Resuscitation Policy

This procedural document supersedes: PAT/EC 1 v.7- Resuscitation Policy

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| Author/reviewer: (this version) | Lisette Caygill Lead- Resuscitation Officer  
Dr Jonathan Allen-Resuscitation Committee Chairperson |
<table>
<thead>
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<tr>
<td>Date written/revised:</td>
<td>February 2014</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Resuscitation Committee – 4 March 2014</td>
</tr>
<tr>
<td>Date issued:</td>
<td>26 March 2014</td>
</tr>
<tr>
<td>Next review date:</td>
<td>February 2017</td>
</tr>
<tr>
<td>Target audience:</td>
<td>Trust wide</td>
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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed without change, this information will still need to be recorded although the version number will remain the same.

<table>
<thead>
<tr>
<th>Version</th>
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<th>Brief Summary of Changes</th>
<th>Author</th>
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<tr>
<td>Version 8</td>
<td>26 March 2014</td>
<td>• References updated&lt;br&gt;• Terms of reference updated&lt;br&gt;• Test bleep procedure added&lt;br&gt;• Procedure for calling for an ambulance in an emergency at MMH/Retford hospital OR outside of the main hospital complex&lt;br&gt;• Monitoring compliance updated&lt;br&gt;• Appendix 3 PAWS charts included&lt;br&gt;• Appendix 4 Resuscitation Teams updated</td>
<td>L Caygill J Allen</td>
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<tr>
<td>Version 7</td>
<td>November 2010</td>
<td>• <strong>Major changes throughout - PLEASE READ IN FULL.</strong></td>
<td>L Caygill</td>
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<tr>
<td>Version 6</td>
<td>August 2007</td>
<td>• Page 4 – Objectives&lt;br&gt;• Pages 5, item 1 – Immediate Action&lt;br&gt;• Pages 5/6, item 2 – Members of the Cardiac Arrest Team&lt;br&gt;• Page 6/7, item 3 – Resuscitation Equipment&lt;br&gt;• Pages 7-10, item 4 – Training&lt;br&gt;• Page 10, item 6 – Audit&lt;br&gt;• Pages 11-14, items 7/8 – Specialist Areas&lt;br&gt;• Page 17, Appendix 2&lt;br&gt;• Pages 19-34, Appendix 4 – Algorithms&lt;br&gt;• Page 35, Appendix 5 – Resuscitation Event Record&lt;br&gt;• Page 36/37, Appendix 6 – Medical Equipment Training &amp; Fault Reporting&lt;br&gt;• Page 38, Appendix 7 – Cardiac arrest occurring in an area where a defibrillator is not currently available</td>
<td>L Caygill K Pears</td>
</tr>
<tr>
<td>Version 5</td>
<td>August 2006</td>
<td>• Page 5, item 4 – Training&lt;br&gt;• Page 6, item 5 – Resuscitation of New-born and Paediatrics&lt;br&gt;• Page 13 – Retford</td>
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1. INTRODUCTION

This resuscitation policy fully supports the Quality Standards for Cardiopulmonary Resuscitation Practice and Training in Acute Care published by the Resuscitation Council (UK) (2013).

http://www.resus.org.uk/pages/QSCPR_Acute.htm

2. PURPOSE

The purpose of the policy is to provide direction and guidance for the planning and implementation of a high-quality and robust resuscitation service to Doncaster & Bassetlaw Hospitals NHS Foundation Trust (hereafter referred to as the Trust). The strategy for resuscitation incorporates the current published guidelines for resuscitation (Resuscitation Council (UK), 2010).


3. DUTIES AND RESPONSIBILITIES

The Trust has an obligation to provide an effective resuscitation service to their patients and appropriate training to their staff. A suitable infrastructure is required to establish and continue support for these activities.

3.1 Duties within the Organisation

It is the responsibility of the Chief Executive to designate responsibility to a ‘non-executive Director of the Trust’ to ensure that a resuscitation policy is agreed, implemented and regularly reviewed within the clinical governance framework (Health services Circular 2000/028).

It is the responsibility of the Resuscitation Committee, Lead Resuscitation Officer and Policy Coordinator to ensure policy distribution, implementation and compliance throughout the organisation.

