The Dudley Group NHS
NHS Foundation Trust

Resuscitation Policy
(Prevention and Management of the Deteriorating Patient)

Document Title:	**Resuscitation Policy (Prevention and Management of the Deteriorating Patient**
Name of Originator/Author & Speciality:	Lead Resuscitation Officer (Resuscitation Training /Nursing Directorate)
Director Lead:	Director of Nursing
Target Audience:	All staff with Clinical responsibility and contact with patients
Version:	3
Date of Final Ratification	5th September 2012
Name of Ratifying Committee:	Risk & Assurance Committee
Review Date:	June 2015
Expiry Date:	September 2015
Registration Requirements Outcome Number(s) (CQC)	Care Quality Commission Outcome 4 and 16
Relevant Documents /Legislation/Standards	Resuscitation Council UK Guidelines 2010 Resuscitation Council Uk: Cardiopulmonary Resuscitation Standards For Clinical Practice and Training. (Revised 2008)
Linked Procedural documents	Mandatory Training Policy Procedural Document Development & Management Policy http://joint.dudley.nhs.uk/cmsextra/documents/cms/583-2011-11-25-6032948.pdf Obstetric MEOWS Chart Guidelines Policy on advanced decisions Policy on assessing mental capacity, dealing with patients who lack capacity and complying with the mental capacity act 2005 Policy on using the Independent Mental Capacity Advocate Service. Policy on Lasting Powers of Attorney
The electronic version of this document is the definitive version	

Resuscitation Policy (Prevention and Management of the Deteriorating Patient)		
	Contributors:	**Designation:** Resuscitation Group Acute Illness Group
	Consulted:	**Designation:** Chair of Resuscitation Group (Consultant Anaesthetist) Resuscitation Officers Nursing Leads (Matron for critical care and Paediatrics) Consultant Physicians (Lead for MHDU) Out Reach Lead ED Consultants NNU ANP's Pharmacy Policy Group Governance Manager Risk and Standards Manager
	EQUALITY SCREENED	**Yes** **Date: August 2012**
	EQUALITY IMPACT ASSESSMENT	**N/A**

CHANGE HISTORY

Version	Date	Reason
1	December 2008	New Policy
2	September 2010	Minor amendments
3	Sept 2012	Reviewed to include care of the deteriorating patient

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

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THE DUDLEY GROUP NHS FOUNDATION TRUST

RESUSCITATION POLICY
(Prevention and Management of the Deteriorating Patient)

1. INTRODUCTION

In the event of a patient, visitor or a member of staff requiring resuscitation in the Trust it is important that a prompt response is made by staff who are trained in effective resuscitation techniques and that functional equipment is readily available. The policy describes roles and responsibilities of Trust staff with regard to resuscitation and embodies the current recommendations for clinical practice and training in cardiopulmonary resuscitation published by the Resuscitation Council (UK) at http://www.resus.org.uk/pages/standard.htm.

2. STATEMENT OF INTENT

The purpose of the resuscitation policy is to provide direction and guidance for the delivery of a high-quality and robust resuscitation service within the Trust incorporating current clinical guidelines from the Resuscitation Council (UK), which can be found at http://www.resus.org.uk/pages/guide.htm.

The policy details how detection of and management of the deteriorating patient is delivered, and the management of cardiopulmonary resuscitation events. The equipment required and audits undertaken and what resuscitation training is required for clinical staff groups.

3. SCOPE

This document applies to all staff employed by the Dudley Group NHS Foundation Trust who have clinical responsibility and contact with patients.

4. DEFINITIONS/ABBREVIATIONS

Resuscitation: may be applied to the revival of the sick or unconscious, to differentiate within this document when actions are required in the interventions of the lifeless individual will talk about cardiopulmonary resuscitation (**CPR**).

Defibrillators: Manual and AED (automated external defibrillators) are devices that deliver a controlled direct current with the aim to stop an arrhythmic event that has lead to cardiac arrest.

Arrhythmic/arrhythmia: Abnormal heart rhythm.

Anaphylaxis: A systemic hypersensitivity manifesting with life threatening changes to the airway and/or breathing and/or circulation.

5. DUTIES

5.1 Risk and Assurance Committee

The Risk and Assurance Committee ratifies the Resuscitation Policy on behalf of the Board of Directors. Twice a year a report on resuscitation issues, training and audit are presented to the Risk and Assurance Committee.

Any recommendations made to improve risk assurance are taken to the Resuscitation Committee by the Resuscitation Officers and acted upon reporting back to the Risk and Assurance Committee in the next scheduled report unless requested earlier.

5.2 Patient Safety Group

Twice a year a Resuscitation Officer attends the Patient Safety Group meeting to present a report and discuss any resuscitation issues, policy developments, audits and training matters that have arisen from the latest Resuscitation Group meetings.

Communication to other staff groups is facilitated through the Patient Safety Group representatives attending this meeting to ensure delivery of the Resuscitation Policy.

5.3 Resuscitation Group

The Resuscitation Group (Refer to ***Appendix 1*** for Terms of Reference) meets 4 times a year and is responsible for developing, implementing and monitoring operational policies governing cardiopulmonary resuscitation practice and training in accordance with current Resuscitation Council (UK) recommendations. It is the responsibility of the Resuscitation Group to provide professional advice and guidance on resuscitation issues. The Resuscitation Group reports to the Patient Safety Group.

5.3 Chief Executive

The Chief Executive is ultimately accountable for the implementation of the organisation wide process.

5.4 Director of Nursing

The Director of Nursing is the Board lead for executive implementation of this policy.

5.5 Resuscitation Officers

The Resuscitation Officers are accountable to the Resuscitation Group. They are responsible for the development and co-ordination of resuscitation training throughout the Trust.

The Resuscitation Officers audit all cardiac arrest events and attend resuscitation events when possible. A quarterly report of cardiac arrest audits is presented to the Resuscitation Group. The Resuscitation Officers undertake a rolling programme of audits of the checking and stocking of the cardiac

arrest trolleys and an annual audit of the “do not attempt resuscitation” policy, which are then presented to the Resuscitation Group.

5.6 Medical Staff

Consultants are responsible for facilitating resuscitation training for junior medical staff that are not in a training post within their departments.

College Tutors are responsible for facilitating resuscitation training for junior medical staff in training posts.

5.7 Matrons

Matrons are responsible for monitoring the cleanliness and checking of cardiac arrest trolleys while conducting their rounds in their own clinical areas.

5.8 Lead Nurses and Clinical Department Managers

Lead Nurses/Midwifes and Clinical Department Managers are responsible for ensuring both daily and weekly checking of the cardiac arrest trolley in their clinical area of responsibility and maintaining a written record of this.

