiac arrest bleep(s), who may be involved in arrest/emergency calls away from the unit, to be familiar with the contents of the standard emergency trolley used throughout the rest of the Trust (in particular the contents of the two airway drawers).

NB: The standard emergency trolley is used on all adult and paediatric courses run by the Resuscitation Department. These courses are attended by the ICU clinical staff.
4 Map of Pack Locations.

LOP Operating Procedure
SMS LOP – Cardiac Arrest and Emergency Assistance calls

Document Details

<table>
<thead>
<tr>
<th>LOP Reference</th>
<th>Contract Local Document Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Date</td>
<td>27th January 2016</td>
</tr>
<tr>
<td>Issue</td>
<td>V4</td>
</tr>
<tr>
<td>Document Approver</td>
<td>Christine Pope – Operations Manager</td>
</tr>
<tr>
<td>Document Author/Owner</td>
<td>Louise Pelley – FOH Coordinator</td>
</tr>
<tr>
<td>Audience</td>
<td>Front of House Co-ordinators, Helpdesk Operatives, Porters, Resuscitation team, PNHT facilities</td>
</tr>
</tbody>
</table>

CONTENT

1 DOCUMENT CONTROL
2 INTRODUCTION
3 ROLES AND RESPONSIBILITIES
4 PROCEDURE
4.1 Heading
4.2 Heading
4 RECORDS REQUIRED
5 DEFINITIONS
6 SUPPORT AND FEEDBACK

Classification: Serco Internal
We recommend that you read the following documentation to assist you with this procedure:

<table>
<thead>
<tr>
<th>Document Title &amp; Reference</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
INTRODUCTION

This document outlines the expected response times from the Portering department in the event of cardiac arrest or medical assistance/emergency calls at the Derriford hospital site.

ROLES & RESPONSIBILITIES

It is the responsibility of the Helpdesk operative to ensure that the task is allocated within the set response times.

The porter(s) that are allocated the task must ensure that they stay in radio contact with the Helpdesk to enable the Helpdesk to keep the log up to date.

The following table advises on the core responsibilities for delivering this procedure.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities within this procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helpdesk Operative</td>
<td>Log details in to the computer system and ensure that the task is allocated</td>
</tr>
<tr>
<td>Porter</td>
<td>Attend the relevant task and ensure that all equipment is delivered within the Service level agreement</td>
</tr>
</tbody>
</table>

PROCEDURE

3.1 Notification of a call

The Derriford switchboard will notify the hospital arrest team and the Serco Helpdesk, this will be completed by using bleep 301 and/or calling the Serco Helpdesk on extension 32300, stating the location and nature of the incident, the Serco Helpdesk will notify the switchboard that the task has been received.

The Serco Helpdesk Operative will input the details of the call into the computer system and allocate the role of attending the call to one or two porters as deemed necessary.

The task will be allocated immediately to the porter(s) that is nearest to the emergency call. Should the porter(s) be in the process of transferring a patient, they will complete the transfer and then respond immediately to the site of the emergency call.

Upon arrival of the site of the emergency call the porter(s) will radio the Helpdesk to confirm attendance.
It is the responsibility of the attending porter(s) to keep the Serco Helpdesk informed of the situation.

### 3.2 Calls to areas in the main building

The allocated porter(s) will attend the area of the emergency call and await instructions from the hospital arrest team.

This may include:

- Fetching equipment as directed
- Transferring the patient by trolley, wheelchair or bed
- Emergency handling of patients as per manual handling SOP

### 3.3 Calls to the grounds of the hospital

The allocated porter(s) will identify the nearest emergency bag location as per section 4 (below), they will collect the emergency bag and take it to the requesting area. They will then await instructions from the hospital arrest team.

This may include:

- Fetching equipment as directed
- Transferring the patient by trolley or wheelchair to the main hospital
- Emergency handling of patients as per manual handling SOP

### 3.4 Calls to buildings detached from the main hospital

Buildings that are detached from the main part of the hospital include:

- Post graduate medical centre
- Peninsula medical school (John Bull building)
- Glenbourne
- Occupational Health
- Estates building including the boiler house
- Derriford Health & Leisure centre

The allocated porter(s) will attend the area, it is the responsibility of the staff within these areas to collect the nearest equipment themselves or else direct the porter(s) to collect.

### 3.5 Calls to areas off site

The hospital resuscitation team and the portering department do not attend off site emergencies and staff are expected to contact the emergency services via 999.
## 4 Equipment

<table>
<thead>
<tr>
<th>Equipment type</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic defibrillator</td>
<td>Level 3 inside Mayflower ward</td>
</tr>
<tr>
<td>(NB: if the defibrillator has been requested by the cardiac arrest team no permission is required from staff working in these areas to take it)</td>
<td>Level 06 inside MAU Thrushel</td>
</tr>
<tr>
<td></td>
<td>Level 09 corridor by Hexworthy ward</td>
</tr>
<tr>
<td></td>
<td>Low trolley from ED</td>
</tr>
<tr>
<td>Emergency scoops</td>
<td>Level 06 Helpdesk</td>
</tr>
<tr>
<td>Emergency scoop with low trolley</td>
<td>Level 3 Medical equipment Library (by entrance)</td>
</tr>
<tr>
<td>Arrest/Emergency packs</td>
<td>Level 06 main entrance</td>
</tr>
<tr>
<td></td>
<td>Level 06 ED triage room</td>
</tr>
<tr>
<td></td>
<td>Health &amp; Leisure centre reception</td>
</tr>
<tr>
<td></td>
<td>Postgrad Medical centre main entrance</td>
</tr>
<tr>
<td></td>
<td>Level 05 Maternity entrance main corridor</td>
</tr>
<tr>
<td></td>
<td>Occupational Health 1st floor</td>
</tr>
<tr>
<td></td>
<td>Level 03 coffee shop area (by vending machines)</td>
</tr>
<tr>
<td></td>
<td>Level 03 REI Entrance (By automatic Doors)</td>
</tr>
<tr>
<td></td>
<td>Multi Storey Car park Level 0</td>
</tr>
<tr>
<td></td>
<td>Multi Storey Car park level 2</td>
</tr>
</tbody>
</table>

