



CLINICAL POLICY Care of the Deteriorating Patient Policy

(This policy replaces the former Deteriorating Patient (Physical Health Policy) and Medical Emergency Guidelines CLP260)

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<u>clinical.policies@ghc.nhs.uk</u> prior to making any amendments. Documents are password protected to prevent any unauthorised changes.

Policy Number	CLP105
Version:	V3.9
Purpose:	To provide guidance and necessary resource for patient facing staff working within the Trust
Consultation:	End of Life special interest group, Heads of Professions Heads of Services, Improving Care Group, Physical Health Expert Reference Group, Quality and Safety Team, Quality Assurance Group, Resuscitation Committee
Approved by:	Clinical Policy Group
Date approved:	05/07/2022
Author / Reviewer:	Angela Willan, Lead Nurse for Physical Health (MH&LD) Raili Worthington, Resuscitation Training Team Lead
Date issued:	26/07/2022
Review date:	01/07/2025
Audience:	All clinical staff who are patient facing, working in community and inpatient settings
Dissemination:	The policy will be made available on the organisation's Intranet, and it will also be highlighted in team meetings. Access to training in Care of the Deteriorating Patient will be via Care to Learn system
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust

Version History

Version	Date Issued	Reason for Change
V1	May 2016	Removal of draft Unwell Patient Form – replaced with Patient
	-	Treatment Options Form, move away from Modified Early

		Warning Score (MEWS) within inpatient areas and adopt
		NEWS across all services, incorporate children's services and
		PEWS into policy, change name to from 'adult' to 'patient'
V2	Dec 18	Action Cards added
V2.1	16/11/19	Transferred to new Trust Template and updated Trust Name and details following merger of trusts
V3	26/07/2022	Policy reviewed and updated. Name of policy changed to Care of the Deteriorating Patient - Amalgamation of the Deteriorating Patient (Physical Health Policy CLP105) and Medical Emergency Guidelines (MH/LD Policy CLP260)
V3.1	10/02/2023	Amendment to Community Eating Disorders Team Action Card
V3.2	11/10/2023	Amendment to Hope House Action Card and NEWS Chart
V3.3	02/11/2023	Amendment to appendix 9 pages for ages MIIU
V3.4	17/11/2023	Amendment to Hope House Action Card
V3.5	22/02/2024	Addition of Restore 2 Mini attachments which have been linked in section 7
V3.6	26/06/2024	New Escalation Procedure Action Card for the Physical Health Community Hospital On-Site Escalation Procedure to replace all other PH action cards
V3.7	28/06/2024	Amendment to Escalation Action Cards 2 and 4 and amended and new SEPSIS screening tools added in appendix 10
V3.8	03/09/2024	Updated PEWS Charts in appendices and new Action Card 13
V3.9	21/11/2024	Action Card 4 amended to include IUC

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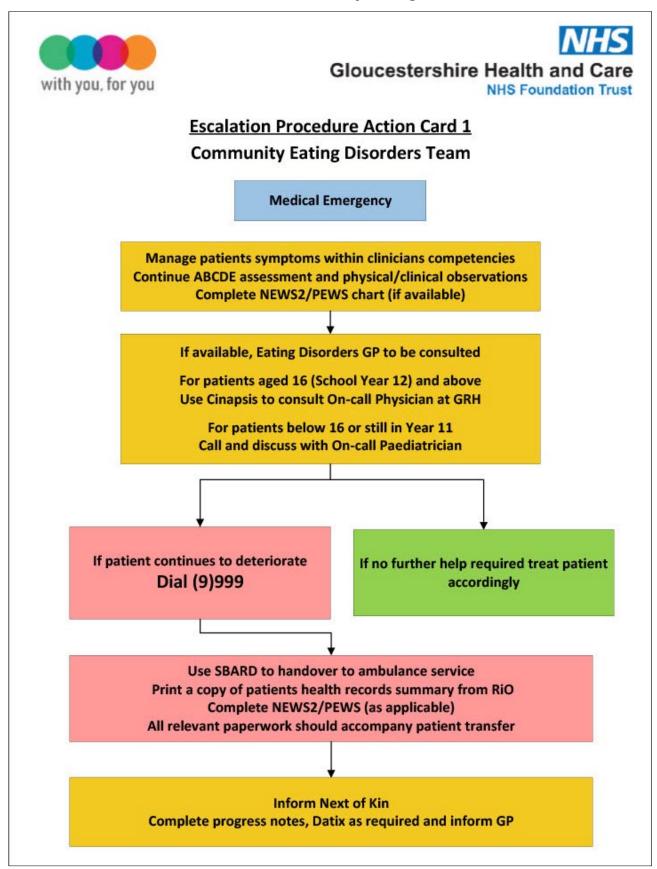
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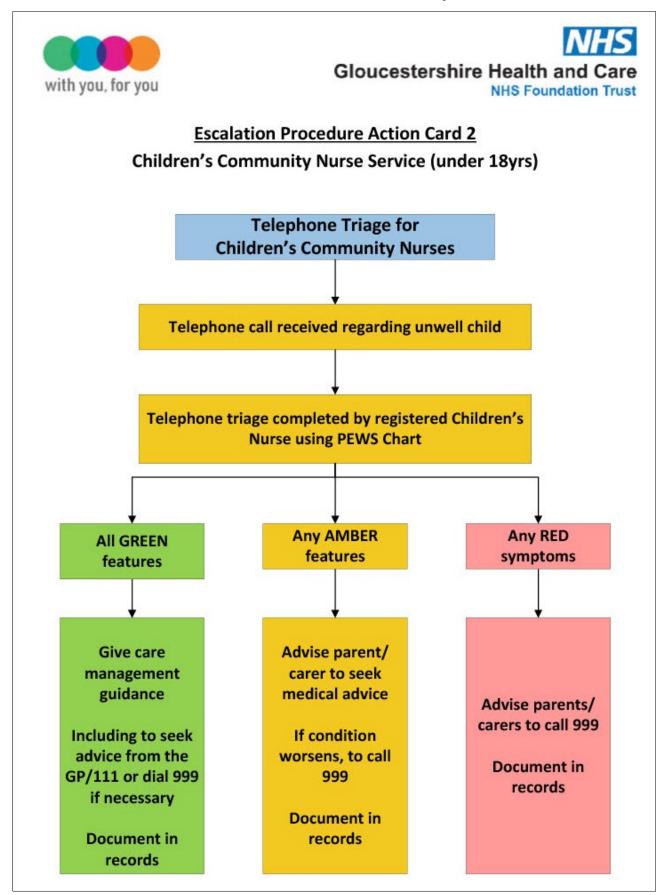
ABBREVIATIONS

Abbreviation	Full Description
GHC	Gloucestershire Health and Care NHS Foundation Trust
NEWS2	National Early Warning Score version 2
PEWS	Paediatric Early Warning Score
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RESTORE	Recognise Early Soft signs, Take Observations, Respond and Escalate
SBARD	Situation, Background, Assessment, Recommendation, Decision

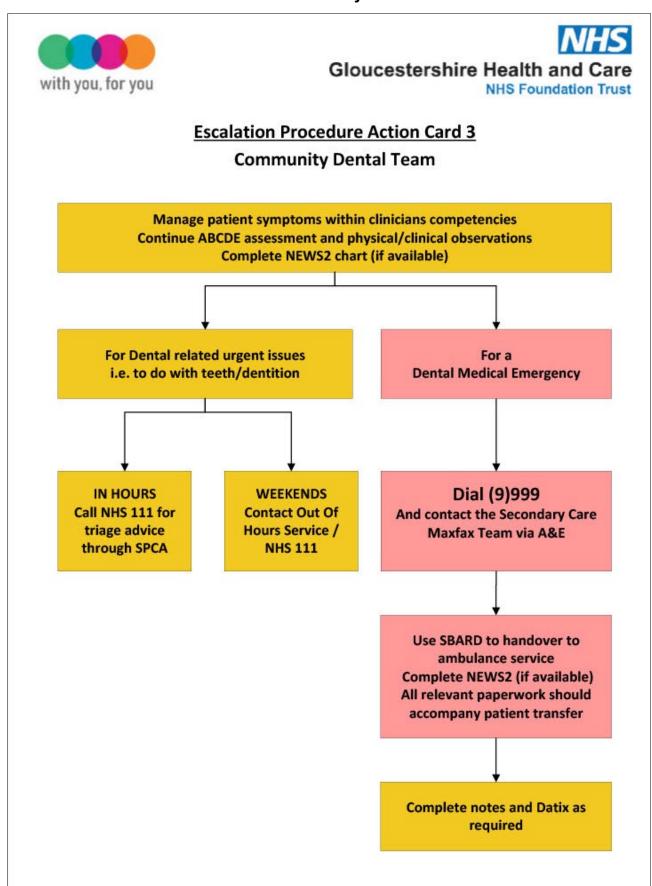
Escalation Procedure Action Card 1 - Community Eating Disorders Team