Lead Nurses/Midwifes and Department Managers must facilitate resuscitation training for their staff.

5.9 All Clinical Staff

All clinical staff with patient contact, are responsible for ensuring they undertake annual resuscitation training appropriate to their expected role in a resuscitation event, this should be facilitated by their managers and leads.

6. THE PROCESS FOR MEDICAL EMERGENCY TEAM RESPONSE AND THOSE RESPONDING TO THE DETERIORATING PATIENT OR CARDIOPULMONARY RESUSCITATION WITHIN THE TRUST

6.1.1 Early Warning Systems

The Trust has an early warning system in place for the recognition of patients at risk of cardiorespiratory arrest. This incorporates a chart (***Appendix 2***) to be completed. The chart details a graduated response to deal with the patient at risk of cardiopulmonary arrest depending on their physiological parameters. (User guidelines can be found in the track and trigger user document (***Appendix 6***).

A variation of this chart is used in the obstetric department (Obstetric MEOWS Chart Guidelines).

The organisation of this preventative system incorporates the Outreach Services and the Medical Emergency Team (MET). The MET is orientated to respond to medical emergencies in addition to cardiopulmonary arrest on the Russells Hall Hospital site.

6.1.2 Russells Hall Hospital

In the event of a cardiac arrest / medical / obstetric / neonatal emergency being identified and triggered the appropriate emergency team must be alerted immediately.

The emergency team (***Appendix 3***) will be summoned by using the universal number **2222**. The precise location of the patient must be communicated promptly and clearly to the switchboard operator:

- For adult patients state ***adult cardiac arrest or medical emergency or obstetric emergency;***
- For paediatric patients state ***paediatric cardiac arrest paediatric medical emergency;***
- For neonates state ***neonatal emergency.***

All emergency bleeps will be alerted simultaneously by the switchboard operator via a speech channel. Each member of the appropriate emergency team must respond immediately it is safe to do so. Switchboard will repeat the crash call alert through the speech channel, 1 minute after the initial call.

In operating theatres, critical care and emergency department, staff are responsible for carrying out cardiopulmonary resuscitation (CPR) using their own equipment. If further assistance is required then the appropriate emergency team can be summoned in the usual way.

The emergency bleep speech channel will be tested daily, or in the case of the obstetric and neonatal bleeps weekly, to ensure that the system and individual bleeps are in working order, **all bleep holders must respond to this test call.**

Resuscitation will be initiated by the ward teams to their level of competence (at least hospital basic life support) until the emergency team arrives, continuing care will be maintained in accordance's to RC UK guidelines 2010 or other appropriate clinical management in respect to patients needs.

6.1.3 Car Parks and Hospital Grounds at Russell's Hall Hospital

Dial 2222, inform the operator of the exact nature of the emergency stating the precise location, and request a paramedic ambulance attends the resuscitation. Staff from the Emergency Department will also attend. The Emergency Department porter, carrying the cardiac arrest bleep at that time, will bring the portable resuscitation equipment to the resuscitation event.

Should both porters have to leave the Emergency Department at the same time their cardiac arrest bleep must be handed to the nurse in charge of the department.

Resuscitation in a non-clinical area will consider patient and attending team safety in balance with delivering optimum resuscitation. When deemed most appropriate by team leader the patient will be transferred to the Emergency

Department. If deemed appropriate assistance will be requested from emergency ambulance services to safely transfer the patient.

6.1.4 Guest and Corbett Outpatient Centres

Dial 2222; inform the operator of the exact nature of the emergency giving the precise location. Staff must also request a paramedic ambulance to be called. Local Bleep holders will respond to assist.

6.1.5 Community Services

Dial 999 and request a paramedic ambulance attends the resuscitation stating that cardiopulmonary resuscitation has been commenced. Community staff are responsible for carrying out cardiopulmonary resuscitation using their own equipment until the ambulance arrives.

The equipment available will depend on the environment in which the patient has collapsed; shared accommodation with other primary care providers (poly clinics and GP surgeries) may have AEDs available. It would be appropriate for Trust staff with appropriate training or awareness to utilise the AED during resuscitation http://www.resus.org.uk/pages/AEDtrnst.htm . Resuscitation should continue in accordance with basic life support guidelines http://www.resus.org.uk/pages/bls.pdf and with respect to Dudley NHS Guidelines to ensure a cohesive delivery of care.

All community directorate staff involved in the administration of drug therapies especially vaccinations must ensure they are aware of and act appropriately to suspected anaphylaxis in accordance to current guidance. http://www.resus.org.uk/pages/reaction.pdf

6.2 Anaphylaxis

The management of suspected anaphylaxis / anaphylactoid reactions should be conducted in accordance with the Resuscitation Council (UK) Guidelines for the management of anaphylaxis, this should be treated as a medical emergency and a **2222** call activated.
http://www.resus.org.uk/pages/reaction.pdf.

6.3 Composition of the Resuscitation Team in the Acute Trust

The composition of the respective emergency teams (Adult / Obstetric / Paediatric / Neonatal) is detailed within ***Appendix 3.***

The adult team will have roles delegated at hand over meetings am and pm. The team leadership should be the medical registrar designated to the team.

6.4 Actions to prevent and minimise or prevent further deterioration.

The trust has an established mechanism in place (track and trigger) to minimise or prevent further deterioration in adult and obstetric care. The procedure for the adult track and trigger and its graduated response mechanism can be found in ***Appendix 6*****.**

6.5 Post Resuscitation Care

Following resuscitation the medical emergency team will make provision for safe continuity of care and where necessary, safe transfer. This may involve the following steps:

- Referral to a specialist;
- Full and complete hand-over of care;
- Preparation of equipment, oxygen, drugs and monitoring systems;
- Intra-hospital or inter-hospital transfer;
- Liaison with the Ambulance Services;
- Staff experienced in patient retrieval and transfer;
- Informing relatives.

6.6 Resuscitation Equipment, Replenishment and Cleaning:

6.6.1 In Hospital

All key clinical areas have a resuscitation trolley. These trolleys must be maintained in a state of readiness at all times. The lead nurse / manager of each area is responsible for ensuring all resuscitation equipment is available, clean and functional.

Daily checks (or each day clinic areas are in use) the cardiac arrest trolley paper seal must be checked to ensure it is intact. At the same time the defibrillator must be checked for self-test messages. All hard surfaces of the trolley and equipment must be cleaned. A written record of daily checks must be maintained at ward/department level and made available for audit.

Once a week and immediately after use, all trolley contents must be checked against the contents list (***Appendix 4***) for availability, function and expiry date. Missing items must be replaced as well as any item due to become out of date in the next week.