Many wards have a red resus trolley, it is the responsibility of the ward / departments to undertake the checks on their resus trolleys and should the cylinder require changing they are to inform the Serco Helpdesk on 32300. It is the Portering department’s responsibility to ensure that this task is undertaken.
Car Park Packs
for Cardiac Arrest/Medical Emergencies in the grounds of Derriford Hospital

Location of car park packs:
1. Main entrance (opposite porters lodge)
2. Emergency Department (triage room)
3. Derriford Health & Leisure (reception)
4. Postgrad Medical Centre (main entrance)
5. Terence Lewis Building (level 03 coffee shop)
6. Maternity entrance (main corridor)
7. Bircham Car Park (formally car park E) (level 0 and 2)
8. Occupational Health

Main entrance
Emergency Department
azar

Derriford Health and Leisure

Maternity Entrance
Terence Lewis Building
Postgrad Medical Centre

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Page 6 of 7
Uncontrolled document unless viewed on the Contract's Document Control Register
4 Map of Pack Locations.

5 RECORDS REQUIRED.

<table>
<thead>
<tr>
<th>Record Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation department</td>
</tr>
<tr>
<td>Expected response from Portering staff in the event of cardiac arrest or medical assistance/emergency calls at Derriford hospital</td>
</tr>
<tr>
<td>Emergency packs map</td>
</tr>
<tr>
<td>Car Park Packs – for cardiac arrest/medical emergencies in the grounds of Derriford hospital</td>
</tr>
</tbody>
</table>

6 SUPPORT & FEEDBACK

If you require additional support or guidance on this document, please e-mail the document owner.

This document is only valid when viewed within the Contract’s Document Control Register. Changes to this document will be communicated via e-mail, internal memoranda or external notices.

We welcome feedback from users on this document in order to enhance user understanding and improve its effectiveness and efficiency. To provide feedback the channels are:-

- Contact the document owner.
- Contact the Assurance Lead for the Contract.
**Treatment Escalation Plan (TEP) and Resuscitation Decision Record**

This form is for clinical guidance and it does not replace clinical judgement.

### Mental Capacity
Do you believe the patient has capacity to be involved in making these decisions?

- **Yes**: Proceed with making decisions based on patient's capacity.
- **No**: Complete the 2 stage Mental Capacity Assessment as per Mental Capacity Act (2005).

### If the patient is currently very unwell or in the event their condition deteriorates

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Acute setting only</th>
<th>Acute setting only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is admission to an acute hospital appropriate?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are IV therapies appropriate? (e.g. fluids/antibiotics)</td>
<td>Yes</td>
<td>No</td>
<td>Is a referral to a critical care service appropriate? (e.g. Outreach Team or MET Team).</td>
<td>Yes</td>
</tr>
<tr>
<td>Are oral antibiotics appropriate?</td>
<td>Yes</td>
<td>No</td>
<td>Is ward non-invasive ventilation appropriate?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is artificial feeding appropriate?</td>
<td>Yes</td>
<td>No</td>
<td>Is a referral for dialysis appropriate?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Are there any other Advance Care Planning documents in place? **If yes, what?**

### In the event of a cardiorespiratory arrest this patient is:

- **FOR RESUSCITATION**
- **DO NOT ATTEMPT RESUSCITATION (DNACPR)**

**Sign:** .................................................................

**Date:** ......................... **Time:** .........................

**Name:** .................................................................

**Role:** ......................... **GMC/NMC No:** .........................

**Document rationale for best interest treatment decisions and resuscitation status and whom this was discussed with (be as specific as possible).**

Has the treatment escalation plan and resuscitation decision been discussed with the patient/patient’s relatives/next of kin/carers? **Yes / No**

**Date:** ......................... **Time:** .........................

All treatment decisions above should be reviewed as the patient's clinical condition changes.

Documentation that TEP form has been completed in medical notes. **Circle: Yes/ No**

Has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? **Circle: Yes/No**

**Date this document was reviewed (if required):** .........................

Signed: .................................................................

**Role:** ......................... **GMC/NMC No:** .........................

---

On discharge, if appropriate and the patient and or family have been informed of the decisions, then the original form should accompany the patient and a photocopy should remain in the patient's medical notes.
Mental Capacity Assessment

The Mental Capacity Act (2005) requires you to assume that individuals have capacity, unless you suspect the person has an impairment or disturbance of the mind or brain. It also requires any assessment to be decision specific. If you suspect someone lacks capacity you are required to complete the 2 stage Mental Capacity Assessment.

Stage 1:
Document the reason you believe the individual has an impairment or disturbance of the functioning of the mind or brain.
Reason: .................................................................................................................................

Stage 2: Can the individual:

1. Understand information about the decision to be made?
2. Retain that information in their mind?
3. Use or weigh that information as part of the decision making process?
4. Communicate their decision (by talking, using sign language or any other means)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is the response yes to all four Stage 2 questions?

No

If No

- Is this loss of capacity likely to be temporary and can the decision wait?
- Is there a valid ADRT? (Advance decision to refuse treatment)
- Is there a Personal Welfare Lasting Power of Attorney (PW-LPA) registered with the Office of the Public Guardian?