It is the responsibility of Clinical Service Unit Managers and Matrons to ensure that staff are provided with the opportunity to attend training appropriate to their role.

It is the responsibility of individual staff members to attend training appropriate to their roles.
3.2 Approval of the Resuscitation Policy

The policy has been approved by the Resuscitation Committee (Appendix 1) and is ratified in accordance with the Policy – Approved Procedural Documents (APDs) Development and Management Process - CORP/COMM 1.

3.3 Scope of Policy

This policy applies to all clinical staff and those with direct patient contact.

4. PROCEDURE

4.1 The Early Warning System

The early warning system (EWS), has been established for use with all patients to identify those who are clinically deteriorating and require urgent intervention, which may prevent cardiopulmonary arrest. All clinical staff should be trained in the identification of critically ill patients and the use of Trust generic observation charts which incorporates EWS, to enhance decision-making and care escalation if required. **Staff should initiate the early warning score (EWS) protocol (see appendix 2) to provide early identification of patients at risk of cardio respiratory arrest.** The paediatric advanced warning score (PAWS) system should be used for all paediatric patients. The associated charts are age specific and should be used accordingly. (see appendix 3).

4.2 Composition of the cardiac arrest team

The composition of the respective emergency teams (Adult / Paediatric / Obstetric) is detailed within Appendix 4.

4.3 Cardiac Arrest Calls

All Trust and temporary staff must familiarise themselves with the layout of the hospital to enable a rapid response in emergency situations. In the event of a cardiac arrest / medical / obstetric or neonatal emergency the appropriate emergency team must be alerted immediately.

The emergency telephone number is **2222.** This number should be used in the following circumstances:

- Cardiac arrest
- Paediatric cardiac arrest
• Neonatal emergency team
• Obstetric emergency team
• Maternal cardiac arrest – call cardiac arrest team and obstetric emergency team
• Fast bleep (name specific individual required, i.e. on-call medical registrar)
• Trauma team
• Fire
• Security

The precise location of the patient must be communicated promptly and clearly to the switchboard operator *do not use old names/locations*. The switchboard operator will activate all emergency bleeps simultaneously via a speech channel. Each member of the appropriate emergency team must respond at his or her earliest opportunity to this call. All emergency calls are logged by switchboard.

4.4 Response to 2222 calls

Cardiac arrest/emergency calls take precedence over all other activities unless the cardiac arrest bleep holder is already involved in another life threatening procedure.

If a team member becomes indisposed they must inform switchboard immediately and arrange for a member of staff of at least equal ability to carry their cardiac arrest bleep. Switchboard should be notified as soon as the situation returns to normal.

4.5 Cancelling 2222 calls

If the cardiac arrest team is no longer required, staff should dial 2222 and request the cardiac arrest call to (state location) be cancelled. This will then be sent via the speech channel to all emergency bleeps.

4.6 Test Bleeps

The Trust must ensure that the resuscitation team is activated within 30 seconds of the call for help. This system must be tested daily. Responses to test calls must be monitored and where there is a failure to respond this must be followed up and remedied immediately.

4.7 Cardiac Arrests occurring at Mexborough Montagu Hospital/ Retford Hospital OR outside Main Buildings across the Trust

If a cardiac arrest or other medical emergency occurs in any location at MMH/Retford Hospital or outside of the main hospital complex across the Trust, a (9) 999 call should be made to
request a paramedic ambulance. Any member of staff attending a casualty should provide first aid/ resuscitation according to their skills and ability in conjunction with any available equipment.

**4.8 Cardiac Arrest Trolleys**

Standardised sealed adult and paediatric cardiac arrest trolleys are in place at DRI, BDGH and MMH sites.

Following the use of a cardiac arrest trolley, replacement equipment should be sought immediately. At DRI, BDGH and MMH sites a trolley exchange system is in place via main theatres. All other Trust sites are responsible for the replenishment of used equipment to ensure the immediate availability of a cardiac arrest trolley at all times.

**4.9 Post Resuscitation Care**

After initial resuscitation, the patient may require further specific treatment. The resuscitation team leader and the patient’s own medical team should dictate subsequent management. This may involve transfer to another area e.g. DCC/CCU.