Non-disposable items should be de-contaminated / cleaned in accordance with both the manufacturers' policy and the organisation-wide infection control policy and re-instated to the trolley as soon as is practical.

All hard surfaces of the trolley and equipment must be cleaned.

The signed and dated cardiac arrest trolley paper seal must be placed through the top bar and drawer handles then sealed.

A written record of weekly checks must be maintained at ward/department level and made available for audit.

6.6.2 Community

It is recommended that community staff carry single use pocket mask's and when in shared accommodation with other primary care services familiarise themselves with available resuscitation equipment (AEDs).

6.6.3 Defibrillation

Defibrillators must only be operated by persons specifically trained in their use. The operation of defibrillators by Doctors, Nurses, Midwives and Allied Health Professionals is subject to their satisfactory completion of either an

Immediate Life Support (ILS) course, Advanced Life Support (ALS) or AED and Basic Life Support (BLS) for ambulatory care course followed by annual refresher training.

6.6.4 Procurement

All resuscitation equipment purchasing is subject to the organisation's standardisation strategy; therefore all resuscitation equipment purchased must be sanctioned by the Resuscitation Training Department and Medical Devices Group prior to ordering. Disposable items for the cardiac arrest trolley, excluding syringes, needles and disposable tourniquets are available in a red box obtainable from the procurement department

6.7 Manual Handling

In situations where the collapsed patient is on the floor, in a chair or in a restricted / confined space the organisational guidelines for the movement of the patient must be followed to minimise the risks of manual handling and related injuries to both staff and the patient.

Please also refer to the Resuscitation Council (UK) statement which can be found at http://www.resus.org.uk/pages/safehand.pdf

6.8 Cross Infection

Whilst the risk of infection transmission from patient to rescuer during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. It is therefore advisable that direct mouth-to-mouth resuscitation be avoided in the following circumstances:

- All patients who are known to have or are suspected of having an infectious disease;
- All undiagnosed patients entering the Accident & Emergency department, Outpatients or other admission source;
- Other persons where the medical history is unknown.

All clinical areas should have immediate access to airway devices (e.g. bag/valve/mask or pocket mask) to minimise the need for mouth-to-mouth ventilation. However, in situations where airway protective devices are not immediately available, start chest compressions whilst awaiting an airway device.

6.9 Do Not Attempt Cardiopulmonary Resuscitation (DNAR) Orders

The Trust has developed a procedure for DNAR orders **(*Appendix 5*)** which fully comply with the guidance issued by the BMA / RCN / Resuscitation Council (UK) (2007) and the recommended standards issued in the Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians, the Intensive Care Society and the Resuscitation Council (UK) standards for clinical practice and training that state:

- *It is essential to identify (a) patients for whom cardiopulmonary arrest is an anticipated terminal event and in whom cardiopulmonary resuscitation (CPR) is inappropriate; and (b) patients who do not want to be treated with CPR.*

- *All institutions should ensure that there is a clear and explicit resuscitation plan for all patients. For some patients this will involve a DNAR decision.*
- *Where there is no resuscitation plan and the wishes of the patient are unknown, resuscitation should be initiated if cardiopulmonary arrest occurs*
- *However, a decision not to attempt resuscitation may be appropriate when; the patient's condition indicates that CPR is unlikely to be successful, or CPR is not in accord with an applicable Advanced Decision or successful CPR is likely to be followed by a length and quality of life that is not in the best interests of the patient.*

The overall responsibility for decisions about DNAR orders rests with the consultant in charge of the patient's care. Some patients may be admitted with existing DNAR orders initiated in primary care, these decisions should be respected and reviewed by the named admitting consultant at their earliest review to determine the continued appropriateness of the order.

7. TRAINING

7.1 Organisational expectation in relation to staff training

The Trust provides resuscitation training for the main staff groups as detailed in the Trust Training Needs Analysis.

Individual staff requirements are available from each line manager and are detailed in the ward/department mandatory training reports.

All new clinical staff are told during induction of the need to book onto induction CPR or appropriate sessions for their role; the resuscitation training team will advice on this when contacted by the individual.

Training is commensurate to each of the staff group's expected role in a resuscitation event and incorporates current statements and guidelines published by the Resuscitation Council (UK) found at http://www.resus.org.uk/pages/guide.htm. The training explicitly incorporates the following:

- Identification of patients at risk from cardiac arrest and a strategic approach to implement preventative measures using a "track and trigger" system with graduated response (***Appendix 2***) within in patient and day case surgery areas.
- Cardiopulmonary resuscitation and post resuscitation care
- Rapid utilisation of defibrillation where indicated in either manual or automated external defibrillator mode (in accordance to training of operator and environment).

7.2 General Training Recommendations

7.2.1 Medical Emergency Team

The members of the medical emergency team will have been trained to Advanced Life Support Level, in accordance to the Resuscitation Council UK ALS Course and have annual local training to reinforce these guidelines.

7.2.2 Registered Healthcare Professionals

The Trust requires all Doctors, Nurses, Midwives and Allied Health

Professionals to attend annual resuscitation training so they are adequately and regularly trained in cardiopulmonary resuscitation appropriate to their discipline and environment for community staff and staff based in outpatient centres, Corbett and Guest sites.

In some instances the level of training may be determined by their respective professional bodies (e.g. Royal Colleges) however the Trust Training Needs Analysis is based on the duties that those staff would be expected to undertake when in attendance at a cardiac arrest / medical / obstetric / neonatal emergency.

7.2.3 Healthcare Support Workers and Support Services

All healthcare staff and support services with patient contact should be trained in hospital basic life support.

7.3 Resource issues

Resuscitation training may at times be prioritised to optimise the availability of staff groups. Equipment and training environment will be monitored by the Resuscitation Officer and reported back to the Resuscitation Group in accordance with guidance give in the Resuscitation Council UK: Cardiopulmonary Resuscitation Standards For Clinical Practice and Training. (Revised 2008)

7.4 Non attendance

The Manager is informed by email of those staff who are booked onto a training session and do not attend. The clinical tutor is informed of the attendance of Foundation Doctors.

An annual report of all training undertaken by the Resuscitation Officers is presented to the Resuscitation Group and Patient Safety Group

All clinical and service leads and managers also receive monthly reports on mandatory training from human resources highlighting those who are compliant and those who require training.