If No

- Proceed with completing TEP in line with Best Interest principles (please note if the person has no friends, relatives or unpaid carers then you must include IMCA services). Please document rationale/Best Interest principles for treatment and discussion in boxes overleaf.

If Yes

Set decision review date:
............................................

Yes

Complete TEP form as part of discussion with patient.

If ADRT is valid and applicable, use it to complete TEP form. For decisions to which ADRT is not applicable, apply “best interests” principles as per box below.

Ensure that the PW-LPA is consulted and incorporated in any decisions regarding TEP.

This form should be completed legibly in black ball point ink
- Complete patient details or affix the patient’s identification label to the top right hand corner.
- The date and time of writing the form should be entered.
- This form will be regarded as ‘INDEFINITE’ unless it is clearly cancelled.
- The form should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare setting to another, and admitted from home or discharged home.
- Further guidance on the use of TEP Version 11 can be found on the Devon local joint formularies.

If following clinical review, treatment decisions are changed:
- Clearly score through this form, then sign and date the discontinuation box overleaf.
- File at the back of the patient’s medical notes.
- Document the change of decision in the patient’s medical notes.
- Complete a new form and insert in the patient’s medical notes.
The Mental Capacity Act (2005) defines a lack of capacity as:

‘… a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.’

The definition contains a number of important elements:

a. **Time specific**: assessment of capacity must be time-specific, recognising that capacity may fluctuate over time.

b. **Decision specific**: assessment relates to a specific decision that has to be made and not to a general ability to make decisions.

c. **Diagnostic threshold**: to lack capacity, a person must have a medically recognised impairment of, or disturbance in the functioning of, the mind or brain, which may be temporary or permanent.

d. **Age, appearance, condition or behaviour**: lack of capacity cannot be decided merely by reference to these factors.

e. **Balance of probabilities**: any question over lack of capacity must be decided on the balance of probabilities ie. what is more likely than not.

The Act has 5 principles:

**When assessing capacity:**

1. A person must be assumed to have capacity unless it is proved otherwise.

2. Until all practicable steps have been taken to help someone make a decision without success they cannot be regarded as lacking capacity.

3. An unwise decision does not in itself indicate a lack of capacity.

**When acting or making decisions on behalf of someone lacking capacity:**

4. Any act or decision made must be in the person’s best interests.
5. Any act or decision must be the least restrictive option to the person in terms of their rights and freedom of action.

A person lacks capacity if some impairment or disturbance of functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when:

a) The patient is unable to comprehend and retain the information which is necessary for the decision, especially about the likely consequences of having or not having the treatment in question.

b) The patient is unable to use this information and weigh it in the balance as part of a process or arriving at the decision.

c) The patient is unable to believe the information. If a compulsive disorder of phobia from which the patient suffers stifles belief in the information presented to him or her, then the decision may not be a true one.

Persons aged 16 and over are presumed to be mentally capable unless the contrary is shown. Confusion, shock, pain, drugs and panic may affect mental capacity. The doctor concerned must be satisfied that such factors are operating to a degree that the ability to decide is impaired. There is a separate policy for those under 16.

**Mental capacity is discussed further in the Reference Guide to Consent for Examination or Treatment (ref 6). Reference to the separate guidance and policy on the Mental Capacity Act (in development) is advised.**
PAEDIATRIC OBSERVATION CHART: 0 - 12 MONTHS

**PAEDIATRIC EARLY WARNING (PEW) SCORE – ACTION / RESPONSE / ESCALATION**

<table>
<thead>
<tr>
<th>Score 0 - 4</th>
<th>Score 5 - 9</th>
<th>Score 10 - 12</th>
<th>Score 13 - 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>S - SBAR report the PEWS to the RN overseeing the child’s care, or the nurse-in-charge. Review &amp; consider increasing the observation monitoring plan with the above personnel.</td>
<td>S - SBAR report the PEWS to the nurse-in-charge and agree a management plan. Consider increasing the frequency of observations. Repeat the PEWS within 30 mins. If no improvement within 30 mins, SBAR report the PEWS to the SHO (0426) - review in 30 mins.</td>
<td>S - SBAR report the PEWS to the nurse-in-charge and agree a management plan. Increase the frequency of the observations. Repeat PEWS within 30 mins.</td>
<td>S - Immediately SBAR report the PEWS to the nurse-in-charge, and agree a management plan. Immediately SBAR report the PEWS to the Outreach Nurse and the child’s own medical team. Request registrar attendance &amp; review within 15 minutes. If no response or attendance fast bleep Paed Reg (3333) requesting an urgent patient review, or consider dialling 2222</td>
</tr>
</tbody>
</table>

**PEW SCORE ≥ 20 = EMERGENCY or LIFE THREATENING SITUATIONS → CALL 2222**

**PAEDIATRIC PAIN MANAGEMENT**

**ANALGESIA**

Consider the following:

1. Increasing Pain
2. Severe – Paracetamol + NSAID + Morphine (PCA / NCA or epidural)
3. Moderate – Paracetamol + NSAID + Oramorph
4. Mild – Paracetamol + NSAID
5. No Pain

In cases of increasing or severe pain, please contact:

- Clinical Nurse Specialist - Paediatric Pain - Bleep No. 0024
- Consultant Paediatric Anaesthetist - Paediatric Pain 0800-1800 phone 02901
- 1800-0800 On call consultant through switchboard

**FLACC Score**

![FLACC Score Table]

For a score of 0-2, have drug chart at hand. For a score of 3, treatment to date. Have drug chart at hand. For a score of 4-7, have drug chart at hand. For a score of 8-10, have drug chart at hand.