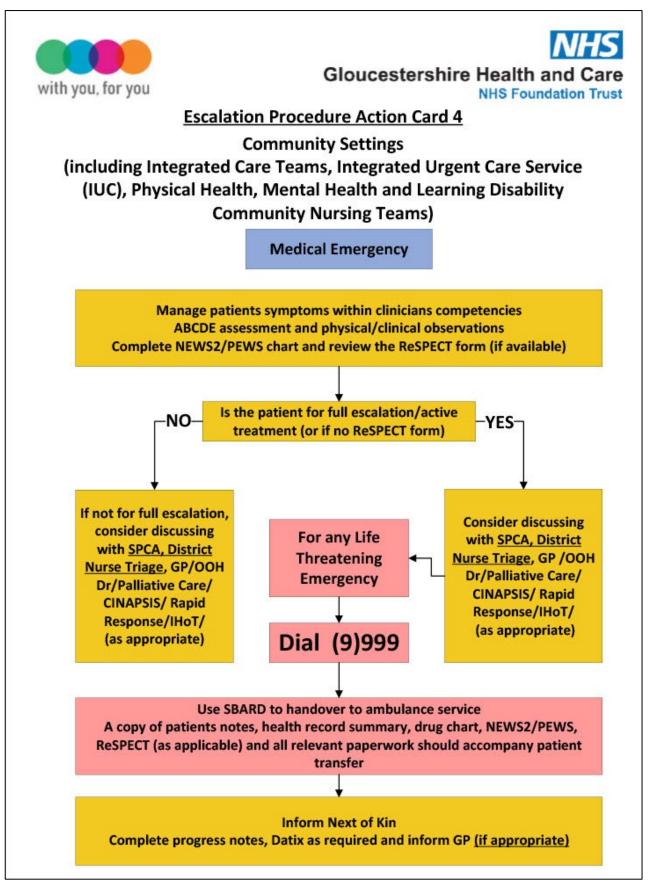
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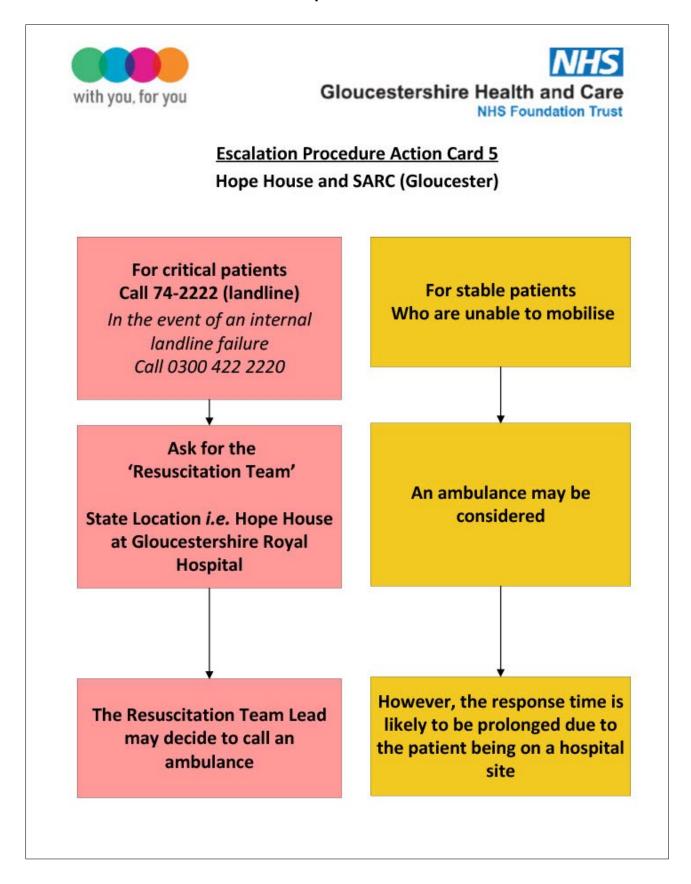
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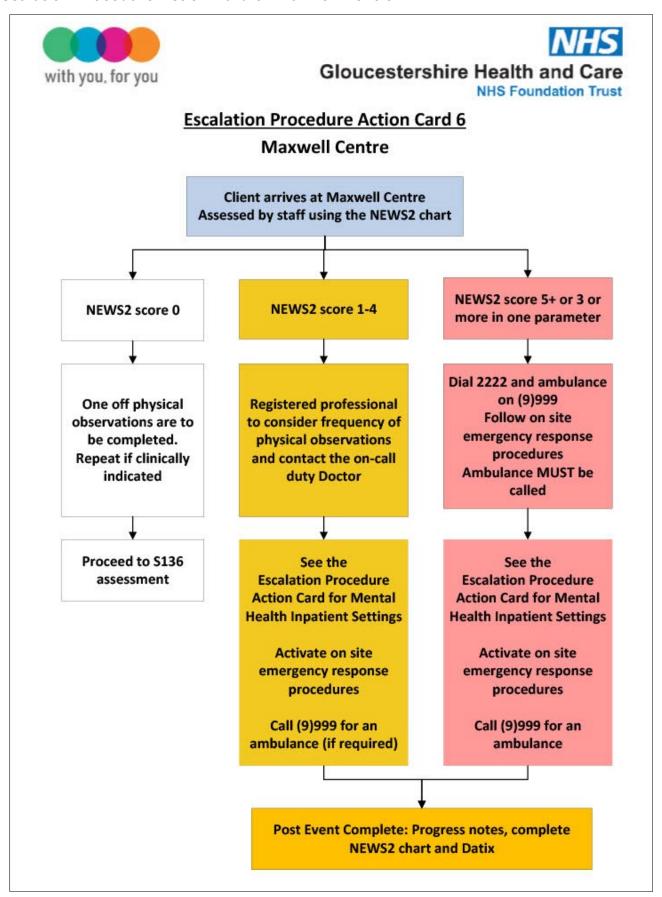
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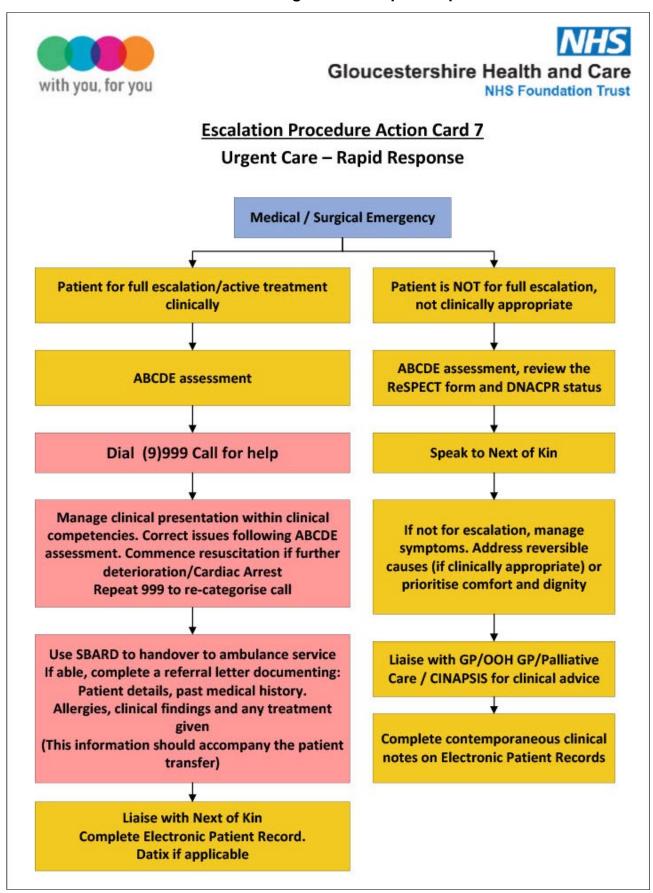
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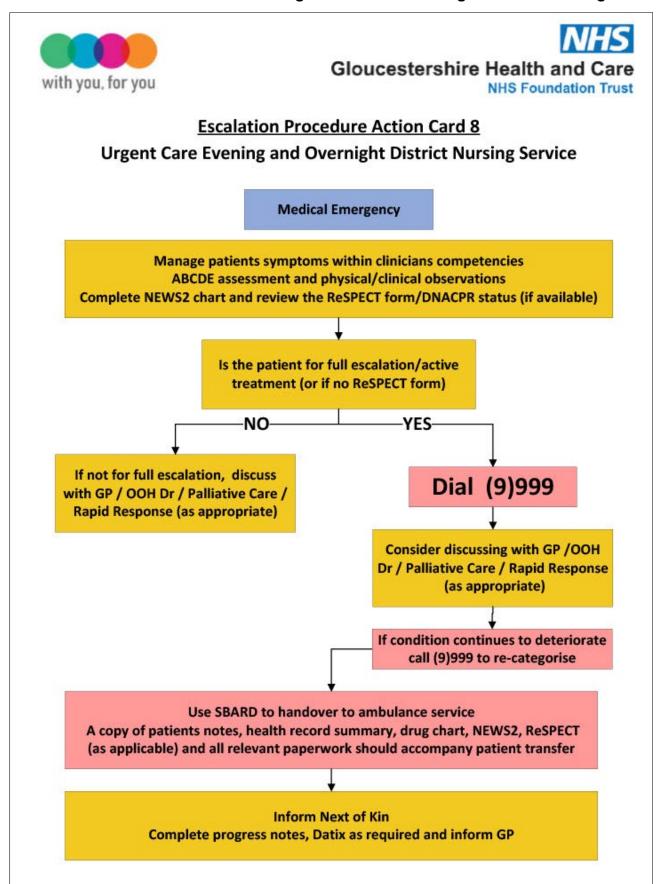
Escalation Procedure Action Card 6 - Maxwell Centre