8. PROCESS FOR MONITORING COMPLIANCE

	LEAD	TOOL	Frequency	Reporting arrangements	Acting on recommendations and leads	Change in practice and lessons to be shared
Early Warning system	Outreach lead Resuscitation Officers	Audit of track and trigger during assessment or MET calls in-accordance with track and trigger graduated guidance.	Continuous to events	Reporting to the Acutely ill Group quarterly and the Resuscitation Group. Clinical and service leads for area reviewed.	Leads to ensure procedures are adhered to and correct practice where needed.	Personal management plans and training in areas of improvement identified.
Trust participates with the NCCA (national cardiac arrest audit), allowing both local and national review of cardiac arrest events.	Resuscitation Officers	NCCA data collection flow chart	Every cardiac arrest event where a 2222 call is made or equivalent team attends	Quarterly reports to the Resuscitation Group and biannual reports to Patient Safety and Risk & Assurance	The chair of the Resuscitation Group and Resuscitation Officers along with recommendations from the Risk & Assurance and Patient Safety Groups will take action forward.	Training strategies will be planned and deployment of MET teams and use of Track and triggers reviewed.
The Trust is compliant with the established process for Do not attempt Resuscitation (DNAR)	Resuscitation Officers	Audit	Annually	Report to the Resuscitation Group Report to the Patient Safety Group	Group will act on findings and will investigate risk management issues. Group will consider challenge, agree and monitor actions from the report.	Change in practice will be communicated through clinical leads, matrons/managers from the Patient Safety Group and Risk & Assurance. Change in practice will be communicated through clinical leads, matrons/managers from the Patient Safety Group and Risk & Assurance
The Trust has continual availability of resuscitation equipment that is clean and fit for purpose which requires: Cardiac arrest paper seal intact All hard surfaces of the trolley and equipment are clean Ward check lists are completed on daily/weekly and after use checks.	Resuscitation Officers	Audit	Annually	Resuscitation Group Patient Safety Group	Group will act on findings and will investigate risk management issues. Group will consider challenge, agree and monitor actions from the report.	Changes in practice will be recommended and compliance where issues addressed will be reviewed in three months Change in practice will be communicated through clinical leads, matrons/managers from the Patient Safety Group and Risk & Assurance
Organisation's expectations in relation to staff training as identified in the training needs analysis	Resuscitation Training Department	ESR records	Monthly	Human Resources	Activity will acted upon and feed into mandatory training group.	This will be monitored by all managers receiving the monthly training reports from human resources.

9. EQUALITY AND DIVERSITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly.

10. REFERENCES

Mental Capacity Act 2005 Department of Health

National Health Service Litigation Authority NHSLA Risk Management Standards for Acute Trusts

Resuscitation Policy. Health Services Circular (HSC) 2000/028. London. Department of Health

Resuscitation Council (UK) (2007) Decisions Relating to Cardiopulmonary Resuscitation. A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. http://www.resus.org.uk/pages/dnar.htm [online]

Resuscitation Council (UK) (2008) Emergency Treatment of Anaphylactic Reactions http://www.resus.org.uk/pages/reaction.pdf [online]

Resuscitation Council (UK) (2008) Cardiopulmonary Resuscitation - Standards for Clinical Practice and Training. A Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians of London, the Intensive Care Society and the Resuscitation Council (UK). London. Resuscitation Council (UK) http://www.resus.org.uk/pages/standard.htm [online]

Resuscitation Council (UK) (2005) Resuscitation Guidelines 2005. http://www.resus.org.uk/pages/guide.htm [online]

Resuscitation Council (UK) (2009) Guidance for Safer Handling during Resuscitation in Healthcare settings http://www.resus.org.uk/pages/safehand.pdf

Appendix 1

RESUSCITATION GROUP - TERMS OF REFERENCE

1. Constitution

1.1 The Patient Safety Group resolves to establish a reporting group to be known as the Resuscitation Group. The Resuscitation Group in its workings will be required to adhere to these Terms of Reference and has no delegated powers outside of these.

2. Membership (Chair will be held by any of the consultants in acute or anaesthetic adult care.)

Anaesthetic Consultant
Medical consultant
Emergency medicine consultant
Paediatric/Neonatal Consultant
Junior medical representative (training grade who may be on crash team during on calls).
Resuscitation Officers
Senior Nurse (Matron) representative.
Outreach/Critical care nurse representative.
Neonatal nurse.
Senior paediatric nurse.
Pharmacist
Community service directorate representative.
Senior manager

3. Attendance

3.1 The following shall be entitled to attend and receive papers to be considered by the Group: *Patient safety leads, clinical directors.*

3.2 Other managers/staff may be invited to attend meetings depending upon issues under discussion.

3.3 Chair will ensure that an efficient secretariat service is provided to the Group.

4. Quorum

4.1 A quorum shall be 4 members, *(Extra to the chair of the resuscitation group*)

5. Frequency of meetings

5.1 The Resuscitation Group will meet (*Quarterly*)

.

5.2 Additional meetings may be held at the discretion of the Chairman of the Group

6. Authority

6.1 The group is authorised by the Patient Safety Group to investigate any activity within its terms of reference only.

7. Duties

The Resuscitation Group will advise the Trust on all aspects of Resuscitation. The duties of the Group can be categorised as follows:

7.1 **Policy**

- To develop a central point of reference and expertise for the Trust on matters relating to Resuscitation and Resuscitation equipment.

- To produce and maintain a workable Trust Resuscitation Policy embracing current National Standards and Guidance and to comply with NHSLA requirements.

7.2 Audit

- To advise on the design and implementation of the audit process which will monitor the incidence and outcomes of cardiac arrest/medical emergency calls and maintain data input to the NCAA.

- To advise on the design and implementation of the audit process which will monitor decisions relating to resuscitation? This will involve the underpinning rationale behind the decision making process and those involved.

- To oversee audits of cardiac arrests and act appropriately on findings.

- To undertake a quarterly review of compliance with the progress of audits on early warning systems, resuscitation outcomes, post resuscitation care, attendance at training, training requirements, equipment provision.

- To produce an annual audit report which will be presented to the Patient Safety Group .

7.3 Training

- To offer guidance on the minimum level of resuscitation training for individual staff groups, based on their role and exposure to cardiac arrest/emergency situations and in line with nationally published standards.

- To ensure that any new developments in resuscitation are communicated appropriately and incorporated into training schedules as soon as possible.

- To ensure that the uptake of training is audited and reported to appropriate governance leads for the trust.

- To review annually the educational needs of the Trust and the resources available to meet those needs

- To produce an annual Activity Report

7.4 Risk Management

- To investigate risk management issues relating to resuscitation according to Trust procedure, reporting to the Patient Safety Group

- Lead on the monitoring of all the minimum (Level1) requirements within the current NHSLA Risk Management Standards.

7.5 Equipment

- To advise on the appropriate choice of equipment and medicines for use in resuscitation procedures.