**AG Age Group: 2 years to 7 years**

**BEHAVIOURAL**

**FLAG Score**

<table>
<thead>
<tr>
<th>Face</th>
<th>Leg</th>
<th>Activity</th>
<th>Cry</th>
</tr>
</thead>
<tbody>
<tr>
<td>No particular expression or smile</td>
<td>Normal position on either side</td>
<td>Lying quietly, normal respiratory rate, normal bowel sounds</td>
<td>Lying quietly, normal respiratory rate, normal bowel sounds</td>
</tr>
<tr>
<td>Occasional grimace or mouth opening</td>
<td>Pouting, noisy breathing, no bowel sounds</td>
<td>Crying steadily, occasional mouth opening</td>
<td>Crying steadily, occasional mouth opening</td>
</tr>
<tr>
<td>Occasional sneezing</td>
<td>Squirming, arched back and head to one side</td>
<td>Crying steadily, occasional mouth opening</td>
<td>Crying steadily, occasional mouth opening</td>
</tr>
<tr>
<td>Occasional grimace or frown, no mouth opening</td>
<td>Kicking, or leg drawn up</td>
<td>Occasional sneezing</td>
<td>Occasional sneezing</td>
</tr>
<tr>
<td>Occasional grimace or frown, no mouth opening</td>
<td>Arching, rigid or jerking</td>
<td>Occasionally obstructing or blocking</td>
<td>Occasionally obstructing or blocking</td>
</tr>
<tr>
<td>Occasional grimace or frown, no mouth opening</td>
<td>Arched, rigid or jerking</td>
<td>Occasional obstructing or blocking</td>
<td>Occasionally obstructing or blocking</td>
</tr>
<tr>
<td>Occasional grimace or frown, no mouth opening</td>
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<tr>
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<td>Arched, rigid or jerking</td>
<td>Occasionally obstructing or blocking</td>
<td>Occasionally obstructing or blocking</td>
</tr>
</tbody>
</table>

**VAS (Visual Analogue Score)**

Ask the child to indicate on the line the severity of their pain.

**FLACC Score**

0 - No Pain
1 - Slight Pain
2 - Mild Pain
3 - Moderate Pain
4 - Severe Pain
5 - Very Severe Pain
6 - Pain as bad as it can be

**Historical**

- Name: ………………………….
- Address: ………………………….
- Date of Birth: …………………………….
- Ward / Hospital: …………………………….
- Date: …………………………….

**Additional Observations**

- e.g. reassessment of pattern & effort, change SO2, probe sections, chest drain, vapoband, abscess, wound or infection
### Observation Monitoring

**PLAN 1**

- Frequency of Obs
- Print Name
- Signature
- Date / Time

**PLAN 2**

- Print Name
- Signature
- Date / Time

### Guide to Respiratory Distress

- **Severe**
  - Impending respiratory arrest
- **Moderate**
  - Tracheal tug
- **Mild**
  - Subcostal recession

### Guide to Neurological Status

- **0**
  - Sternal recession
- **1**
  - Exhaustion
- **2**
  - Impending respiratory arrest

### Paediatric Early Warning (PEW) Score:

1. **Box Colour**
2. **Points to Score:**
   - **Zero**
   - **One**
   - **Two**
   - **Four**

3. **A PEW score must be calculated every time observations are recorded**
4. **If a parameter is not recorded – the value is '0'**
5. **Add up total score & place in box opposite**
6. **'Action' as indicated over page**

### Acceptable Parameters for the Patient / Modifications

<table>
<thead>
<tr>
<th>Desired Parameter</th>
<th>Drs Initials / Print Name</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>No modifications required</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Observation Chart

#### Date

<table>
<thead>
<tr>
<th>Nurse / Parent Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
</tr>
<tr>
<td>100</td>
</tr>
<tr>
<td>90</td>
</tr>
<tr>
<td>80</td>
</tr>
<tr>
<td>70</td>
</tr>
<tr>
<td>60</td>
</tr>
<tr>
<td>50</td>
</tr>
<tr>
<td>40</td>
</tr>
<tr>
<td>30</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>

#### Time

<table>
<thead>
<tr>
<th>Nurse / Parent Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
</tr>
<tr>
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</tr>
<tr>
<td>90</td>
</tr>
<tr>
<td>80</td>
</tr>
<tr>
<td>70</td>
</tr>
<tr>
<td>60</td>
</tr>
<tr>
<td>50</td>
</tr>
<tr>
<td>40</td>
</tr>
<tr>
<td>30</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>

### Respiration Rate

- **Delivery Key**
  - Nasal Cannula (NC)
  - Face Mask (FM)
  - Head Box (HB)
  - Trachy Mask (TM)
  - Socket Mask (SM)
  - Noninvasive (NV)
  - Invasive (IV)

- **O2 Saturation (%)**
  - Room Air
  - Delivery Mode

### Oxygen Delivery

- **Sedation**
  - **None**
  - **Severe**
  - **Moderate**
  - **Mild**

### Nausea / Vomiting

- **None**
- **Severe**

### Pruritus

- **None**
- **Severe**

### Pain Score

- **Rest**
  - **0 – 10**
- **Responds to**
  - **Voice**
- **Responds to**
  - **Pain**
- **Unresponsive**

### Capillary Refill Time

- **0 – 2 sec**
  - 33 sec

### Heart Rate

- **BPM**
  - 220
  - 210
  - 200
  - 190
  - 180
  - 170
  - 160
  - 150
  - 140
  - 130
  - 120
  - 110
  - 100
  - 90
  - 80
  - 70
  - 60
  - 50
  - 40
  - 30
  - 20
  - 15
  - 10
  - 5
  - 4
  - 3
  - 2
  - 1