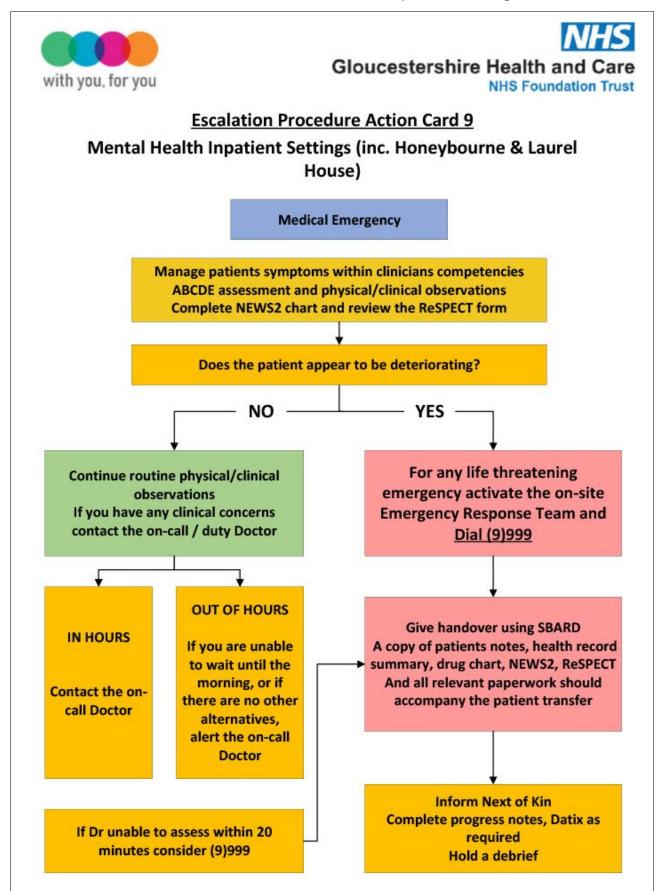
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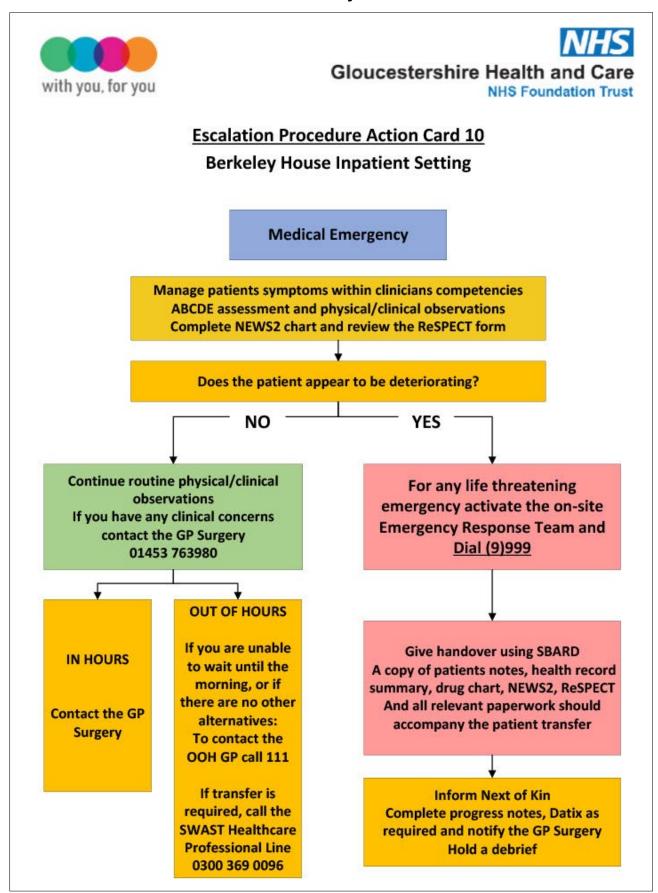
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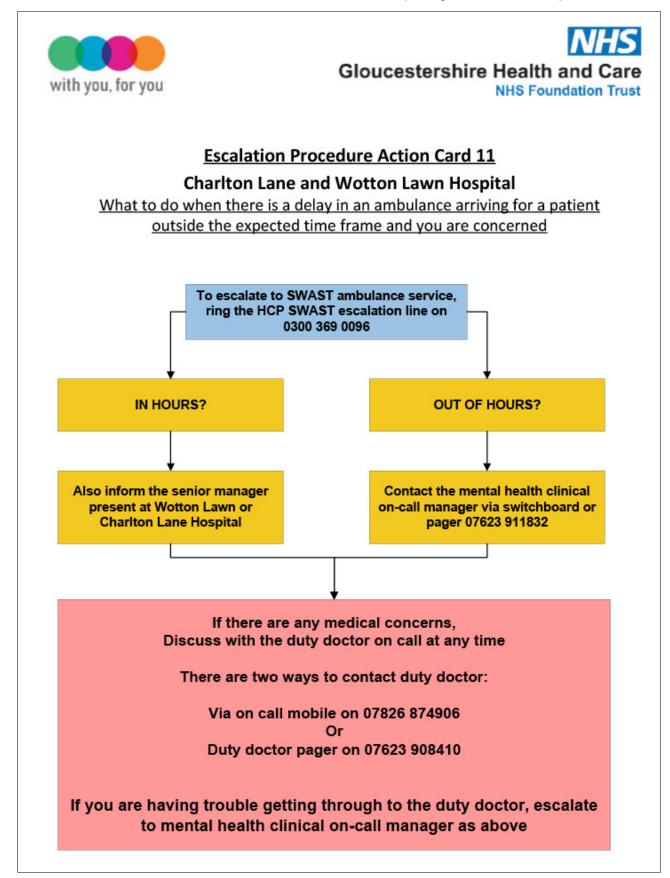
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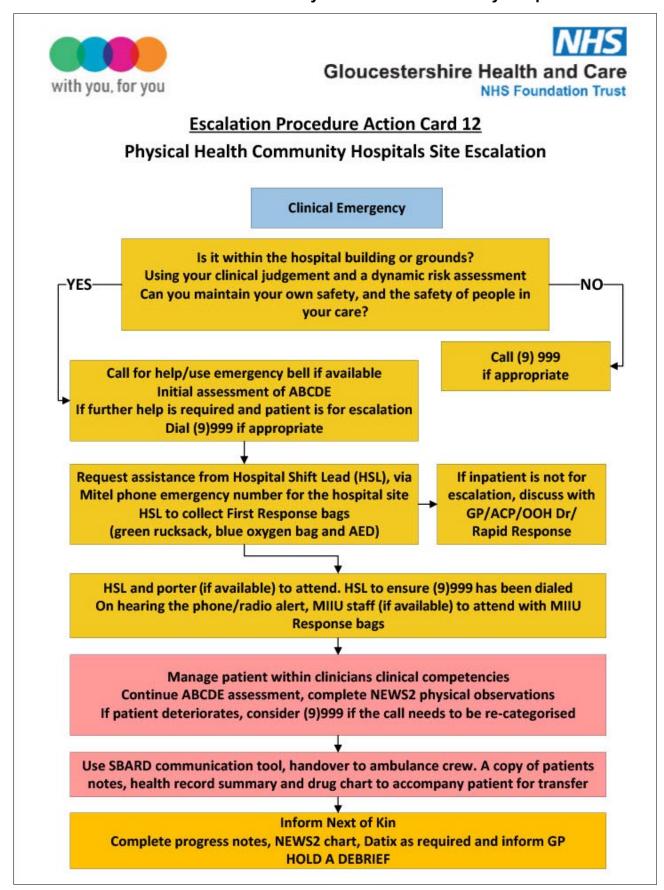
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Escalation Procedure Action Card 11 – CLH and WLH (Delay in Ambulance)



Escalation Procedure Action Card 12 - Physical Health Community Hospital Sites



Escalation Procedure Action Card 13 - PEWS GHC MIIU Escalation Level Action Card

ESCALATION LEVEL		LOW (L)	MEDIUM (M) HIGH (H)		EMERGENCY (E)
TRIGGER CRITERIA: Respond as per	Specific concern		New Suspicion of sepsis	AVPU: Change to AVPU Responsive only to "V" Voice Or New suspicion of septic shock	AVPU: Change to AVPU 'P' Responsive only to 'Pair or 'Unresponsive' OR abnormal pupillary respons
the highest level based on CHANGE in ANY ONE of these criteria	Clinical Intuition	Nurse/clinician concern that patient needs a 'increased' monitoring despite low PEWS	Nurse/clinician concern that patient needs a 'Review' irrespective of PEWS	Nurse/clinician concern that patient needs a 'Rapid Review' irrespective of PEWS	Nurse/clinician concern tha patient needs emergency review for life-threatening situation
	Carer Question	Carer uses words that suggest the child needs 'increased' monitoring or intervention despite low PEWS	Carer concern that patient needs a 'Review' irrespective of PEWS	Carer uses words that suggests the child needs a 'Rapid Review' irrespective of PEWS	Carer uses the words that suggest the child has collapsed or significantly deteriorated
	PEWS	1.4	5-8	9-12	>13
				output and check blood glu	
Communication and Response Situation Background Assessment Recommendation		Paeds advice/referral if required via Cinapsis Feed back plan to carers	Consider clinical presentation & need for discussion with Paeds or referral via Cinapsis Consider 999 transfer Feed back plan to carers	Paed discussion is required +/- Referral/999 transfer Feedback plan to carers	999 transfer Feed back plan to carers
Decision		127	12	2.7	•
Review Timings / Observations		Nurse/clinician must reassess within 60 minutes (and document ongoing plan)	Within 30 minutes	Within 15 minutes	Continuous monitoring

1. INTRODUCTION

- 1.1 This policy states the position of Gloucestershire Health and Care NHS Foundation Trust (GHC) standards on the prevention and management of the deteriorating patient, and aims to reduce patient harm which can occur from the risk of deterioration.
- 1.2 The policy will highlight the importance of recognising the deteriorating patient and contains the associated documentation required to assess those at risk of further deterioration. The policy will aid clinicians to recognise and respond to physical / clinical deterioration in a timely manner.