8. Reporting

8.1 The Resuscitation Group reports to the Patient Safety Group and is required to comply with any reporting requirements set by the Patient Safety Group as to format and frequency.

9. Review

9.1 The Terms of Reference of the Group shall be reviewed by the Patient Safety Group at least annually.

Name: _____ Unit No: _____ Ward: _____ **Appendix 2**

Date																
Time																
RESPIRATIONS	40															
	35															
	30															
	25															
	20															
	15															
	10															
	<8															
SATS	91-100															
	85-90															
	<84															
O2 % or L's																
BLOOD PRESSURE/PULSE	>190															
	180															
	170															
	160															
	150															
	140															
	130															
	120															
	110															
	100															
	90															
	80															
	70															
	60															
	50															
	40															
	30															
PULSE	>141															
	111-140															
	51-110															
	41-50															
	<40															
SYSTOLIC BP	>191															
	91-190															
	71-90															
	<70															
TEMPERATURE	>39															
	39															
	3.5															
	38															
	37.5															
	37															
	36.5															
	36															
	<35.5															
NEURO	Alert															
	Voice															
	Pain															
	Unresponsive															
	New Confusion															
BM's																

PAIN ASSESSMENT

0 = NO PAIN 1 = MILD PAIN 2 = MODERATE PAIN 3 = SEVERE PAIN

PAIN LEVEL																

ADULT OBSERVATIONS CHART GUIDELINES

OBSERVATIONS TO BE RECORDED EVERY 4 HOURS UNLESS OTHERWISE STATED.

If you are concerned about the patients condition you can call for medical assistance or Outreach (Bleep no.7838) at any time.

Green Observations
Continue established observations and treatment plan

ANY ONE AMBER

- **Re-check observations manually and inform Nurse-in- Charge.**
- **Take any appropriate actions as required.**
- **Increase frequency of observations.**
- **Inform medical staff if concerned about patient.**

ANY TWO AMBER

- **Re-check observations manually and inform Nurse in Charge.**
- **Seek advice from Outreach.**
- **Bleep Doctor and inform,**
- **Take appropriate actions as required.**
- **Continue to monitor patient.**
- **Hourly observations and fluid balance monitoring until stable.**

ANY THREE OR MORE AMBER OBSERVATIONS.

- **Re-check observations manually and monitor FLUID BALANCE (measure urine output), and inform Nurse in Charge.**
- **Contact Outreach.**
- **Bleep Doctor to review immediately.**
- **If no review within 30 minutes inform Registrar.**
- **Continue to monitor patient with 30 minute observations until stable.**
- **If no improvement in patients condition following Registrar review, patient to be discussed with own Consultant or duty Consultant.**

Any Red Observation
CALL 2222 for M.E.T. TEAM.
If Cardiac Arrest call 2222

EXCEPTIONS BOX – To be signed by Doctors if above criteria not applicable (i.e. palliative care or chronic condition)	
Date/time	**Comment and signature**

Appendix 3

COMPOSITION OF THE RESUSCITATION TEAMS FOR RUSSELLS HALL HOSPITAL

Medical Emergency Team

a) Medical Registrar – Team Leader
b) ITU on call anaesthetist.
c) RMO 2
d) Outreach Service member
e) The ward or department staff are part of emergency team for the duration of the resuscitation event in their clinical area.

Paediatric Emergency Team

a) Paediatric Registrar on call
b) ITU Anaesthetist on call
c) Shift lead from Paediatric Ward
d) The ward or department staff are part of the cardiac arrest team for the duration of the arrest event in their clinical area.
e) Outreach Service Member

Neonatal Emergency Team

a) Neonatal Registrar
b) Neonatal ST
c) Advanced Nurse Practitioner in neonates

Obstetric Emergency Team

a) Obstetric Registrar
b) Obstetric ST
c) Anaesthetist on call for obstetrics
d) Lead Midwife
e) Scrub nurse for obstetric theatre
f) Operating Department Practitioner

Appendix 4

THE DUDLEY GROUP NHS FOUNDATION TRUST

Contents List for Lifepak 20 Cardiac Arrest Trolley

Item	Size	Quantity	Location on trolley
Advisory External Defibrillator (AED) Lifepak 20		1	Top
AED Monitoring pads single use		2	Top drawer
Laerdal Suction Unit Disposable liners for suction unit		1	Top
Oxygen cylinder	F	1	In oxygen cage
Oxygen nipple connector			middle drawer
Bag/valve/mask single patient use - Marshalls	Adult/large	1	Top
I V cannula	14G 18G 20G	2 2 2	Top drawer
IV Line dressing		2	Top drawer
Dispensing pin, with one-way valve, for syringes		1	Top drawer
Sterets		10	Top drawer
Single patient use non-latex tourniquet		1	Top drawer
Syringes	20ml	8	Top drawer
Gauze	10x10cm	2	Top drawer
Green needles		6	Top drawer
Arterial blood gas syringe		2	Top drawer
Disposable razor		1	Top drawer
Minijet drug box		1	Lower drawer
Dextrose 5%	500ml	1	Lower drawer
Volplex x 1	500ml	1	Lower drawer
Hartmanns Solution	500ml	2	
Wide-bore IV giving set		2	Lower drawer
Reusable Laryngoscope handles	standard	2	Middle drawer
Laryngoscope blades single patient use.	Mac 3 Mac 4	1 1	Middle drawer

Item	Size	Quantity	Location on trolley
Laryngeal mask airway - Single use.	4 5	1 1	Middle drawer
Intubating catheter – single use		1	Middle drawer
Endotracheal tubes – Portex Uncut and sealed	5mm 7mm 8mm 9mm	1 1 1 1	Middle drawer
Yankaur catheter		2	Middle drawer
Tracheal suction catheters	10fg 12fg 14fg	2 2 2	
Magills forceps single use		1	Middle drawer
Syringe	10ml 50ml	1 1	Middle drawer
Lubricating gel - water soluble x1		1	Middle drawer
2.5cm wide tape roll		1	Middle drawer
Oropharyngeal airways	2 3 4	1 1 1	Middle drawer
Nasopharyngeal airways (no safety pin)	6 7 8	1 1 1	Middle drawer
Oesophageal detector		1	Middle drawer
Catheter mount		1	Middle drawer
Paediatric face mask for ventilation of neck breathers	Size 2	1	Middle drawer
Roll of ECG paper for Lifepak 20		1	Lower drawer
Aprons disposable		6	Lower shelf
Nitrile Disposable gloves	large	1 box	Lower shelf
Nitrile Disposable gloves	medium	I box	Lower shelf
Sharps Bin		1	Lower shelf

December 2010

Appendix 5

DECISIONS RELATING TO CARDIOPULMONARY RESUSCITATION

1. Introduction

Cardiopulmonary resuscitation (CPR) could be attempted on any individual in whom cardiac or respiratory function ceases. Failure of these functions is inevitable as a part of dying and thus CPR can theoretically be used on every individual prior to death. It is, therefore, essential to identify patients for whom cardiopulmonary arrest represents a terminal event in their illness and in whom CPR is inappropriate. For some patients the benefits may be outweighed by the risks of attempting resuscitation. The survival rate of cardiac arrest and CPR is low and CPR can be traumatic and associated with a prolonged ICU stay and brain damage. These decisions that involve quality of life issues require consultation with the patient to ascertain their wishes. It is also essential to identify those patients who do not want CPR to be attempted and who completely refuse it.