**4.10 Patient transfer**

Transfer should only take place after discussion with senior members of the admitting team. To ensure safe transfer it is essential to consider the following; stabilisation, continued monitoring, securing of all cannulae, drains, tubes and catheters, and good communication skills. The transfer team must be able to respond to other emergencies, including cardiac arrest or subsequent deterioration whilst moving the patient. A full re-assessment MUST take place prior to transfer. Portable suction, oxygen and other essential equipment must accompany the patient and transfer team.

**4.11 Maintenance of Resuscitation Equipment**

It is the responsibility of the ward/department manager to ensure that all resuscitation equipment and supplies are checked at least once every 24 hours, and following the use of equipment to replenish supplies.

The expiry dates on all accessible items should be checked, including drugs and disposable items. A list should be kept of equipment and a record signed stating ALL equipment is present and functioning correctly.
4.12 Defibrillators

Defibrillators are serviced regularly by Medical Technical Services (ext. 3558). If a defibrillator malfunctions, it should be reported immediately to Medical Technical Services, removed from service and temporarily replaced with the spare defibrillator located in the equipment library. If this defibrillator is unavailable, clinical areas should share defibrillators until the problem is resolved. Defibrillators must not be removed from the resuscitation training unit to replace malfunctioning machines. It is the responsibility of the nurse/person in charge to inform all relevant staff of the situation and ensure that they know the location of the defibrillator to be used in the event of cardiac arrest.

Defibrillators are only suitable for cardiac monitoring in the peri-arrest situation and should not be used for routine monitoring. If prolonged cardiac monitoring is necessary, the patient should be transferred to a suitable area, where they can be observed by appropriately trained staff.

4.13 Drugs

The contents of the cardiac arrest drug packs are in accordance with current Resuscitation Council (UK) guidelines for the treatment of cardio respiratory arrest.

4.14 Manual Handling

When resuscitating a patient who is on the floor, in a chair, or other confined space, the Trust guidelines for patient movement should be followed. The objective of this is to minimise the risks of manual handling and related injuries to all parties.

4.15 Cross Infection

Although 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 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 so that mouth-to-mouth ventilation is not necessary. In situations where airway protective devices are not immediately available, chest compressions should commence whilst awaiting an airway device.
4.16 Anaphylaxis

The management of suspected anaphylaxis should be conducted in accordance with Trust policy – Emergency Treatment of Anaphylaxis Policy and Guidelines (PAT/EC 3) and with the Resuscitation Council (UK) Guidelines.


4.17 Procurement

All resuscitation equipment purchasing is subject to the organisation’s standardisation strategy; therefore the Resuscitation Service must sanction all resuscitation equipment prior to ordering. During any future development of services/building redesign/relocation, early advice should be sought from Resuscitation Services regarding procurement of additional/new resuscitation equipment.

4.18 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

The Trust’s DNACPR Policy complies with the guidance issued by the BMA / RCN / Resuscitation Council (UK) (2007), the General Medical Council’s guidance on ‘Treatment and care towards the end of life: good practice in decision making’ (2010) and the Resuscitation Council (UK) Quality standards for cardiopulmonary resuscitation practice and training – acute care (2013).

http://www.resus.org.uk/pages/dnar.htm
http://resus.org.uk/pages/QSCPR_Acute.htm

5. TRAINING/ SUPPORT

The strategy for resuscitation training shall embody the statements and guidelines published by the Resuscitation Council (UK) and the European Resuscitation Council, incorporating the most recent updates to these guidelines.

This explicitly incorporates the identification of patients at risk from cardiac arrest and a strategic approach to implement preventative measures such as Early Warning Systems. The Trust will provide sufficient and appropriate resuscitation training for each of the main staff groups. Profession specific resuscitation training will be directed by their respective functional role and the guidelines and directives issued by their professional bodies (e.g. The Royal College of Anaesthetists). Levels of training appropriate to role are detailed in the Trust Mandatory & Statutory Policy CORP/EMP 29.
The approach to teaching is one of positive encouragement and proven educational efficacy which follows the recommendations for resuscitation teaching advocated by the Resuscitation Council (UK) (Mackay-Jones & Walker, 1998).