### Blood Pressure (BP) (mmHg)

- **Systolic**
  - 160
  - 150
  - 140
  - 130
  - 120
  - 110
  - 100
  - 90
  - 80
  - 70
  - 60
  - 50
  - 40
  - 30
  - 20
  - 15
  - 10
  - 5
  - 4
  - 3
  - 2
  - 1

### Temperature (°C)

- **37.5 – 38.5**
  - 41.0
  - 40.0
  - 39.0
  - 38.0
  - 37.0
  - 36.0
  - 35.0

### Total PEW

- **Total PEW = Number of coloured boxes (see opposite for score and over page for 'ACTION')**

### Glucose (mmol/L)

### Pain Monitor

- **Desired Parameter**
  - **Score**
  - **VIA**
  - **T**

### Pain Score

- **Rest**
  - **0 – 10**

### Motor Block

- **Muscle Tone**
  - **0**
  - **1**
  - **2**
  - **3**

### VIP Score

- **Practitioner Initials**
**PAEDIATRIC OBSERVATION CHART: 1 - 4 YEARS**

### PAEDIATRIC EARLY WARNING (PEW) SCORE – ACTION / RESPONSE / ESCALATION

<table>
<thead>
<tr>
<th>Score 0 - 4</th>
<th>Score 5 - 9</th>
<th>Score 10 -12</th>
<th>Score 13 - 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBAR report the PEWS to the nurse-in-charge.</td>
<td>Consider increasing the frequency of observations.</td>
<td>SBAR report the PEWS to the nurse-in-charge and agree a management plan.</td>
<td>Immediately SBAR report the PEWS to the nurse-in-charge.</td>
</tr>
<tr>
<td>Review &amp; consider increasing the observation monitoring plan with the above personnel.</td>
<td>Increase the frequency of the observations. Repeat PEWS within 30 mins.</td>
<td>If no improvement within 30 mins, SBAR report the PEWS to the Paed SHO (0428) - request review in 30 mins.</td>
<td>If no response fast bleep Paed Reg (3333) requesting an urgent patient review, or consider dialling 2222 / contact on call Consultant Paed.</td>
</tr>
<tr>
<td>If further concerned about the child, SBAR report the situation to the Senior Nurse 0919.</td>
<td>If no improvement within 30 mins.</td>
<td>SBAR report the PEWS to the Paed SHO (0428) requesting patient review within 15 mins.</td>
<td>SBAR report the PEWS to the Paed Registrar requesting attendance &amp; review within 15 minutes.</td>
</tr>
</tbody>
</table>

**PEW SCORE ≥ 20 = EMERGENCY or LIFE THREATENING SITUATIONS **→ CALL 2222

### PAEDIATRIC EARLY WARNING (PEW) SCORE

- Score 0 - 4
- Score 5 - 9
- Score 10 -12
- Score 13 - 19

**Background**
- Readback
- Recommendation / Readback

**Situation**
- The patient’s name
- Your name and designation
- The ward/department you are calling from

**Assessment**
- AIRWAY
  - Patient talking
  - Noises (gurgling, wheeze, snoring)
  - Visible foreign body
- BREATHING
  - Difficulty breathing
  - Respiratory rate
  - Accessory muscles used
- CIRCULATION
  - Pulse
  - Capillary Refill Time
  - Blood Pressure
- DISABILITY
  - Pupils (equal / reacting)
  - Alert / Voice / Pain / Unresponsive (AVPU)
  - Skin Colour
  - Blood Glucose
- EXPOSURE
  - Pain Assessm ent:
    - Monitoring
    - Whilst on Patient Controlled Analgesia (PCA), IV Morphine or an epidural, monitor BP, pulse, respiratory rate, sedation and pain scores (as per guidelines on PCA / Epidural chart)
  - Pain Chart C D
  - Pain Nurse Specialist - Paediatric Pain - Bleep No. 0 9 24
  - Consultant Paediatric Anaesthetist - Paediatric Pain phone 5250 1
  - In cases of increasing or severe pain, please contact:
    - Consultant Paediatric Pain Management
    - Paediatric Pain Team
    - Pain Nurse Specialist
  - Consolability; giving a total out of 10
    - 10 = No Pain
    - 2 = Little more
    - 4 = H urts
    - 6 = Hurts ever more
    - 8 = Hurts whole lot
    - 1 0 = Hurts worst

**Recommendation / Readback**
- SBAR report the PEWS to the RN overseeing the child’s care, or the nurse-in-charge.
- Review & consider increasing the observation monitoring plan with the above personnel.
- If further concerned about the child, SBAR report the situation to the Senior Nurse 0919.

### PAEDIATRIC PAIN MANAGEMENT

**ANALGESIA**

Consider the following:
- Score
  - 0 - No Pain
  - 1 - Mild – Paracetamol + NSAID
  - 4 - Moderate – Paracetamol + NSAID + Oramorph
  - 7-10 Severe – Paracetamol + NSAID + Morphin (PCA / NCA or epidural)

**ALGIA**

Consider the following:
- Score
  - 0 - No Pain
  - 1 - Mild – Paracetamol + NSAID
  - 4 - Moderate – Paracetamol + NSAID + Oramorph
  - 7-10 Severe – Paracetamol + NSAID + Morphin (PCA / NCA or epidural)

### PAEDIATRIC EARLY WARNING (PEW) SCORE

- Score 0 - 4
- Score 5 - 9
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**Background**
- Readback
- Recommendation / Readback