2. Advance care planning

Clinicians have an important role in helping patients plan future care including the patient's wishes regarding attempted CPR. If there is an identifiable risk of cardiac arrest because of an underlying incurable condition or because of the patient's current clinical state, it is desirable to make decisions about CPR in advance.

3. Non-discrimination

A Do Not Attempt Resuscitation (DNAR) decision must be made on an individual basis according to the patient's own particular circumstances. Advanced age, disability or particular conditions are not, in themselves, indications for not attempting CPR.

All other treatments and care are not affected by a DNAR decision and must not be influenced by it.

4. Human Rights Act 1998

This Act aims to promote human dignity and transparent decision-making. CPR policies and individual decisions must comply. In particular, decisions must reflect the right to life (Article 2), freedom from inhuman or degrading treatment (Article 3), respect for privacy and family life (Article 8), freedom of expression which includes the right to hold opinions and to receive information (Article 10) and freedom from discriminatory practice in respect of these rights (Article 14).

5. Presumption in favour of CPR when there is no DNAR decision

If no DNAR decision has been made, CPR should be initiated if cardiac or respiratory arrest occurs. In such emergencies there is rarely time to make a proper assessment of the patient's condition or likely outcome of CPR.

Medical and nursing staff commencing CPR under such circumstances should be supported by their seniors.

If, subsequently, information comes to light that continued attempted resuscitation is not appropriate either because of a DNAR order, a valid and applicable advance decision or that the clinical condition of the patient means CPR will not be successful then CPR may be discontinued.

If it is clear that attempting CPR is inappropriate, for example, in a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR will not be successful, then CPR may not be commenced. Medical and nursing staff not commencing CPR under such circumstances should be supported by their seniors.

6. Appropriate Circumstances to Consider Making a DNAR Decision

a) When attempted CPR will not restart the patient's heart and breathing for a sustained period. If the healthcare team is as certain as it can be that attempting CPR would not restart the patient's heart and breathing, the patient cannot gain any clinical benefit from an attempt.

b) Where the expected benefit is outweighed by the burdens of attempting CPR. Where CPR may be successful in restarting the patient's heart and breathing, and thus prolong the patient's life, the benefits to be gained from the prolongation of life must be weighed against the risks to the patient of the treatment. Such risks include the traumatic complications of chest compressions, intensive care treatment in the post-resuscitation period and permanent brain damage.

c) Where the patient has made an advance decision refusing CPR.

7. Clinical Decisions not to attempt CPR

Taking due regard of the patient's individual circumstances, if the clinical team believes that CPR will not re-start the heart and maintain breathing and is, therefore, of no benefit, it should not be offered or attempted. CPR is very unlikely to be successful in patients in the final stages of an incurable illness where death is expected within a few days. Such attempts may prolong or increase suffering and subject the patient to a traumatic and undignified death. Earlier discussions with the patient about their general care and treatment aims for the future could address these issues.

Uncommonly, patients with a DNAR decision may develop a cardiac or respiratory arrest from a readily reversible cause such as choking, induction of anaesthesia, anaphylaxis or blocked tracheostomy tube. In such circumstances CPR may be appropriate whilst the reversible cause is being treated unless the patient has specifically refused treatment under these circumstances. Also a DNAR decision may be temporarily suspended before a procedure that could precipitate a cardiopulmonary arrest, for example, cardiac catheterisation, pacemaker insertion or surgical operation. The DNAR decision should be reviewed and discussed with the patient as part of the consent process.

The DNAR decision may remain valid or be suspended until an agreed date and time in the future. In the case of surgery, a “Consent Form for DNAR Management during perioperative period" form must be completed.

8. Decisions about CPR that are based on benefits and burdens

If CPR may be successful in re-starting the patient’s heart and maintaining breathing for a sustained period, the benefits of prolonging life must be weighed against the potential burdens for the patient.
Such decisions must involve consideration of the patient’s best interests including their known or likely wishes. In these circumstances, discussion with the patient (or, if the patient lacks capacity, those close to the patient) about whether CPR should be attempted is an essential part of the decision-making process.

Sensitive discussions should include information about the risks and complications of attempted CPR which might include rib fractures, intensive care treatment in the post-resuscitation period and permanent brain damage. Many people have unrealistic expectations about the likely success and potential benefits of CPR.

9. Communicating DNAR decisions with patients

When a clinical decision is made that CPR should not be attempted, because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR.

Whether a patient should be informed about a DNAR decision will depend on individual circumstances. Patients who know they are dying may not wish to know of possible interventions that are likely to be unsuccessful. Other patients may wish to be fully informed of all decisions regarding their care. An assessment should be made of what information the patient wishes to receive. It is usually preferable for a patient to be informed of a decision rather than find out by chance without explanation.

When a patient with capacity is at foreseeable risk of cardiorespiratory arrest, and the healthcare team has doubts about whether the benefits of CPR would outweigh the burdens there should be a sensitive exploration of the patient’s wishes, feelings, beliefs and values. However, information should not be forced on unwilling recipients and if patients indicate that they do not wish to discuss CPR this should be respected.

10. Requests for CPR in situations where it will not be successful

Neither patients, nor those close to them, can demand treatment that is clinically inappropriate. In such a case, if the clinician believes that CPR will not re-start the heart and breathing, this should be explained in sensitive way. If the patient requests a second opinion this should be arranged whenever possible.

11. Refusal of CPR by adults with capacity

Adults with capacity have the right to refuse medical treatment even if that refusal results in their death. This includes CPR. A formal written advance decision may be made by the patient to this effect.

12. Adults who lack capacity

By law adults lack capacity and are unable to make decisions for themselves if they are unable to understand the information relevant to the decision, retain that information, use or weigh that information as part of the process of making the decision, or communicate the decision.