2. PURPOSE

The Trust is committed to ensuring the best possible physical health for all of its service users and patients. This policy provides documented and approved processes for assessing and managing clinical conditions and the risks associated with deteriorating patients.

3. SCOPE

This policy applies to practitioners and support staff employed by Gloucestershire Health and Care NHS Foundation Trust (GHC), who are patient facing and undertake physical / clinical observations as part of their clinical role.

4. DUTIES

4.1 General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its service users and patients, and to support them in making decisions about their care and treatment.

Responsibility for the development, maintenance, review and ratification of this policy lies with the Trust board. This level of responsibility has been delegated to the Director of Nursing, Therapies and Quality.

In addition, the Trust will ensure that:

- All employees have access to up-to-date evidence-based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements (dependent on the level of training attended and equipment available for role).

4.2 Managers and Heads of Service will ensure that:

- All staff are aware of and have access to policy documents.
- All staff access training in accordance with the Trust Training Matrix
- All colleagues participate in the appraisal process, including the review of competencies.

4.3 Employees (including bank, agency and locum staff) must ensure that they:

• Practice within their level of competency and within the scope of their professional

- bodies where appropriate.
- · Read and adhere to Trust policy
- Identify any areas for skill update or training required and attend training in line with the Trust's Training Matrix, ensuring training remains current.
- Participate in the appraisal process.
- Ensure that all care and consent comply with the Mental Capacity Act (2005) see section on MCA Compliance below.

4.4 Roles, Responsibilities and Accountability Specific to this Policy:

- The Director of Nursing, Therapies and Quality Accountable for ensuring the Care of the Deteriorating Patient Policy is agreed, implemented, and regularly reviewed within the clinical governance framework.
- Associate Director of Quality Assurance and Clinical Compliance Responsible for ensuring that agreed actions are implemented.
- **Resuscitation Committee** To provide assurance and oversight regarding Care of the Deteriorating Patient activity across GHC, this will include and not be limited to; policy guidelines and activity regarding processes and procedures (such as equipment, training etc.) The Group will monitor incidents and set standards.

5. MENTAL CAPACITY ACT COMPLIANCE

- Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -
 - Establish if the person able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
 - Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment.
 - Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).
 - Establish if there is an attorney under a relevant and registered Lasting Power of Attorney or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
 - If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the persons best interests by other people. To be legally binding the person must have been over 18 when it was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.

• Where the decision relates to a child or young person under the age of 16, the MCA does not apply. In these cases, the competence of the child or young person must be considered under Gillick competence. If the child or young person is deemed not to have the competence to make the decision then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining or which will prevent significant long-term damage to a child or young person under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

6. POLICY DETAIL

6.1 General Position Statement

This policy provides documented and approved processes for triaging and managing the clinical condition and risks associated with the potentially deteriorating patient; it applies to practitioners and clinical support staff employed by GHC who undertake physical/clinical observations as part of their clinical role.

- **6.1.1** Early detection, timeliness and competency of the clinical response comprise a triad of determinants of clinical outcome in people with acute illness.
- **6.1.2** Physical / clinical observations should be undertaken by competent staff; however, qualified staff must be aware of their accountability if and when delegating this task.
- **6.1.3** No distinction is made between medical, nursing and allied healthcare professionals.
- **6.1.4** This policy is designed to provide a ratified process to support the physical assessment and clinical management of deteriorating patients, to ensure early treatment and escalation where indicated, providing guidance for taking physical/clinical observations, recording finding and ongoing care / referral of patients within clinical areas.
- **6.1.5** At all times the registered practitioner can use their own clinical judgement of the patient's condition and can escalate their concerns in accordance with locally agreed escalation protocols, this must be documented in the patient's electronic records, with a rational for the decision-making process.
- When tools and paper charts are used to support this decision-making process, all findings should be recorded/documented on the charts, and then uploaded in the patient's electronic records.
- **6.3** Every effort should be made to provide appropriate supportive care and treatment to the patient to minimise or prevent further deterioration.

7. DEFINITIONS

Deteriorating Patient - Defined as patients in and out of hospital (NICE, 2016, and NHSE 2017).

National Early Warning Score2 (NEWS2) - The Royal College of Physicians developed a National Early Warning Score to facilitate a standardised and unified national approach to alerting clinical staff to the deteriorating patient and to the appropriate clinical response.

Paediatric Early Warning Score (PEWS) - Vital signs and observations are essential to assess the child's clinical status; using Paediatric Early Warning Score (PEWS) system enables the early recognition of sick patients and management of any deterioration.

Neurological Observations – are investigations and examinations that relate to the assessment of the nervous system, commonly focussing on 6 key areas: level of consciousness, pupillary activity, motor function, sensory function, FAST (stroke recognition and vital signs.

ReSPECT – Recommended Summary Plan for Emergency Care and Treatment is a personalised recommendation for a person's care in a future emergency, in which they do not have capacity to make or express choices, such events could include death or cardiac arrest but are not limited to those events.

RESTORE 2 (Mini) - uses a 'soft signs' approach as a pre-diagnostic indicator of concern to facilitate earlier treatment and avoid unnecessary transfers to hospital. Please see Restore Mini2 attachment 1 and attachment 2.

SBARD (Situation, Background, Assessment, Recommendation, Decision) - is a recognised handover tool that can be used to frame conversations, especially critical ones requiring a practitioner's immediate attention and action. The tool consists of standardised prompt questions, to ensure that staff colleagues are sharing concise and focused information. It allows colleagues to communicate assertively and effectively, reducing the need for repetition.

SEPSIS – is a life-threatening reaction to an infection. It happens when the body's immune system overreacts to an infection and starts to damage the body's own tissues and organs.

8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in	VEC
line with national, regional, trust or local requirements?	150

Monitoring Requirements and Methodology	Frequency	Further Actions
Monitoring of this policy will vary according to the specific pathway or team being reviewed and may form part of supervision of staff by managers in applicable situations	On-going	Any matters of non- compliance will be escalated in line with Governance and Policy.

9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

9.1 To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the <u>Duty of Candour Policy</u> and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

10. TRAINING

- **10.1** All clinical staff have a duty to update their knowledge to ensure their practice adheres to the standards set by both their regulatory bodies and the detail of this policy.
- **10.2** Regular monitoring and early, effective treatment of sick/deteriorating patients improves the clinical outcome and prevention of cardiopulmonary events. Learning opportunities are available, further courses and training can be accessed through the Care to Learn.

11. REFERENCES

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12. ASSOCIATED DOCUMENTS

- CLP110 Resuscitation Policy
- CLP113 Verification of Death for Adults and Children Clinical Policy
- CLP245 Physical Examinations for MH and LD Inpatient and Community Services
- CLP005 Health Records and Clinical Record Keeping Policy
- CLG090 Administration of Subcutaneous Fluids in End-of-Life Care for Adults Clinical Guideline
- CLP053 Patient Group Direction Policy
- CLP062 Venepuncture (including blood cultures) Policy
- CLP077 A to Z of Equipment Decontamination (Infection Control) Policy

- CLP213 Consent to Examination or Treatment Policy
- CLPr107 Physical Health Procedures for Gloucestershire Health Based Place of Safety Maxwell Centre
- Prescribing, Administration and Monitoring of Oxygen Therapy Guideline (CLG099)

Appendix 1 – Sample copy of the GHC047 NEWS2 Chart

Time and date	Total	Please document action and further comments below	Staff name	A1E1446		Gloucest	ershire i	Health and	-/S Care	Name:			
	NEWS2	(Give reason for any 'refusals')		NEWS2	2 Char	t		NHS Foundation	Trust	Date of	f Birth:	DD/MM/Y	
				Date of admission DD				al to s Less than or	equal to	MRN /	RiO Numb	er:	
				Targeted SpO, (pleas Sign below if using S	SpO ₂ Scale 2 (eg confi	irmed hypercapnic r	SpO, Scale 2:81 espiratory fa	ilure)		NHS No	ımber:		
				Name		Signature		Date		(OR AFFIX	HO SPITAL LAB	EL HERE)	
				NEWS2 KEY									
				0 1 2 3	Time	nitoring physical ob	resustions :	advers the same	anviota d	ada valauant	at time about	wations were a	n and ad
				*Rapid Tranquilisation	on (RT) Record physic	cal observations eve	ery 15 mins fo	or first 4 hrs post	RT - note	medication,	dose & time	in Variants sec	tion on reverse
				Hourly = H 4x Daily	= QDS 2x Dsi		ly = OD	Weekly = W		*Rapid Traq =	RT	Other = O (spe	cify in Variants s
				A+B RECORD	21-24				3				
				A+B RECORD AS	18-20 15-17								
				Ureat to min	12-14				1				
					9-11 s8				3				
				§A+B	>96 94-95				1				
				SpO, Scale 1	92-93 <91				2				
				Oxygen saturation (%)	297 on O _s				3				
				SpO ₂ Scale 2* Oxygen saturation (%)	95–96 on O ₂				2				
				Use Scale 2 if target range is 88 92%.	≥93 on air								
				*Only use SpO, Scale 2	88-92 86-87				1				
				under the direction of a qualified clinician	84-85				2				
					s83% A=Ar				3				
				Air or Oxygen?	G, L/M in Device				2				
				C X	2220				3				
				C	201-219 181-200								
				Blood Pressure	161–180 141–160								
				mmHg Score uses	121-140								
	-			systolic BLOOD BF only PRESSURE	111=120 101=110				1				
				i i	91–100 81–90				2				
					71-80 61-70								
				X	51-60 <50								
					s50 a131				3		++-		
				C	121-120 111-120				2				
	+			Pulse Beats/min	101-110				1				
	-			RECORD AS	81-90								
					71-80 61-70								
					51-60 41-50				1				
					31-40				3				
				D	≤30 Alert								
				Consciousness	Confusion V								
				Score for New I Sudden onset of	P				3				
				Confusion	≥39.1°				2				
				RECORD	38.1-39.0*				1				
				°C AS	37.1-38.0° 36.1-37.0°								
					35,1-36.0° ±35.0°				1 3				
					IEWS2 TOTAL								
				Blood Escalation	glucose level of concern WAI								\Box
				656003000	Initials	-	-		-11				