### 5.1 Training recommendations

All newly appointed trust employees must receive training as part of their induction programme. **ALL staff must know how to summon help using the emergency system (2222) and be made aware of the location of emergency equipment.**

### 5.2 Clinical Staff

All doctors, nurses, midwives and Allied Health Professionals must be adequately and regularly trained in cardiopulmonary resuscitation appropriate to their discipline. The level of that training is determined by their respective professional bodies and / or the duties that those staff would be expected to undertake when in attendance at a cardiac arrest / medical / obstetric / neonatal emergency. It is the responsibility of departmental managers to ensure that any of his/her clinical and clinical support staff attend training appropriate to their role.

Training and facilities must ensure that, when cardiorespiratory arrest occurs, as a minimum all clinical staff can:

- Recognise cardiorespiratory arrest
- Summon help
- Start CPR
- Attempt defibrillation, if appropriate, within 3 minutes of collapsing using an automated external defibrillator or manual defibrillator

Clinical staff should have at least annual updates.

### 5.3 Non-clinical Staff

As a minimum, non-clinical staff should be trained to:

- Recognise cardiorespiratory arrest
- Summon help
- Start CPR using chest compressions

### 5.4 Training Records

Resuscitation Services are responsible for updating individual staff records of attendance at resuscitation training (delivered by Resuscitation Officers) on the Oracle learning management (OLM) system. Training delivered by approved link trainers will be inputted locally. All certified
resuscitation training that has been successfully completed at an external course centre should also be recorded.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

<table>
<thead>
<tr>
<th>What is being Monitored</th>
<th>Who will carry out the Monitoring</th>
<th>How often</th>
<th>How Reviewed/Where Reported to</th>
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<tr>
<td>Cardiac arrest reviews of management &amp; escalation</td>
<td>Resuscitation Services will monitor reviews completed at ward level.</td>
<td>Weekly</td>
<td>Reported monthly to Trust Board. Reported quarterly to the Resuscitation Committee, Review of Mortality Group and Patient Safety Review Group</td>
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<tr>
<td>Equipment Audit</td>
<td>Resuscitation Services</td>
<td>Annually with reaudit for non compliance</td>
<td>Reported annually to the Resuscitation Committee, CD’s, GM’s, Matrons, ward managers and Patient Safety Review Group</td>
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</table>

7. DEFINITIONS

Advanced Life Support
Use of all basic life support techniques with added intervention of drugs, defibrillation and other mechanical devices acting on the patients cardiac rhythm and output.

Anaphylaxis
Anaphylaxis is a severe life-threatening, generalised or systemic hypersensitivity reaction. Investigations will show whether the reaction is allergic (immunoglobulin E (IgE) or non IgE mediated) or non-allergic anaphylaxis.

Basic Life Support
External chest compressions and ventilation with the use of airways, face masks, bag-valve-mask systems and oxygen in any combination.

Cardiac Arrest
Cardiac arrest may be defined as the abrupt cessation of cardiac function that is potentially reversible.

Defibrillation
Defibrillation is the passage of electrical current across the myocardium to depolarise a critical mass of the cardiac muscle simultaneously to enable the natural pacemaker to resume control.
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
A clinical decision not to commence cardiopulmonary resuscitation.

8. **EQUALITY IMPACT ASSESSMENT**

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

A copy of the EIA is available on request from the HR Department.

9. **ASSOCIATED TRUST PROCEDURAL DOCUMENTS**

Do Not Attempt Resuscitation (DNAR) Policy - PAT/EC 2

Manual handling Policy - CORP/HSFS 04

Mental Capacity Act 2005 Policy and Procedure - PAT/PA 19

Physiological Observations: policy for adult in-patients in acute hospitals - PAT/T 33

Policy and Guidelines for the Emergency Treatment of Anaphylaxis - PAT/EC 3

Privacy and Dignity Policy - PAT/PA 28

Standard Infection Control Precautions Policy - PAT/IC 19

Trust Mandatory & Statutory Policy - CORP/EMP 29

10. **REFERENCES**

General Medical Council (2010) Treatment and care towards the end of life: good practice in decision making’.


Mental Capacity Act 2005 Department of Health

Resuscitation Council (UK) (2001) Guidance for Safer Handling during Resuscitation in Hospital


APPENDIX 1

Resuscitation Committee

TERMS OF REFERENCE

1. INTRODUCTION

The Resuscitation Committee is a multi-disciplinary committee who report to the Clinical Governance Standards Committee via the Patient Safety Review Group.