People over the age of 18 with capacity may make a lasting power of attorney (LPA) appointing a welfare attorney to make health and personal welfare decisions on their behalf once such capacity is lost. Before relying on the authority of this person the healthcare team must be satisfied that:

- the patient lacks capacity
- a statement has been included in the LPA authorising the welfare attorney to make decisions relating to life-prolonging treatment
- the LPA has been registered with the Office of the Public Guardian
- the decision being made by the attorney is in the patient's best interests.

Welfare attorneys cannot demand treatment that is clinically inappropriate but where CPR may re-start the heart and breathing for a sustained period and a decision whether or not to attempt CPR is based on the balance of benefits and burdens, their views about patients' likely wishes must be sought. Where there is disagreement between the healthcare team and an appointed welfare attorney or court-appointed guardian about whether CPR should be attempted in the event of a cardiorespiratory arrest, and this cannot be resolved through discussion and a second clinical opinion, the Court of Protection may be asked to make a declaration.

13. Adults who lack capacity, have neither an attorney nor an advance decision but do have family or friends

The treatment decision rests with the consultant in charge of the patient's care acting in the best interests of the patient. Where CPR may re-start the heart and breathing for a sustained period, the decision as to whether CPR is appropriate must be made on the basis of the patient's best interests. The views of those close to the patient should be sought, if possible, about any expressed wishes regarding attempted resuscitation and what level or chance of recovery the patient would be likely to consider of benefit. It should be made clear that their role is not to take decisions on behalf of the patient. Family and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision-making but they cannot insist on treatment or non-treatment.

14. Adults who lack capacity, and have no family, friends or other advocate whom it is appropriate to consult

An independent mental capacity advocate (IMCA) must be consulted about all decisions relating to "serious medical treatment" where patients lack capacity and have nobody to speak on their behalf. In all cases where a DNAR decision is made, the IMCA should be informed at the earliest sensible opportunity whether or not the admitting team consider that any attempt at

CPR would be futile. The IMCA does not have the power to make a decision about CPR but must be involved to determine the patient's best interests if there is genuine doubt about whether or not CPR may succeed or if a DNAR decision is based on the balance of benefits and burdens. If an IMCA is not available the decision should be made and recorded in the health record and then discussed with an IMCA at the first available opportunity.

15. Children and young people

Clinical decisions relating to children and young people should be taken within a supportive partnership of patients, their families and the healthcare team. Discussion must involve the child's parents or carers. Decisions based on the balance of benefits and burdens should consider the views of the child or young person where this is possible.

Young people with capacity are entitled to give consent to medical treatment, and where they lack this capacity, it is generally those with parental responsibility who make decisions on their behalf. The courts have ruled that refusal of treatment by young people up to the age of 18 is not necessarily binding upon doctors.

If a child is discharged home for terminal care it is essential that the DNAR decision be reviewed in consultation with the G.Pand Community Paediatric Nursing Team. The Primary Health Care Team will take responsibility for the ongoing care, in particular to support the family as appropriate.

A letter regarding information about DNAR should be given to the parents or carers, and sent to Emergency Department and west Midlands Ambulance Service.

16. Confidentiality

If patients have capacity to make decisions about how their clinical information is shared their agreement must always be sought before sharing information with family and friends. It may also be helpful to ask patients with capacity who they want, or do not want, to be generally involved in decision-making if they become incapacitated. Refusal by a patient with capacity to allow information to be disclosed to family or friends must be respected.

Where patients lack capacity and their views on involving family and friends are not known, doctors may disclose confidential information to people close to the patient where this is necessary to discuss the patient's care and not contrary to the patient's interests.

Where there is a welfare attorney, deputy, or guardian involved in the discussions, relevant information should be provided to them to enable them to fulfill their role.

It is generally good practice to involve people close to patients in discussions that inform decisions. IMCAs have a legal right to information, including access to the relevant part of the patient's records in order to enable them to carry out their statutory role.

17. Responsibility for decision-making

DNAR decisions should normally be made at Consultant level by those responsible for the patient's care at the time in consultation with senior nursing staff.

Wherever possible, these decisions should involve the Consultant with overall responsibility for that patient's care. However, if this Consultant is not available, a decision should not be delayed in order to prevent any unnecessary distress for the patient and/or his family and friends. Decisions, made shortly after admission, may be made by a doctor at ST3 or higher grade who has seen the patient. Nevertheless, the decision must be subject to review by a consultant at the earliest opportunity. Further consultant review should occur at appropriate regular intervals thereafter and especially whenever changes occur in the patient's condition or in the patient's expressed wishes.

The decision may have an unlimited duration and would continue into any step-down care facility under the responsibility of The Dudley Group of Hospitals NHS Foundation Trust and, with the agreement of West Midlands Ambulance Service and Ambuline, for the duration of transfer to home or other place of care.

Teamwork and good communication are of paramount importance. Further decisions on resuscitation once a patient is in primary care should then be taken by leads in management of primary care GP. Any decisions made in the acute trust should be communicated within the discharge informations. Any decision made within primary care will be respected and reviewed at admission to acute trust to ensure appropriate supportive care is maintained.
Dudley NHS DNAR Policy
http://joint.dudley.nhs.uk/cmsextra/documents/cms/583-2011-11-25-6032948.pdf

18. Recording decisions

The DNAR decision should be communicated to all relevant members of the multidisciplinary team and documented in the medical and nursing notes. A DNAR communication sheet must be completed by a member of the medical team at the time of the decision and placed in front of KMR 1 in the medical notes. This acts as the medical part of the documentation.

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Generic Adult Observation and Monitoring (Track and Trigger)

1. Aim

To standardise the approach towards the recording, monitoring and intervention indicated from vital signs observations recorded in general acute adult care utilising a track and trigger system with a graduated response.

- **Introduction**

This applies to all areas of acute areas of adult care where bedside observations are performed EAU, SAU, acute medicine, elective and emergency surgery and day case areas.

This policy is not meant to replace guidance on observation in specific clinical events where observation regimes are given such as blood transfusions, peri-operative periods, patients requiring neurological observation or management plans in high dependency or critical care areas in terms of frequency but triggers should still be utilised unless document otherwise.

- **Definition of Patient Group**

All adults under acute inpatient or day case care weather via an elective or emergency admission to Trust. Not to be used in paediatric or obstetric care where specific observational tools are used.

- **Aims and Objectives**

To standardise the approach to the recording of observations and action taken in accordance to triggers within adult care in the Dudley Group of Hospitals NHS Foundation Trust.