NEWS2 Score	Frequency o	f monitoring	Clinical response
LOW RISK	Continue with ro	utine monitoring	Continue routine monitoring and observe for any clinical change
Total 1-4		ency of physical vations	Registered Practitioner to assess patient and to decide if increased frequency of monitoring and/or escalation of care is required. See local guidance
			Registered Practitioner to discuss with either: Medical Team, Ou Of Hours or Rapid Response-Red Team Lead (0300 421 6570).
Consider Sepsis			Use SBARD to handover
LOW-MEDIUM		ency of physical Minimum 4 hourly	Registered Practitioner to discuss with either: Medical Team, Ou Of Hours or Rapid Response-Red Team Lead (0300 421 6570).
RISK 3 in single parameter Consider Sepsis		frequecy of physical as necessary.	Use SBARD to handover
MEDIUM		ency of physical Minimum 1 hourly	Registered Practitioner to immediately seek urgent medical review/advice. If applicable refer to ReSPECT form.
MEDIUM RISK	Slurred speech	FLAG SIGNS	For Rapid Response-Red Team Lead (0300 421 6570) will decide if medical input can be provided in the community
Total 5-6	Extreme shivering/n Passing no urine (in Severe breathlessne	a day)	SWAST Health Care Professional Line (0300 369 0096) Use SBARD to handover
Complete Sepsis Screening Tool	"I feel like I might di Skin mottled/discolo	e" oured	Initiate emergency response and call (9)999 if transfer of patient is required
	Continuous of patient's phys	monitoring ical observations sis Screening Tool	Initiate emergency response and call (9)999 for emergency ambulance to transfer patient to nearest acute hospital site. If applicable refer to ReSPECT form.
HIGH RISK Total 7 or more	never to the sep.	sis screening root	For Rapid Response-Red Team Lead (0300 421 6570) will decide if medical input can be provided in the community
			SWAST Health Care Professional Line (0300 369 0096)
If a decision is a	nade to deviate fi	om the clinical re	Use SBARD to handover
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Physiological Parameter	3	2	1	0	1	2	3
Respiration rate	≤8		9-11	12-20		21-24	≥25
SpO, Scale 1	≤91	92-93	94-95	≥96			
SpO, Scale 2	≤83	84-85	86-87	88-92 ≥93 on air	93-94 on oxygen	95-96 on oxygen	≥97 on oxygen
Air or Oxygen		Oxygen		Air			
Systolic BP (mmHg)	≤90	91-100	101-110	111-219			≥220
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥39.1	
Time and date	Total NEWS2	Please docume	ent action and we reason for a	further comm	ents below	Staff	name
		(, , , , , , , ,	No.		
							<u> </u>
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						1	
	-					-	
						1	
						+	

Appendix 2 – Sample copy of the GHC036 Adult Neuro Observation and NEWS2 Chart

	Date		pi Scale (mm) NHS Name:
	Time		Gloucestershire Health and Care Date of Birth: DD / MM/ YYYYY
Minimum frequency fo perform every 30 min	for actual / suspected head injury: nutes until GCS 15 for a minimum of 2 hours, then 1 h	hourly for 4 hours, then 2 hourly thereafter.	NHS Foundation Trust RiO Number:
spontaneously to speech	3		Adult Neurological Observation NHS Number:
to pain none	2		and NEWS 2 Chart Cold AFFEX HOSPITAL LABEL HERES Date Date
orientated 東京 confused	5 4		NEWS KEY Date Date Date
inappropriate w			Minimum frequency for actual/suspected head injury: perform every 30 minutes until GCS is 15 for a minimum of 2 hours, then hourly for 4 hours, then 2 hourly thereon
none se obey command	1		6 Frequency Frequency Frequency 3 3 275
localise pain	5		7 A+B Record 5-77 18-20 2 18-20 18-20 18-21 18-20 18-21 18-20 18-21 18-20 18-2
flexion to pain	3		15-17 (15-17 17-18) 1 (15-17 1
extension to pa	1		8 .8
Glasgow Com	Size		-React's 94-95 94-95 1
Pupils Left	Reaction Size		no reaction Organisate action (%) (3) (3) (9) (9) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4
Normal power	Reaction		Sop() Scale 2" Sop(
Mild weakness Severe weakness Seastic flexion			50 85 4% in hypercaptic and the property of th
Spastic flexion Extension			there is a 4
No response Normal power			etween two Garage a qualified clinician GES%.
Mild weakness	_		off (9) and Alr or Oxygen? O, Umin 2 0, Umin 1: 0 0, Umin 2 0, Umin 1: 0 0, Umin 1:
Spastic florion Extension			171-130 121-130 121-131-131 121-131 121-131 121-131 121-131 121-131 121-131 121-131 12
No response			N01-110 101-11 1 101-11
NEWS2 Score	Frequency of monitoring	Clinical response	Autor 81.50 81.50 81.50 71.30 71.30 71.30 61.70 61.70
LOW RISK	Continue with routine monitoring	Continue routine monitoring and observe for any clinical ch	51.60
0	Increase frequency of physical observations	Registered Practitioner to assess patient and to decide if increased	
Total 1-4		monitoring and/or escalation of care is required. See local guidance	2270 3 3 5270 201-279 9 9 701-279 9 101-101
		Registered Practitioner to discuss with either: Medical Team, Out Rapid Response-Red Team Lead (0300 421 6570).	as 161–180 151–18
Consider Sepsis		Use SBARD to handover	Ricod [271-140] [271-140]
LOW-WEDIUN	M Increase frequency of physical observations to a Minimum 4 hourly	Registered Practitioner to discuss with either: Medical Team, Out Rapid Response-Red Team Lead (0300 421 6570).	(Flours or more)
RISK 3 in single	Consider increasing frequecy of physical observa- tions as necessary.	Use SBARD to handover	System x 81-90 71-80 71-80
parameter Consider Sepsis	,		61-70 51-60 50 50 50
	Increase frequency of physical observations to a Minimum 1 hourly	Registered Practitioner to Immediately seek urgent medical review applicable refer to ReSPECT form.	
MEDIUM RISK	SEPSIS REG FLAG SIGNS	For Rapid Response-Red Team Lead (0300 421 6570) will decide if	Contract
Total 5-6	Slurred speech Extreme shivering/muscle pain	can be provided in the community SWAST Health Care Professional Line (0300 369 0096)	drast of certaion (house it drast)
Complete Sepsis	Passing no urine (in a day) Severe breathlessness S. "I feel like I might die"	Use SBARD to handover	2331 2 2 2 3331 331-33 9 2 1 3331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 331-3 1 3 3 31-3 1 3 3 31-3 1 3 3 31-3 1 3 3 3 3
Screening Tool		Initiate emergency response and call (9)999 if transfer of patient	36.1-369 31.1-869 35.1-360 35.1-360 35.
		Initiate emergency response and call (9)999 for emergency ambular	35.0
	Continuous monitoring	minute energency response and can (5/555 for emergency ambular	3000 0000
nich bien	of patient's physical observations Refer to the Sepsis Screening Tool	patient to nearest acute hospital site. If applicable refer to ReSPECT form.	NEWS TOTAL
HIGH RISK	of patient's physical observations Refer to the Sepsis Screening Tool	patient to nearest acute hospital site.	Letter Control Control
HIGH RISK Total 7 or more	of patient's physical observations Refer to the Sepsis Screening Tool	patient to nearest acute hospital site. If applicable refer to ReSPECT form. For Rapid Response-Red Team Lead (0300 421 6570) will decide if	edical input Initials Initials

Appendix 3 – GHC055 Non-Contact Physical Observations





Non-Contact Physical Observations

(When it is not possible to use NEWS2 Physical Observation Chart, e.g. during and after restrictive interventions/manual restraint)

Date of birth: Name: If any statement from the red box is true, raise the alarm and DO NOT leave the patient Airway obstructed? Silence? Coughing? Swelling? · Talking (not just moans and groans). **Gurgling?** Airway clear. Risk of vomiting. Airway Consider moving onto their side into the recovery Airway · Breathing is quiet and regular. position and carry out constant observations to · Breathing between 12-20 breaths per minute. prevent choking. Breathing causes no extra effort of difficulty e.g. no wheezing or gurgling. Noisy or difficult breathing even with an open airway. Breathing · Breathing rate is more than 20 breaths per minute. **Breathing** Breathing rate is less than 12 breaths per minute. Mobility normal. Consider: COPD hypercapnic respiratory failure, Presenting as normal. asthma, heart failure · Warm, pink skin, comfortable presentation. Circulation · Change in ability to mobilise. · Alert and orientated. · Pale or flushed, clamming, sweating, cold, swollen, Circulation · Responsive to voice responding to voice could blue tinge to skin. indicate a decrease in level of consciousness. Dehydrated and / or malnourished. Disability · Drinking & eating. · Trauma / bleeding. Active. · Monitor and record findings and visual observations · Unexpected sleepy/drowsy, confusions, fitting. Disability · Pain, only responds to physical stimulus. using the non-contact physical observations. Exposure Consider checking all observations including blood Consider additional monitoring for asthma, diabetes, epilepsy, intoxication etc., medication side effects. glucose level and epilepsy.