2. PURPOSE AND OBJECTIVES

The purpose of this committee is:

1. To monitor and evaluate the clinical service provided to the Trust regarding all resuscitation related issues.
2. To report quarterly to the Patient Safety Review Group regarding cardiac arrest figures and outcomes including case note review classifications and annually to the Clinical Governance Standards Committee.
3. To support the Resuscitation Service.
4. To provide specialist knowledge/advice in all aspects of resuscitation to this Trust to facilitate the review, development and approval of all resuscitation related Approved Procedural Documents (APD).

3. COMMUNICATION

The Lead Resuscitation Officer will report activity to PSRG on a quarterly basis. All resuscitation related APD’s will be approved by the resuscitation committee and taken to Policy Approval & Compliance Group for final ratification.

4. MEMBERSHIP

The committee will be led by the Chairperson nominated via the committee for an initial term of 3 years subject to approval by the Trust Medical Director. In the absence of the Chairperson the Lead Resuscitation Officer will assume this responsibility. The committee will work as a team and individual actions will be identified after each meeting and recorded in the minutes.

The committee shall consist of the following members:-

- Nominated Chairperson
- Lead Resuscitation Officer
- Resuscitation Officers
Senior clinical representation from:
- A&E
- Anaesthetics
- Medicine
- Medicine for older people & specialist palliative care
- Paediatrics
- Theatres
- Midwifery
- Surgery
- Orthopaedics
- Pharmacy

5. MEETINGS AND ATTENDANCE

The meetings will be scheduled for two hours quarterly.

Attendance is required at all meetings. Members unable to attend should indicate in writing or by e-mail to the Resuscitation Services administrator in advance of the meeting (except in extenuating circumstances of absence). Members are advised to nominate a deputy to attend who is appropriately briefed to participate in the meeting.

Members (or a designated deputy) should attend at least 3 meetings throughout a calendar year.

6. QUORUM

The quorum is 2 Clinicians plus 4 other members (not including the Resuscitation Services team) to be present at the start of the meeting.

7. ADMINISTRATION

The committee administrator’s duties include:

- Drafting of the agenda, and circulating the associated documents at least 1 week before the meeting.
- Produce minutes with actions from each meeting.

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<th>Lisette Caygill - Lead Resuscitation Officer</th>
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</tr>
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<td>Date approved:</td>
<td>16th October 2013</td>
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<td>For review:</td>
<td>October 2016</td>
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In circumstances where the patient’s condition deteriorates rapidly, a cardiac arrest call should also be made.
# APPENDIX 3

## Paediatric Advanced Warning Score (PAWS) Observation Chart

**Term to 11 months**

**PAWS exceptions**

The values in the coloured boxes represent PAWS values for each of the variables. The white blank boxes alongside are for a doctor to enter exception values for the child.

### Date

<table>
<thead>
<tr>
<th>Score</th>
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<tbody>
<tr>
<td>10</td>
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<tr>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
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<td>4</td>
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<td>2</td>
<td>4</td>
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<tr>
<td>1</td>
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### Heart Rate and Blood Pressure

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<tr>
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<th>71 mmHg to 80 mmHg</th>
<th>81 mmHg to 90 mmHg</th>
<th>91 mmHg to 100 mmHg</th>
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</thead>
<tbody>
<tr>
<td>Systolic blood pressure above 115 = 3 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Systolic blood pressure 65 or below = 10 points</td>
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</table>

### Mentation

<table>
<thead>
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<th>Score</th>
<th>V</th>
<th>P</th>
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<tbody>
<tr>
<td>SPP</td>
<td>A</td>
<td>A</td>
<td>A</td>
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### Oxygen saturation score

<table>
<thead>
<tr>
<th>Score</th>
<th>SpO₂ In air</th>
<th>SpO₂ In O₂</th>
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<tr>
<td>0</td>
<td>95 - 100%</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>90 - 94%</td>
<td>95 - 100%</td>
</tr>
<tr>
<td>2</td>
<td>88 - 90%</td>
<td>90 - 94%</td>
</tr>
<tr>
<td>3</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
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## PAWS exceptions