**Situation**
- The patient’s name
- Your name and designation
- The ward/department you are calling from

**Assessment**
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  - Patient talking
  - Noises (gurgling, wheeze, snoring)
  - Visible foreign body
- BREATHING
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    - 1 0 = Hurts worst

**Recommendation / Readback**
- SBAR report the PEWS to the RN overseeing the child’s care, or the nurse-in-charge.
- Review & consider increasing the observation monitoring plan with the above personnel.
- If further concerned about the child, SBAR report the situation to the Senior Nurse 0919.
# Paediatric Observation Chart

## 1 - 4 years

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Nurse / Parent Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Respiration Rate (over 1 minute)

<table>
<thead>
<tr>
<th>Rate</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Normal</td>
</tr>
<tr>
<td>31</td>
<td>Mildly</td>
</tr>
<tr>
<td>32</td>
<td>Moderately</td>
</tr>
<tr>
<td>33</td>
<td>Severely</td>
</tr>
</tbody>
</table>

### Oxygen Delivery

<table>
<thead>
<tr>
<th>Delivery Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room Air</td>
<td>Normal Oxygen</td>
</tr>
<tr>
<td>0% to 29%</td>
<td>Lower Oxygen</td>
</tr>
</tbody>
</table>

### Blood Pressure (BP) (mmHg)

<table>
<thead>
<tr>
<th>Rate</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Normal</td>
</tr>
<tr>
<td>110</td>
<td>Mildly</td>
</tr>
<tr>
<td>120</td>
<td>Moderately</td>
</tr>
<tr>
<td>130</td>
<td>Severely</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Rate</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Normal</td>
</tr>
<tr>
<td>110</td>
<td>Mildly</td>
</tr>
<tr>
<td>120</td>
<td>Moderately</td>
</tr>
<tr>
<td>130</td>
<td>Severely</td>
</tr>
</tbody>
</table>

### Guide to Respiratory Distress

- **Mild**: Nasal flaring
- **Moderate**: Subcostal recession
- **Severe**: Impending respiratory arrest

### Guide to Neurological Status

- **Mild**: Nasal flaring
- **Moderate**: Subcostal recession
- **Severe**: Impending respiratory arrest

### Paediatric Early Warning (PEW) Score:

- **Box Colour Points to Score**
  - Zero
  - One
  - Two
  - Four

### Pain Assessment Tools Used

- FLACC (Face, Legs, Activity, Cry, Consolability)
- Wong and Baker (Faces)
- Visual Analogue Scale (0-10)

### Guide to Pain

- **0** = None
- **1** = Mild
- **2** = Moderate
- **3** = Severe

### Motor Block

- **0** = Free movement hips, knees & feet
- **1** = Able to flex hip, knees with free movement of feet
- **2** = Weakness in hips, knees, unable to lift head, moves toes
- **3** = Unable to move legs & feet

---

HRSG-068901

CSP08351 09/13
**PAEDIATRIC EARLY WARNING (PEW) SCORE – ACTION / RESPONSE / ESCALATION**

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<tr>
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<td>- Immediately SBAR report the PEWS to the Paed registrar requesting attendance &amp; review within 15 minutes.</td>
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</tbody>
</table>

**PAEDIATRIC PAIN MANAGEMENT**

**ANALGESIA**

Consider the following:

- **Score**
  - 7-10 Severe – Paracetamol + NSAID + Morphine (PCA / NCA or epidural)
  - 4-6 Moderate – Paracetamol + NSAID + Oramorph
  - 1-3 Mild – Paracetamol + NSAID
  - 0 No Pain

In cases of increasing or severe pain, please contact:

- Pain Nurse Specialist - Paediatric Pain - Bleep No. 10244
- Consultant Paediatric Anaesthetist - Paediatric Pain phone 5250 1

**VAS (Visual Analogue Score)**

Ask the child to indicate on the line the severity of their pain.

**FLACC Score**

Consider the following:

- **1** Descriptors
  - Lying quietly, normal position, moves easily
  - No particular activity
  - No particular temperature
  - Coping with pain
  - Calmness

- **2** Descriptors
  - Little more than the above:
  - Little more activity
  - Little more temperature
  - Little more coping with pain
  - Little more calmness

- **3** Descriptors
  - More than the above:
  - Even more activity
  - Even more temperature
  - Even more coping with pain
  - Even more calmness

- **4** Descriptors
  - Whole lot:
  - Scream:
  - Crying:
  - Scream:

**FLACC is also effective where the child is sedated or has learning difficulties.**

**AGE GROUP: 2 months to 7 years**

**BEHAVIOURAL**

**PALM Score**

Score each category from 0-2:

- **0** No Hurt
- **1** Little Hurt
- **2** Hurts

**FACE**

- No Hurt
- Little Hurt
- Hurts

**ACTIVITY**

- No Hurt
- Little Hurt
- Hurts

**CONSOLABILITY**

- No Hurt
- Little Hurt
- Hurts

**FLACC Score**

- No Hurt
- Little Hurt
- Hurts

**AGE GROUP: 4 years and over**

**Self-report**

**Wong & Baker**

Point to each face using the words to describe the pain intensity. Ask the child to choose a face that best describes their own pain and record the appropriate number (from Wong & Baker, 1980)

<table>
<thead>
<tr>
<th>VAS (Visual Analogue Score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Hurt</td>
</tr>
<tr>
<td>H urts</td>
</tr>
<tr>
<td>Worst hurt</td>
</tr>
</tbody>
</table>

**Additional Observations**

- *9th Edition - Paediatric Observation Chart C D*
### Acceptable Parameters for the Patient / Modifications

<table>
<thead>
<tr>
<th>Desired Parameter</th>
<th>Drs Initials / Print Name</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>No modifications required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resp. Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpO₂</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any parameter that is outside of the above modifications should have a PEW score of '4' recorded.