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Patient Name DOB NHS No				Name, Signature and Role				
		Α	В	С	D	Ε		
Date	All green statements?							
	(Circle if true)							
Date	All green statements?							
	(Circle if true)							
Date	All green statements?							
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Date	All green statements?							
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Date	All green statements?							
	(Circle if true)							
Date	All green statements?							
	(Circle if true)							
Date	All green statements?							
	(Circle if true)							

Important Notes: NEWS2 is always preferred, in conjunction with an ABCDE assessment. The decision to use only this Non-Contact Physical Health Guidance & Assessment Framework tool is a Registered Clinician decision, on a case by case basis and should be determined each time physical health observations are required. This tool aids assessment, but the clinician should always act on their best professional clinical judgement too. NB: Circumstances why non-contact PHO rather than full NEWS2 should be summarised on the NEWS2 chart along with Respiratory Rate and ACVPU and conscious level.

Differentiating between unconsciousness and sleep: Being asleep is not the same as being unconscious. If someone is asleep we would expect them to occasionally change position while sleeping and for them to have a "normal" complexion for them. If you are at all concerned that the patient is not sleeping, and may be unconscious escalate / evoke full ACVPU assessment of consciousness immediately.

Appendix 4 - RESTORE2 Mini

Get your message across

Raise the Alert within your home e.g. to a senior carer, registered nurse or manager.

If possible, record the observations using a NEWS2 based system.

Report your concerns to a health care professional e.g. Nurse/GP/GP HUB/111/999 using the SBARD Structured Communication Tool.

Situation happened NEWS2 sc

Situation e.g. what's happened? How are they? NEWS2 score if available

Background e.g. what is their normal, how have they changed?

A A

Assessment e.g. what have you observed / done?

R

Recommendation 'I need you to...'

D

Decision what have you agreed? (including any Treatment Escalation Plan & further observations)

Key prompts / decisions

Don't ignore your 'gut feeling' about what you know and see.

Give any immediate care to keep the person safe and comfortable.

CS50656 NHS Creative 12/2019



Ask your resident – how are you today?

Does your resident show any of the following 'soft signs' of deterioration?

= Increasing breathlessness or chestiness

= Change in usual drinking / diet habits

= A shivery fever - feel hot or cold to touch

 Reduced mobility – 'off legs' / less co-ordinated

 New or increased confusion/ agitation / anxiety / pain

= Changes to usual level of alertness / consciousness / sleeping more or less

"Can't pee' or 'no pee', change in pee appearance

Diarrhoea, vomiting, dehydration

Any **concerns** from the resident / family or carers that the person is not as well as normal.

ch Sur

If YES to one or more of these triggers - take action!

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Appendix 5 - ReSPECT V3

Date of birth Address Preferred name Date completed The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document. 2. Shared understanding of my health and current condition Summary of relevant information for this plan including diagnoses and relevant personal circumstances Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipato Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer): Thave a legal welfare proxy in place (e.g. registered welfare attorney, person	ROSPECT Recommended	Date of birth Address						
Preferred name Date completed The ReSPECT process starts with conversations between a person and a healthcare professional. The ResPECT form is a clinical record of agreed recommendations. It is not a legally binding document. 2. Shared understanding of my health and current condition Summary of relevant information for this plan including diagnoses and relevant personal circumstances of the care planning documents and where to find them (e.g. Advance or Anticipator Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer): I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 3. What matters to me in decisions about my treatment and care in an emergency Living as long as possible matters most to me What I most value: What I most fear / wish to avoid: 4. Clinical recommendations for emergency care and treatment Prioritise extending life Balance extending life with company of the care of the company of the care of								
Date completed NHS/CHUHealth and care number Nessenged to be selected of a legally binding document. Legally binding document. Nessenged to be selected or care number of the legally binding document. Nessenged to be selected or care number of the legally binding document. Nessenged to be selected or care number of the legally binding document. Nessenged to be selected or care and treatment or care number or care number or care number of the care	1. This plan belongs to:							
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5. Capacity for i	5. Capacity for involvement in making this plan							
Does the person had to participate in ma recommendations	aking on this plan?	No J	no, in what way does					
the clinical record.	current the full capacity assessment in e clinical record. If the person lacks capacity a ReSPECT conversation take place with the family and/or legal welfare pro							
6. Involvement	in making this	plan						
and a second			that (select A,B or C,					
A This person h been fully in	as the mental capa volved in this plan	acity to part	icipate in making the	se recommendation	ns. They have			
recommenda account. The	ations. Their past a	nd present v de, where a	city, even with suppor views, where ascertain pplicable, in consulta bers/friends.	nable, have been ta	ken into			
	less than 18 years explain in section		cotland) and (please s	elect 1 or 2, and als	io 3 as			
			anding to participate	in making this plan	arto to marci			
2 They do not		aturity and u	understanding to par					
			been fully involved i	n discussing and ma	aking this plan.			
D If no other optio	n has been selecte		sons must be stated h					
the clinical recon	d.)							
7. Clinicians' sig	natures	7 Clinicians' signatures						
7. Clinicians' signatures Grade(speciality Clinician pages GMC/NMC (NCRC pages Girosature Date & store								
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Grade/speciality Senior responsible dinie	Clinician name		GMC/NMC/HCPC no.	Signature	Date & time			
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Appendix 6 - SBARD Communication Tool







SITUATION Identify self, environment and person using services. What is happening? Give a concise statement of the problem.



BACKGROUND State the pertinent information relating to the situation. What data will help to clarify? –
Observations – Early Warning Score – Relevant history



ASSESSMENT what do you think is going on? What is your clinical opinion? What are you concerned about?



RECOMMENDATION What is your request or recommended action and when is it required?



DECISION/DOCUMENTATION Document times of communication with medical staff, ambulance staff etc. Remember to include people who use services and all advice received from other professionals.

Appendix 7 – NICE Traffic Light System for identifying risk of serious illness in under 5s

Traffic light system for identifying risk of serious illness in under 5s

Refer to the summary version of table 3 for the NICE guideline on sepsis if a child presents with fever and symptoms or signs that indicate possible sepsis

	Green – low risk	Amber – Intermediate risk	Red – high risk
Colour (of skin, lips or tongue)	Normal colour	Pallor reported by parent/carer	Pale/mottled/achen/ blue
Activity	Responds normally to social cues Content/smiles Stays awake or awakens quickly Strong normal cry/not crying	Not responding normally to social cues No smile Wakes only with prolonged stimulation Decreased activity	No response to social cues Appears III to a healthcare professional Does not wake or if roused does not stay awake Weak, high-pitched or continuous cry
Respiratory		Nasal flaring Tachypnoea: RR >50 breaths/ minute, age 6–12 months RR >40 breaths/ minute, age >12 months Coxygen saturation >95% in air Crackles in the chest	Grunting Tachypnoea: RR >60 breaths/minute Moderate or severe chest indrawing
Circulation and hydration	Normal skin and eyes Moist mucous membranes	Tachycardia:	Reduced skin turgor
Other	None of the amber or red symptoms or signs	Age 3–6 months, temperature ≥39°C Fever for ≥5 days Rigors Swelling of a limb or joint Non-weight bearing limb/not using an extremity	 Age <3 months, temperature 28°C° Non-bianching rash Buiging fontanelle Neck stiffness Status epilepticus Focal neurological signs Focal setzures
" Some va This traff	llary refil time; RR, r accinations have bee ic light table should guideline on fever i	n found to induce fever in children a I be used in conjunction with the i	ged under 3 months recommendations in

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Appendix 8 – Example Copies of the PEWS Charts

Please click on each link below to view the relevant chart - Charts will need to be ordered from Colour Connect. Online training for these PEWS charts is available on Care to Learn

Appendix 8a: <u>PEWS – 0 to 11mths National Paediatric Early Warning System Observation and Escalation Chart (GHC071) Sample Copy</u>

Appendix 8b: <u>PEWS – 1 to 4 years National Paediatric Early Warning System Observation and</u> Escalation Chart (GHC070) Sample Copy

Appendix 8c: <u>PEWS – 5 to 12 years National Paediatric Early Warning System Observation and Escalation Chart (GHC068) Sample Copy</u>

Appendix 8d: <u>PEWS – 13 years and above National Paediatric Early Warning System</u> Observation and Escalation Chart (GHC069) Sample Copy