- Temperature exceptions:
  - 39°C and over
  - 36 to 38.9°C
  - 35 to 38.9°C
  - Less than 35°C

- Conscious level exceptions:
  - E4: normal for child
  - D4: normal for child

- Saturations exceptions:
  - SpO₂ In air
  - SpO₂ In O₂

- Colour:
  - Recession
  - Probe site changed
  - Section
  - Glucose (mmol)
  - Pain score / action
  - Initial

Refer to local key for documenting colour, recession, suction and pain.
### Paediatric Advanced Warning Score (PAWS) Observation Chart 12 to 23 months

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**Date**

<table>
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<tr>
<th>Date</th>
<th>Time</th>
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**Doctor**

- Name
- Position

**PAWS exceptions**

- 1 to 10
- 11 to 15
- 16 to 20
- 21 to 25
- 26 to 30
- 31 to 35
- 36 to 40
- 41 to 45
- 46 to 50
- 51 to 55
- 56 to 60
- 61 to 65
- 66 to 70
- 71 to 75
- 76 to 80
- 81 to 85
- 86 to 90
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- 671 to 675
- 676 to 680
- 681 to 685
- 686 to 690
- 691 to 695
- 696 to 700
- 701 to 705
- 706 to 710
- 711 to 715
- 716 to 720
- 721 to 725
- 726 to 730
- 731 to 735
- 736 to 740
- 741 to 745
- 746 to 750
- 751 to 755
- 756 to 760
- 761 to 765
- 766 to 770
- 771 to 775
- 776 to 780
- 781 to 785
- 786 to 790
- 791 to 795
- 796 to 800
- 801 to 805
- 806 to 810
- 811 to 815
- 816 to 820
- 821 to 825
- 826 to 830
- 831 to 835
- 836 to 840
- 841 to 845
- 846 to 850
- 851 to 855
- 856 to 860
- 861 to 865
- 866 to 870
- 871 to 875
- 876 to 880
- 881 to 885
- 886 to 890
- 891 to 895
- 896 to 900
- 901 to 905
- 906 to 910
- 911 to 915
- 916 to 920
- 921 to 925
- 926 to 930
- 931 to 935
- 936 to 940
- 941 to 945
- 946 to 950
- 951 to 955
- 956 to 960
- 961 to 965
- 966 to 970
- 971 to 975
- 976 to 980
- 981 to 985
- 986 to 990
- 991 to 995
- 996 to 1000

**Systolic blood pressure above 120**

- Score: 121
- Exception: Systolic Blood Pressure

**Systolic blood pressure 90-120 below**

- Score: 70
- Exception: Systolic Blood Pressure

**Mean Rate and Blood Pressure**

- Score:
  - 0 to 10
  - 11 to 20
  - 21 to 30
  - 31 to 40
  - 41 to 50
  - 51 to 60
  - 61 to 70
  - 71 to 80
  - 81 to 90
  - 91 to 100
  - 101 to 110
  - 111 to 120
  - 121 to 130
  - 131 to 140
  - 141 to 150
  - 151 to 160
  - 161 to 170
  - 171 to 180
  - 181 to 190
  - 191 to 200

**HRBP Score**

- Score: 0

**CPO2 (sat) seconds**

- Score: 0

**Temperature °C**

- Score: 0

**Conscious level exceptions (circle normal for child)**

- Score: A

**SpO2 score**

- Score: 0

**Oxygen saturation score**

- Score: 0

**SpO2 in air**

- Score: 0

**SpO2 in O2**

- Score: 0

**Pain score**

- Score: 0

**Action**

- Score: 0

---

**Refer to local key for documenting colour, recession, suction and pain**

---

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### PAT/EC 1 v.8

#### Doncaster and Bassetlaw Hospitals

<table>
<thead>
<tr>
<th>PAWS Item Score</th>
<th>0</th>
<th>1</th>
<th>3</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Observation Chart

**2 to 3 Years**

<table>
<thead>
<tr>
<th>PAWS exceptions</th>
</tr>
</thead>
</table>
| Date | Time | Doctor | Sign | Print name | 51 and over | 39 to 50 | 33 to 38 | 33 to 32 | 19 to 22 | 0 to 14 | 16/1 and over | 14 to 160 | 12 to 140 | 91 to 125 | 81 to 100 | 66 to 80 | 50 to 65 | Systolic Blood Pressure
| Exception       |      |       |      |            |             |          |          |          |          |         |         |             |            |            |          |          |          |          |          |