#### Observation Monitoring

<table>
<thead>
<tr>
<th>PLAN 1</th>
<th>PLAN 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Obs</td>
<td>Print Name</td>
</tr>
<tr>
<td>Signature</td>
<td>Date / Time</td>
</tr>
</tbody>
</table>

#### Guide to Respiratory Distress

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal flaring</td>
<td>Head bobbing</td>
<td>Intercostal recession</td>
</tr>
<tr>
<td>Subcostal recession</td>
<td>Inspiratory or expiratory noises</td>
<td>Sternal recession</td>
</tr>
<tr>
<td>Expiration</td>
<td>Tachaeal tug</td>
<td>Impending respiratory arrest</td>
</tr>
</tbody>
</table>

#### Guide to Neurological Status

Any child who scores ‘4’, ‘3’ or ‘2’ on the AVPU score, i.e. only responds to ‘Voice’, ‘Pain’ or is ‘Unresponsive’ MUST have full Neurological Observations undertaken using the Modified Paediatric Come Score.

#### Paediatric Early Warning (PEW) Score:

- **Box Colour Points to Score:**
  - **Zero:**
  - **One:**
  - **Two:**
  - **Four:**

- **A PEW score must be calculated every time observations are recorded.**
- **If a parameter is not recorded – the value is ‘0’**
- **Add up total score & place in box opposite**
- **‘Action’ as indicated over page**

#### Pain Assessment Tools Used (Please ✓)

- PLACC (Pain, Legs, Activity, Cry, Consolability)
- Wong and Baker (Faces)
- Visual Analogue Scale (0-10)

#### Pain, Vomiting, Pruritus

<table>
<thead>
<tr>
<th>0 = None</th>
<th>1 = Mild</th>
<th>2 = Moderate</th>
<th>3 = Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = None</td>
<td>0 = None</td>
<td>2 = Asleep but easy to arouse</td>
<td></td>
</tr>
<tr>
<td>1 = Nausea</td>
<td>1 = Mild</td>
<td>3 = Severe</td>
<td></td>
</tr>
<tr>
<td>2 = Vomiting</td>
<td>2 = Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 = Severe nausea or vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Pain Score

<table>
<thead>
<tr>
<th>0 = No Pain</th>
<th>1 = Mild</th>
</tr>
</thead>
</table>
| 0 = Wide awake | 1 = Drowsy 
| 1 = Pain |
| 2 = Moderate Pain |
| 3 = Severe Pain |

#### Sedation

<table>
<thead>
<tr>
<th>0 = None</th>
<th>1 = Mild</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = None</td>
<td>0 = None</td>
</tr>
<tr>
<td>1 = Mild</td>
<td></td>
</tr>
<tr>
<td>2 = Drowsy</td>
<td></td>
</tr>
<tr>
<td>3 = Severe</td>
<td></td>
</tr>
</tbody>
</table>

#### Motor Block

| 0 = Free movement hips, legs & feet |
| 1 = Able to flex hip, knees with free movement of feet |
| 2 = Weakness in hips, knees, unable to lift heels, moves toes |
| 3 = Unable to move legs or feet |

Level 3 – PLEASE seek help/support from Anaesthetist or pain service.
**Background Readback**

- SBAR report the PEWS to the nurse-in-charge.
- Review & consider increasing the observation monitoring plan with the above personnel.
- If further concerned about the child, SBAR report the situation to the Senior Nurse 0919.

**Recommendation / Readback**

- SBAR report the PEWS to the nurse-in-charge and agree a management plan.
- Consider increasing the frequency of observations.
- Repeat the PEWS within 30 mins.
- If no improvement within 30 mins, SBAR report the PEWS to the Paed SHO (0428) - request review in 30 mins.

---

**PAEDIATRIC PAIN MANAGEMENT**

**ANALGESIA**

Consider the following:

- **Score**
  - 7-10 Severe – Paracetamol + NSAID + Morphine (PCA / NCA or epidural)
  - 4-6 Moderate – Paracetamol + NSAID + Omoraph
  - 1-3 Mild – Paracetamol + NSAID
  - 0 No Pain

In cases of increasing or severe pain, please contact:
- **Paediatric Nurse Specialist** - Paediatric Pain - Bleep No. 0294
- **Consultant Paediatric Anesthetist** - Paediatric Pain phone 5250 1

**FLACC Score**

**Age Group:** 2 months to 7 years

**Behavioural**

- **Consolability:**
  - No Consolable or difficult to consolable
  - Partially consolable
  - Fairly easily consolable
  - Consolable

- **Activity:**
  - No Activity
  - Slow activity
  - Upright activity
  - Wide awake

- **Cry:**
  - No Cry
  - Low or mellow
  - Mauve or whiney
  - Occasional complaining, whining
  - Occasional complaint, moaning
  - Occasional complaint, moaning
  - Frequent complaints

- **Consolability:**
  - No Consolable or difficult to consolable
  - Partially consolable
  - Fairly easily consolable
  - Consolable

**VAS (Visual Analogue Score)**

Ask the child to indicate on the line the severity of their pain.