Appendix 9 - GHC Page for Age MliU





Gloucestershire Health and Care NHS Foundation Trust

Page for Age - 3 months

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	5 kg
Heart Rate- refer to PEWS chart	110-160 bpm
Respiration Rate- refer to PEWS chart	30-40 bpm
Systolic BP- refer to PEWS chart	70-90mmHg
OP Airway	00
Adrenaline I.V (1:10,000) 10mg/1ml	50mcg (0.5ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with	100ml Given over less than 10 minutes
pre-existing cardiac or kidney disease	
Amiodarone I.V (300mg/10ml) Cardiac Arrest 5mg/kg	25mg (0.8ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	25mg (0.5ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	150mcg (0.15ml)
Suspected/confirmed anaphylaxis	Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial)	500microgrammes (0.5mg) as a single dose by IM or SC injection
severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	
Diazepam rectal solution 5mg/2.5ml Seizures	2.5mg (1.25ml) Repeat after 10 minutes if still convulsing. Max 5mg
Midazolam (Buccal) 2.5mg/0.5ml Seizures	2.5mg (0.5ml) Repeat after 10 minutes if still convulsing. Max 5mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICINES

Page for Age - V3 October 2023 (Chief Pharmacist)





Page for Age - 6 months

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	7 kg
Heart Rate- refer to PEWS chart	110-160 bpm
Respiration Rate- refer to PEWS chart	30-40 bpm
Systolic BP- refer to PEWS chart	70-90mmHg
OP Airway	00
Adrenaline I.V (1:10,000) 10mg/ml	70mcg (0.7ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V	140ml
(20ml/kg up to a maximum of 500ml)	Given over less than 10 minutes
Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) Cardiac Arrest 5mg/kg	35mg (1.2ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	35mg (0.7ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	150mcg (0.15ml)
Suspected/confirmed anaphylaxis	Repeat dose after 5 minutes if A irway/ B reathing/ C irculation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 5mg/2.5ml Seizures	5mg (2.5ml) Repeat after 10 minutes if still convulsing. Max 10mg
Midazolam (Buccal) 2.5mg/0.5ml Seizures	2.5mg (0.5ml) Repeat after 10 minutes if still convulsing. Max 5mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATIO

Page for Age - V3 October 2023 (Chief Pharmacist)





Page for Age - 9 months

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	9 kg
Heart Rate- refer to PEWS chart	110-160 bpm
Respiration Rate- refer to PEWS chart	30-40 bpm
Systolic BP- refer to PEWS chart	70-90mmHg
OP Airway	00
Adrenaline I.V (1:10,000) 10mg/ml	90mcg (0.9ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml)	180ml
Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) Cardiac Arrest 5mg/kg	45mg (1.5ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if
	still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	45mg (0.9ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	150mcg (0.15ml)
Suspected/confirmed anaphylaxis	Repeat dose after 5 minutes if A irway/ B reathing/ C irculation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 5mg/2.5ml Seizures	5mg (2.5ml) Repeat after 10 minutes if still convulsing. Max 10mg
Midazolam (Buccal) 2.5mg/0.5ml Seizures	2.5mg (0.5ml) Repeat after 10 minutes if still convulsing. Max 5mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Gloucestershire Health and Care NHS Foundation Trust

Page for Age - 12 months (1 year)

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	10 kg
Heart Rate- refer to PEWS chart	110-150 bpm
Respiration Rate- refer to PEWS chart	25-35 bpm
Systolic BP- refer to PEWS chart	80-95mmHg
OP Airway	00 or 0
Adrenaline I.V (1:10,000) 10mg/ml	100mcg (1.0ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml)	200ml Given over less than 10 minutes
Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) Cardiac Arrest 5mg/kg	50mg (1.4ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	50mg (1.0ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml Suspected/confirmed anaphylaxis	150mcg (0.15ml) Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 5mg/2.5ml Seizures	5mg (2.5ml) Repeat after 10 minutes if still convulsing. Max 10mg
Midazolam (Buccal) 5.0mg/1ml Seizures	5.0mg (1ml) Repeat after 10 minutes if still convulsing. Max 10mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age - 18 months

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	11 kg
Heart Rate- refer to PEWS chart	110-150 bpm
Respiration Rate- refer to PEWS chart	25-35 bpm
Systolic BP- refer to PEWS chart	80-95mmHg
OP Airway	00 or 0
Adrenaline I.V (1:10,000) 10mg/ml	110mcg (1.1ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V	220ml
(20ml/kg up to a maximum of 500ml)	Given over less than 10 minutes
Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) Cardiac Arrest 5mg/kg	55mg (1.8ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	55mg (1.1ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml Suspected/confirmed anaphylaxis	150mcg (0.15ml) Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 5mg/2.5ml Seizures	5mg (2.5ml) Repeat after 10 minutes if still convulsing. Max 10mg
Midazolam (Buccal) 5.0mg/1ml Seizures	5.0mg (1ml) Repeat after 10 minutes if still convulsing. Max 10mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





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Page for Age - 24 months (2 years)

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	12 kg
Heart Rate- refer to PEWS chart	95-140 bpm
Respiration Rate- refer to PEWS chart	25-30 bpm
Systolic BP- refer to PEWS chart	80-100mmHg
OP Airway	0 or 1
Adrenaline I.V (1:10,000) 10mg/ml	1200mcg (1.2ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml)	240ml Given over less than 10 minutes
Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	
Amiodarone I.V (300mg/10ml) Cardiac Arrest 5mg/kg	60mg (2.0ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	60mg (1.2ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml Suspected/confirmed anaphylaxis	150mcg (0.15ml) Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 5mg/2.5ml Seizures	5mg (2.5ml) Repeat after 10 minutes if still convulsing. Max 10mg
Midazolam (Buccal) 5.0mg/1ml Seizures	5.0mg (1ml) Repeat after 10 minutes if still convulsing. Max 10mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age - 3 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	14 kg
Heart Rate- refer to PEWS chart	95-140 bpm
Respiration Rate- refer to PEWS chart	25-30 bpm
Systolic BP- refer to PEWS chart	80-100mmHg
OP Airway	1
Adrenaline I.V (1:10,000) 10mg/ml	140mcg (1.4ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V	280ml
(20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients	Given over less than 10 minutes
with pre-existing cardiac or kidney disease	
Amiodarone I.V (300mg/10ml) pfs Cardiac Arrest 5 mg/kg	70mg (2.3ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	70mg (1.4ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	150mcg (0.15ml)
Suspected/confirmed anaphylaxis	Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 5mg/2.5ml Seizures	5mg (2.5ml) Repeat after 10 minutes if still convulsing. Max 10mg
Midazolam (Buccal) 5.0mg/1ml Seizures	5.0mg (1ml) Repeat after 10 minutes if still convulsing. Max 10mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age – 4 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	16 kg
Heart Rate- refer to PEWS chart	95-140 bpm
Respiration Rate- refer to PEWS chart	25-30 bpm
Systolic BP- refer to PEWS chart	80-100mmHg
OP Airway	1
Adrenaline I.V (1:10,000) 10mg/ml	160mcg (1.6ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	320ml Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) pfs Cardiac Arrest 5 mg/kg	80mg (2.7ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	80mg (1.6ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	150mcg (0.15ml)
Suspected/confirmed anaphylaxis	Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon I.M (1mg per vial severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 5mg/2.5ml Seizures	5mg (2.5ml) Repeat after 10 minutes if still convulsing. Max 10mg
Midazolam (Buccal) 5.0mg/1ml Seizures	5.0mg (1ml) Repeat after 10 minutes if still convulsing. Max 10mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age - 5 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

(Drug doses are based on Nesuscitation	Council on Guidelines 2021 recommendations;
Guide Weight	18 kg
Heart Rate- refer to PEWS chart	110-160 bpm
Respiration Rate- refer to PEWS chart	30-40 bpm
Systolic BP- refer to PEWS chart	70-90mmHg
OP Airway	1
Adrenaline I.V (1:10,000) 10mg/ml	180mcg (1.8ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	360ml Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs	90mg (3ml) after 3 rd & 5 th shock only
Cardiac Arrest 5 mg/kg	In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps	90mg (1.8ml) after 3 rd & 5 th shock only
Cardiac Arrest 5 mg/kg	In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	150mcg (0.15ml)
Suspected/confirmed anaphylaxis	Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon I.M (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 10mg/5ml Seizures	10mg (5ml) Repeat after 10 minutes if still convulsing. Max 20mg
Midazolam (Buccal) 7.5mg/1.5ml Seizures	7.5mg (1.5ml) Repeat after 10 minutes if still convulsing. Max 15mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age – 6 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