- **Reasons for Development:**

NICE CG50 (2007) indicated that all areas of acute care should operate with a multi-parameter observation tool that gave a graduate response mechanism. RC UK (2010) suggests that up to 80% of in hospital cardiac arrests will show changes in their observations in the hours prior to arrest, the use of some form of track and trigger and medical emergency teams may help to reduce the number of cardiac arrests within the acute care setting.

6. The Process of Using the Track and Trigger Tool In Recording Observations and Escalation of Care:

6.1 Recording Observations:

6.1.1 All observations must be completed and documented using the Dudley Group NHS Foundation Trust Adult Observation Chart for patient within the designated group and settings **Appendix 2.**

6.1.2 All observations should be initially recorded four hourly unless otherwise directed by a physician or indicated by triggers.

6.1.3 All observations from base line on wards must incorporate the following:

- Respiratory rate
- Saturation
- Oxygen flow at time of observation.
- Blood pressure and pulse in graphed form together.
- Pulse
- Systolic Blood Pressure
- Temperature
- Neurological status AVPU (Alert, voice, pain, unresponsive)

6.1.4 When any triggers are given then blood sugar (BM) and pain should be recorded as well.

6.1.5 Accuracy of observations recorded electronically should be confirmed manually via palpation and visual inspection on any triggers or abnormal trend.

6.2 Escalation following change in observations

6.2.1 Escalation of management should be as indicated on the reverse of the chart **Appendix 2.**

6.2.2 Observations within the green observations will continue on 4 hourly observations unless frequency reduced in accordance with section 6.3.

6.2.3 Any single observation within the amber bands should be escalated to the nurse in charge, rechecked manually and decision taken by nurse in charge weather to inform medical team. If a single amber trigger persists and remains on next set of observations recorded treat as two ambers. When discussing with team utilise SBAR communication tool.

6.2.4 Any two ambers, recheck manually, inform nurse in charge, inform medical team (during working hours parent team, out of hours on call team) discuss with out reach (bleep 7838) and increase frequency of observations to hourly with fluid balance. When discussing with team utilise **SBAR** communication tool.

6.2.5 Any three or more ambers, recheck observations manually and monitor fluid balance, inform nurse in charge, bleep doctor for immediate review, contact outreach. If no medical review within 30 minutes inform registrar, continue to monitor half hourly observations. If no improvement following registrar review management to be escalated to consultant (own or on call as appropriate). When discussing with team utilise **SBAR** communication tool.

6.2.6 Any red observation call 2222 requesting the medical emergency team (MET) to ward area. Give clear description of area team needed, ward, room, clinic or environment. MET calls should not be affected by DNAR decisions.

6.3 Exceptions Box

6.3.1 Where patients chronic condition will mean they are continually triggering certain parameters it may be appropriate to adjust triggers, this should be recorded in the exceptions box under the guidance of a senior physician. The

changes need to be clearly outlined and the physician making the change should clearly sign and date/ time the entry.

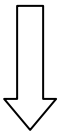
6.3.2 It may also be appropriate in end of life care to remove all observations and as such triggers, this again should be clearly documented and date/ time entered by a senior physician.

6.4 De-escalation of stable observations

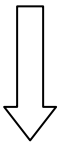
6.4.1 When a patient has shown stability in their observations and condition it may be appropriate to decrease frequency, this should only be done if the patient requires set observations following procedural intervention and any change in stability and trigger should increase frequency again in terms of track and trigger guidance. Monitoring of chronic conditions should also be considered before changing frequency such as patients requiring targeted oxygen therapy to saturation.

6.4.2 Observation frequency can be changed by Band 6 (registered nurse) or above and should be documented on the chart in the exceptions box with the time date and name and nursing process and must follow criteria below before change. If unsure in cases discussed in 6.4.1 then liaise with the medical team in charge of the patients care.

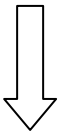
Observations stable within green bands or patients norms (as recorded by physician in exception box) or 48 hours.



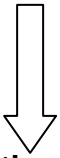
Decrease frequency to 8 hourly



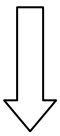
Observations stable within green bands or patients norms (as recorded by physician in exception box) or 48 hours.



Decrease frequency to 12 hourly



Observations stable within green bands or patients norms (as recorded by physician in exception box) or 48 hours.



Decrease frequency to daily once confirmed with medical team in charge of patients care.

6.5 Following MET call return to four hourly observations once agreed by medical team or frequency as indicated by management plan.

The situation, background, assessment and recommendation communication aids with the passing of patient specific information quickly and clearly. The use of such tools is recommended by the institute for improvement and the Resuscitation Council Guidelines 2010.

6.5.1 Use of tool

Requires a primary survey assessment of the triggered patient by looking at the effectiveness of the:

- Airway
- Breathing
- Circulation
- Disability
- Exposure

So that a clear picture of the situation and patients observational status can be assessed. The background should look at diagnosis if known and significant medical history. Following if able an assessment should be given as to course of deterioration or risk level, this should be followed by recommendations.

6.5.2 Documentation

When used the SBAR should then be filed in the patients notes as an event record. It should be clearly dated, timed and named by individual completing the SBAR and include the patient's identifiable information.

7. AUDIT AND MONITORING COMPLIANCE.

7.1 Audit

Every month ten sets of notes will be removed along with patient documents and track and trigger charts as part of the nursing care indicators.

7.2 Monitoring

7.2.1 Track and triggers will be reviewed at all MET/Cardiac arrest calls by the critical outreach team to ensure triggers have not been missed or observation frequency not adhered to.

7.2.2 Any incidence of triggers being missed or not escalated appropriately will be brought to the attention of the lead nurse and an incident report (DATIX) completed. The clinical lead will investigate and will have out reach and resuscitation leads linked to the review.

The Dudley Group NHS
NHS Foundation Trust

Trust Headquarters
Russells Hall Hospital
Dudley
West Midlands
DY1 2HQ

Date: 22/07/2013

FREEDOM OF INFORMATION ACT 2000 - Ref: FOI/011520

With reference to your FOI request that was received on 19/07/2013 in connection with 'Re: Do not attempt cardiopulmonary resuscitation'.

Your request for information has now been considered and the information requested is enclosed.

Further information about your rights is also available from the Information Commissioner at:

Information Commissioner
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF
Tel: 0303 123 1113
Fax: 01625 524510
www.ico.gov.uk

Yours sincerely

Information Governance Manager
Room 34a, First Floor, Esk House, Russells Hall Hospital, Dudley, DY1 2HQ
Email: FOI@dgh.nhs.uk

The Dudley Group NHS
NHS Foundation Trust

I would like to request the DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)policy of your trust, please. If this is not a separate document could you please send me your resuscitation policy instead.

Our resuscitation policy and DNCPR are currently a combined document please see attached.