---

**PAEDIATRIC EARLY WARNING (PEW) SCORE – ACTION / RESPONSE / ESCALATION**

<table>
<thead>
<tr>
<th>Score 0 - 4</th>
<th>Score 5 - 9</th>
<th>Score 10 - 12</th>
<th>Score 13 - 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBAR report the PEWS to the nurse-in-charge</td>
<td>SBAR report the PEWS to the nurse-in-charge</td>
<td>SBAR report the PEWS to the nurse-in-charge and agree a management plan.</td>
<td>Immediately SBAR report the PEWS to the nurse-in-charge,</td>
</tr>
<tr>
<td>Consider increasing the frequency of observations.</td>
<td>Increase the frequency of the observations. Repeat PEWS within 30 mins.</td>
<td>Increase the frequency of the observations. Repeat PEWS within 30 mins.</td>
<td>Immediately SBAR report the PEWS to the nurse-in-charge,</td>
</tr>
<tr>
<td>If no improvement within 30 mins, SBAR report the PEWS to the Paed SHO (0428) - request review in 30 mins.</td>
<td>If no improvement within 30 mins, SBAR report the PEWS to the Paed SHO (0428) - request review in 30 mins.</td>
<td>If no improvement within 30 mins, SBAR report the PEWS to the Paed SHO (0428) - request review in 30 mins.</td>
<td>If no response fast bleep Paed Reg (3333) requesting an urgent patient review, or consider dialling 2222 / contact on call Consultant Paed.</td>
</tr>
</tbody>
</table>

---

**Blood Gas Analysis**

- Date
- Time
- Type of Gas
- pH
- PCO₂
- PO₂
- Base Excess
- HCO₃⁻
- Lactate
- Glucose

---

**SIGNIFICANT EVENTS & ALL PEW Scores ≥ 10, approaches, coagulation, destination**

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

---

**ADDITIONAL OBSERVATIONS**

- e.g. reassessment - pattern & effect change. SpO₂ probe, secretions, chest drain, epidural, obs, wound or traction

---

**ADDRESSOGRAPH LABEL**

- Name:
- Date of Birth:
- Hospital No.:
- Ward / Hospital:
- Ward Area:
- Date:
### Acceptable Parameters for the Patient / Modifications

<table>
<thead>
<tr>
<th>Desired Parameter</th>
<th>Drs Initials / Print Name</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>No modifications required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resp. Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpO₂</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any parameter that is outside of the above modifications should have a PEW score of ‘4’ recorded.

### Observation Monitoring

<table>
<thead>
<tr>
<th>PLAN 1</th>
<th>PLAN 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Obs</td>
<td>Print Name</td>
</tr>
<tr>
<td></td>
<td>Signature</td>
</tr>
<tr>
<td></td>
<td>Date / Time</td>
</tr>
</tbody>
</table>

### Guide to Neurological Status

- Guide to Respiratory Distress
- Guide to Neurological Status

### Paediatric Early Warning (PEW) Score:

<table>
<thead>
<tr>
<th>Box Colour</th>
<th>Points to Score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
<td></td>
</tr>
<tr>
<td>One</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td></td>
</tr>
<tr>
<td>Four</td>
<td></td>
</tr>
</tbody>
</table>

- A PEW score must be calculated every time observations are recorded.
- If a parameter is not recorded – the value is ‘0’
- Add up total score & place in box opposite
- ‘Action’ as indicated over page

### Pain Assessment Tools Used (Please ✓)

- FLACC (Face, Legs, Activity, Cry, Consolability)
- Wong and Baker (Faces)
- Visual Analogue Scale (0-10)

### Guide to Respiratory Distress

- Severe
- Moderate
- Mild
- None

- Subcostal recession
- Head bobbing
- Rhonchi
- Inspiratory or expiratory noises
- Tracheal tug
- Sternal recession
- Exhaustion
- Impending respiratory arrest

### Paediatric Observation Chart

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse / Parent Concern</td>
<td></td>
</tr>
</tbody>
</table>

### Respiratory Rate

- Normal: 15 - 20 breaths per minute
- Tachypnea: > 20 breaths per minute
- Bradypnea: < 15 breaths per minute

### Oxygen Delivery

- Any NPA Oxygen
- Room Air
- Delivery Key

### Heart Rate

<table>
<thead>
<tr>
<th>Heart Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>110 - 150</td>
</tr>
<tr>
<td>100 - 110</td>
</tr>
<tr>
<td>90 - 100</td>
</tr>
<tr>
<td>80 - 90</td>
</tr>
<tr>
<td>70 - 80</td>
</tr>
<tr>
<td>60 - 70</td>
</tr>
<tr>
<td>50 - 60</td>
</tr>
</tbody>
</table>

### Capillary Refill Time

- 0 - 2 sec
- 2 - 3 sec

### Blood Pressure (BP)

- Systolic BP
- Diastolic BP

### Temperature

- 36°C - 38°C
- 38°C - 40°C

### Total PEW

- Total PEWS = Number of coloured boxes (see opposite for score and over page for ‘Action’)

### Glucose (mmol/L)

### Pain Monitor

- Pain Score

### Motor Block

- Level 3 – PLEASE seek help/support from Anaesthetist or pain service
TEP COMPLETION APPROVAL FORM FOR NON-MEDICAL REGULATED PRACTITIONERS.

The below named Non-Medical Consultant Practitioner (NMCP) / Advanced Clinical Practitioner (ACP) has been deemed suitably trained, qualified and skilled to complete TEP forms in University Hospitals Plymouth (UHP) NHS Trust.

The below named practitioner acknowledges that they are authorised to only complete TEP forms for patients within their direct care / speciality and only after direct consultation with the patient / relative and supervising consultant.

The below Named Medical Consultant Practitioner agrees by signing this document to oversee and review the TEP form completion process of the undersigned Non-Medical Practitioner, ensuring TEP form completion meets the standards set out in UHP guidelines.

NMCP / ACP
Name……………………………………………………. Date…………

Supervising Medical Consultant
Name…………………………………………………..Date…………

Review Date…………………………

Please send the completed form to: plh-tr.ResuscitationDepartment@nhs.net