**Systolic Blood Pressure above 125 - 3 points**

**Systolic Blood Pressure 80 or below - 10 points**

#### CPO (PaO) Score

| Score | 6 | 5 | 4 | 3 | 1 | 0 |

#### Temperature °C

<table>
<thead>
<tr>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
</tr>
</tbody>
</table>

#### APG Score

| Score | 6 | 5 | 4 | 3 | 1 | 0 |

#### Oxygen saturation score

<table>
<thead>
<tr>
<th>Score</th>
<th>SpO2 in air</th>
<th>SpO2 in O2</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0 - 54%</td>
<td>0 - 54%</td>
</tr>
<tr>
<td>3</td>
<td>55 - 91%</td>
<td>55 - 91%</td>
</tr>
<tr>
<td>10</td>
<td>&lt;80%</td>
<td>&lt;80%</td>
</tr>
</tbody>
</table>

#### Saturation exceptions

<table>
<thead>
<tr>
<th>SpO2 in air</th>
<th>SpO2 in O2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Refer to local key for documenting colour, recession, suction and pain.
### PAT/EC 1

#### Patient Name

**Date of Birth**

**NHS/District Number**

**Ward**

**Consultant**

---

#### PAWS exceptions

**Date**

**Time**

**Sign**

**Print name**

<table>
<thead>
<tr>
<th>41 and over</th>
<th>25 to 40</th>
<th>27 to 28</th>
<th>19 to 26</th>
<th>15 to 18</th>
<th>13 to 14</th>
<th>10 to 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>151 and over</td>
<td>131 to 150</td>
<td>111 to 120</td>
<td>81 to 119</td>
<td>71 to 80</td>
<td>51 to 70</td>
<td>0 to 50</td>
</tr>
</tbody>
</table>

---

#### Systolic blood pressure above 130 - 3 points

#### Systolic blood pressure 85 or below - 10 points

---

#### HRBP score

#### CBT (sed)

<table>
<thead>
<tr>
<th>5+</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
</table>

#### Temperature °C

| 41 | 40 | 39 | 38 | 37 | 36 | 35 | 34 | 33 |

#### Score

#### AVPU

| 4 | 3 | 2 | 1 | 0 |

#### Oxygen saturation score

## saturation

#### SpO₂ level

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |

## SpO₂ in air

### Refer to local key for documenting colour, recession, suction and pain

---

Page 20 of 24
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>NHS/District Number</th>
<th>Ward</th>
<th>Consultant</th>
<th>Observation Frequency</th>
<th>Follow graded response strategy over page</th>
</tr>
</thead>
</table>

### PAWS exceptions

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Doctor</th>
<th>Sign</th>
<th>Patient name</th>
<th>27 to 30</th>
<th>23 to 26</th>
<th>19 to 22</th>
<th>13 to 14</th>
<th>11 to 12</th>
</tr>
</thead>
</table>

### Respiratory Rate

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

### Heart Rate and Blood Pressure

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

### Systolic Blood Pressure

- Systolic blood pressure above 140 - 3 points
- Systolic blood pressure 90 or below - 10 points

### MAP Score

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

### CTI (sec)

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

### Temperature

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

### AVPU

- U
- V
- A

### Oxygen saturation score

- Score SpO₂ in air
- Score SpO₂ in O₂

### Pain Score / Action

- Refer to local key for documenting colour, recession, suction and pain
Your clinical judgement is paramount regardless of PAW score (even 2 or below)
If you are concerned seek senior support and medical review

Graded Response Strategy: The Four Responses

<table>
<thead>
<tr>
<th>Score</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>Continue with current care (PAW score 4 hourly minimum – unless otherwise agreed by Registrar/Consultant and document in the IFOC).</td>
</tr>
<tr>
<td>3-5</td>
<td>• Notify the nurse in charge.</td>
</tr>
<tr>
<td></td>
<td>• Seek a review by the doctor.</td>
</tr>
<tr>
<td></td>
<td>• Increase the frequency of the observations until the doctor has reviewed the child.</td>
</tr>
<tr>
<td></td>
<td>• Medical review to include how often observations to be carried out.</td>
</tr>
<tr>
<td></td>
<td>• Inform Registrar/Consultant if PAW score deteriorates before next planned medical review.</td>
</tr>
<tr>
<td>6-9</td>
<td>• Notify the nurse in charge.</td>
</tr>
<tr>
<td></td>
<td>• Seek an urgent medical review (within 15-20 minutes of your call).</td>
</tr>
<tr>
<td></td>
<td>• Perform full observations minimum hourly (respiration, oxygen saturation level, heart rate, blood pressure, capillary refill time, temperature and AVPU).</td>
</tr>
<tr>
<td></td>
<td>• Start continuous monitoring (ECG, oxygen saturation). Blood pressure recording as instructed by Registrar/Consultant.</td>
</tr>
<tr>
<td></td>
<td>• Inform Registrar/Consultant if PAW score deteriorates before next planned medical review.</td>
</tr>
<tr>
<td>10+</td>
<td>For any Paediatric Emergency – Call 2222</td>
</tr>
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<td>OTHERWISE:</td>
</tr>
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<td></td>
<td>• Summon help.</td>
</tr>
<tr>
<td></td>
<td>• Review ABC and treat accordingly.</td>
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<td></td>
<td>• Request Urgent Paediatric / Other Specialty/ Registrar / Consultant medical review via the Trust 2222 system stating, “Urgent paediatric medical review needed.”</td>
</tr>
<tr>
<td></td>
<td>• Medical review to include how often observations to be carried out.</td>
</tr>
<tr>
<td></td>
<td>• Inform Registrar/Consultant if PAW score deteriorates before next planned medical review.</td>
</tr>
</tbody>
</table>

For exclusion from Graded Response Strategy see Physiological Observations Policy for Paediatric Patients (Ref. Children’s/General/No.1/Version 1)

Situation:
I am (name), a nurse on ward (X)
I am calling because I am concerned that…
(e.g. BP is low/high, pulse is XXX, temperature is XX, PAW score is XX)

Background:
Child (X) was admitted on (XX date) with (e.g. respiratory infection)
They have had (X operation/procedure/investigation)
Child (X)’s condition has changed in the last (XX mins)
Their last set of obs were (XXX)
The child’s normal condition is …
(e.g. alter/drowsy/confused, pain free)

Assessment:
I think the problem is (XXX)
And I have…
(e.g. given 02/analgesia, stopped the infusion)
OR
I am not sure what the problem is but child (X) is deteriorating
OR
I don’t know what’s wrong but I am really worried

Recommendation:
I need you to…
Come to see the child in the next (XX mins) AND
Is there anything I need to do in the meantime?
(e.g. stop the fluid/repeat the obs)

Record Call When PAWS 3 or More

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>PAWS</th>
<th>Print Name (nurse)</th>
<th>Time of call to doctor</th>
<th>Summary of conversation and name of doctor spoken to</th>
</tr>
</thead>
<tbody>
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APPENDIX 4 – EMERGENCY TEAMS

Adult Resuscitation Team members

DRI and BDGH

Anaesthetist (Core Trainee) (if available)
Medical Registrar & SHO on-call
Operating Department Practitioner (ODP)
Clinical Site Manager
Resuscitation Officer (when available)
Ward Staff

MMH & RETFORD HOSPITAL

No cardiac arrest team call 999

Paediatric Resuscitation Team Members

DRI

Anaesthetist Registrar (if available)
Paediatric Registrar & SHO on-call
Paediatric bleep holder
Operating Department Practitioner (ODP)
Clinical Site Manager
Resuscitation Officer (when available)
Ward Staff

BDGH

Anaesthetist 1st on call (if available)
Paediatric Registrar & SHO on call
Operating Department Practitioner (ODP)
Paediatric bleep holder
Clinical Site Manager
Resuscitation Officer (when available)
Ward Staff
Obstetric Emergency Team

DRI
Obstetric Registrar & SHO on call
Anaesthetist (based in Women’s & Children’s Hospital)
Operating Department Practitioner (ODP)
Senior Duty Midwife

BDGH
Bleep holders are contacted individually via switchboard.