	Council or Guidelines 2021 recommendations)
Guide Weight	20 kg
Heart Rate- refer to PEWS chart	80-120 bpm
Respiration Rate- refer to PEWS chart	20-25 bpm
Systolic BP- refer to PEWS chart	90-110mmHg
OP Airway	1
Adrenaline I.V (1:10,000) 10mg/ml Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	200mcg (2.0ml) repeat 3-5mins For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5th, 7th, 9th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	400ml Given over less than 10 minutes
Amiodarone I.V (300mg/10ml)pfs Cardiac Arrest 5 mg/kg	100mg (3.3ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	100mg (2.0ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml Suspected/confirmed anaphylaxis	150mcg (0.15ml) Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	25kg or over 1mg as a single dose by IM or SC injection under 25kg 500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 10mg/5ml Seizures	10mg (5ml) Repeat after 10 minutes if still convulsing. Max 20mg
Midazolam (Buccal) 7.5mg/1.5ml Seizures	7.5mg (1.5ml) Repeat after 10 minutes if still convulsing. Max 15mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age - 7 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	23 kg
Heart Rate- refer to PEWS chart	80-120 bpm
Respiration Rate- refer to PEWS chart	20-25 bpm
Systolic BP- refer to PEWS chart	90-110mmHg
OP Airway	1 Or 2
Adrenaline I.V (1:10,000) 10mg/ml Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	230mcg (2.3ml) repeat 3-5mins For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	460ml Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) Cardiac Arrest 5 mg/kg	115mg (3.8ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	115mg (2.3ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml Suspected/confirmed anaphylaxis	300mcg (0.3ml) Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	25kg or over 1mg as a single dose by IM or SC injection under 25kg 500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 10mg/5ml Seizures	10mg (5ml) Repeat after 10 minutes if still convulsing. Max 20mg
Midazolam (Buccal) 7.5mg/1.5ml Seizures	7.5mg (1.5ml) Repeat after 10 minutes if still convulsing. Max 15mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age - 8 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	26 kg
Heart Rate- refer to PEWS chart	80-120 bpm
Respiration Rate- refer to PEWS chart	20-25 bpm
Systolic BP- refer to PEWS chart	90-110mmHg
OP Airway	1 or 2
Adrenaline I.V (1:10,000) 10mg/ml Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	260mcg (2.6ml) repeat 3-5mins For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	500ml Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) Cardiac Arrest 5 mg/kg	130mg (4.3ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	130mg (2.6ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	300mcg (0.3ml)
Suspected/confirmed anaphylaxis	Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	25kg or over 1mg as a single dose by IM or SC injection under 25kg 500microgrammes (0.5mg) as a single dose by IM or SC injection
Diazepam rectal solution 10mg/5ml Seizures	10mg (5ml) Repeat after 10 minutes if still convulsing. Max 20mg
Midazolam (Buccal) 7.5mg/1.5ml Seizures	7.5mg (1.5ml) Repeat after 10 minutes if still convulsing. Max 15mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age - 9 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

0	20.1
Guide Weight	29 kg
Heart Rate- refer to PEWS chart	80-120 bpm
Respiration Rate- refer to PEWS chart	20-25 bpm
Systolic BP- refer to PEWS chart	90-110mmHg
OP Airway	1 or 2
Adrenaline I.V (1:10,000) 10mg/ml	270mcg (2.7ml) repeat 3-5mins
Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients	500ml Given over less than 10 minutes
with pre-existing cardiac or kidney disease	
Amiodarone I.V 300mg/10ml pfs Cardiac Arrest 5 mg/kg	145mg (4.8ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	145mg (2.9ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	300mcg (0.3ml)
Suspected/confirmed anaphylaxis	Repeat dose after 5 minutes if A irway/ B reathing/ C irculation problems persist
Glucagon I.M (1mg per vial)	1mg as a single dose
severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	by IM or SC injection
Diazepam rectal solution 10mg/5ml Seizures	10mg (5ml) Repeat after 10 minutes if still convulsing. Max 20mg
Midazolam (Buccal) 7.5mg/1.5ml Seizures	7.5mg (1.5ml) Repeat after 10 minutes if still convulsing. Max 15mg

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Page for Age - 10 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

Guide Weight	30 kg
Heart Rate- refer to PEWS chart	80-120 bpm
Respiration Rate- refer to PEWS chart	20-25 bpm
Systolic BP- refer to PEWS chart	90-110mmHg
OP Airway	2 or 3
Adrenaline I.V (1:10,000) 10mg/ml Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	300mcg (3.0ml) repeat 3-5mins For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest
	For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	500ml Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs Cardiac Arrest 5 mg/kg	150mg (5.0ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	150mg (3.0ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml Suspected/confirmed anaphylaxis	300mcg (0.3ml) Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial) severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	1mg as a single dose by IM or SC injection
Diazepam rectal solution 10mg/5ml Seizures Midazolam (Buccal) 10mg/2ml	10mg (5ml) Repeat after 10 minutes if still convulsing. Max 20mg 10mg (2ml)
Seizures	Repeat after 10 minutes if still convulsing. Max 20mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age - 11 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

	25 I.m.
Guide Weight	35 kg
Heart Rate- refer to PEWS chart	80-120 bpm
Respiration Rate- refer to PEWS chart	20-25 bpm
Systolic BP- refer to PEWS chart	90-110 mmHg
OP Airway	2 or 3
Adrenaline I.V (1:10,000) 10mg/ml Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	350mcg (3.5ml) repeat 3-5mins For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	500ml Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs Cardiac Arrest 5 mg/kg	175mg (5.8ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest	175mg (3.5ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial
5 mg/kg	IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	300mcg (0.3ml)
Suspected/confirmed anaphylaxis	Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial)	1mg as a single dose
severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	by IM or SC injection
Diazepam rectal solution 10mg/5ml	10mg (5ml) Repeat after 10 minutes if still convulsing. Max 20mg
Midazolam (Buccal) 10mg/2ml Seizures	10mg (2ml) Repeat after 10 minutes if still convulsing. Max 20mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION





Page for Age - 12 years

(Body weights listed are averaged on lean body mass from 50th centile for male and female) (Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

	20 Ica
Guide Weight	38 kg
Heart Rate- refer to PEWS chart	70-100 bpm
Respiration Rate- refer to PEWS chart	15-25 bpm
Systolic BP- refer to PEWS chart	100-130 mmHg
OP Airway	2 or 3
Adrenaline I.V (1:10,000) 10mg/ml Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	380mcg (3.8ml) repeat 3-5mins For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	500ml Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs Cardiac Arrest 5 mg/kg	190mg (6.3ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	190mg (3.8ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml Suspected/confirmed anaphylaxis	300mcg (0.3ml) Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial)	1mg as a single dose
severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	by IM or SC injection
Diazepam rectal solution 10mg/5ml Seizures	10mg (5ml) Repeat after 10 minutes if still convulsing. Max 20mg
Midazolam (Buccal) 10mg/2ml Seizures	10mg (2ml) Repeat after 10 minutes if still convulsing. Max 20mg

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Gloucestershire Health and Care NHS Foundation Trust

Page for Age over 12 years of age

(Drug doses are based on Resuscitation Council UK Guidelines 2021 recommendations)

	Council UK Guidelines 2021 recommendations)
Guide Weight	Above 40kg
Heart Rate	70-100 bpm
Respiration Rate	15-25 bpm
Systolic BP	100-130 mmHg
OP Airway	2 or 3
Adrenaline I.V (1:10,000) 10mg/ml Cardiac arrest 10 mcg kg ⁻¹ (or 0.1mL kg ⁻¹⁾ 1 in 10:000 solution	Calculate dose based considering age and development repeat 3-5mins maximum 500mcg For non-shockable rhythms give adrenaline as soon as circulatory access is established, preferably within 3 minutes of identification of cardiac arrest For shockable rhythms give the initial dose of adrenaline immediately after the third shock and then following alternate shocks (5 th , 7 th , 9 th etc.).
Sodium Chloride 0.9% solution I.V (20ml/kg up to a maximum of 500ml) Smaller volumes may be required in patients with pre-existing cardiac or kidney disease	500ml Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs Cardiac Arrest 5 mg/kg	200mg (6.7ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Amiodarone I.V 150mg/3ml amps Cardiac Arrest 5 mg/kg	200mg (4.0ml) after 3 rd & 5 th shock only In the treatment of shockable rhythms, give an initial IV bolus dose of amiodarone 5 mg kg ⁻¹ after the third defibrillation. Repeat the dose after the fifth shock if still in VF/pVT.
Adrenaline I.M (1:1000) 1mg/1ml	If child is small pre-pubertal give: 300mcg (0.3ml)
Suspected/confirmed anaphylaxis	If child not small give: 500mcg (0.5ml) Repeat dose after 5 minutes if Airway/ Breathing/ Circulation problems persist
Glucagon Injection (1mg per vial)	1mg as a single dose
severe hypoglycaemic reactions, which occur in the management of patients with diabetes receiving insulin	by IM or SC injection
Diazepam rectal solution 10mg/5ml Seizures	20mg (10ml) Administer an additional 10mg after 10 minutes if still convulsing. Max 30mg
Midazolam (Buccal) 10mg/2ml Seizures	10mg (2ml) Repeat after 10 minutes if still convulsing. Max 20mg

REFER TO RELEVANT PGD PRIOR TO ADMINISTRATION OF ANY MEDICATION

SEPSIS SCREENING TOOL COMMU	NITY CARE Under 5
RISK FACTORS FOR SEPSIS INCLUDE:	HILD LOOKS UNWELL, IF PARENT GY IS ABNORMAL e.g. PEWS
COULD THIS BE DUE TO A LIKELY SOURCE: Respiratory Urine Skin / joint / wou Brain Surgical Other	CONSIDER'
ANY RED FLAGS PRESENT? Mental state or behaviour is acutely altered Doesn't wake when roused / won't stay awake Looks very unwell to healthcare professional Sp02 <90% on air or increased 02 requirements Severe tachypnoea (see chart) Severe tachycardia (see chart) Bradycardia (<60 bpm) Non-blanching rash / mottled / ashen / cyanotic Temperature <36°C If under 3 months, temperature 38°+	RED FLAG SEPSIS START BUNDLE
ANY AMBER FLAGS PRESENT? IF IMMUNITY IMPAIRED TREAT AS RED FLAG SEPSIS Not behaving normally Reduced activity / very sleepy Parental or carer concern Moderate tachypnoea (see chart) Moderate tachycardia (see chart) Sp02 < 92% on air or increased 02 requirement Nasal flaring Capillary refill time ≥ 3 seconds Reduced urine output (<1ml/kg/h if catheterised) Leg pain / cold extremities Immunocompromised	1 SAME DAY ASSESSMENT BY GP / TEAM LEADER 2 IS URGENT REFERRAL TO HOSPITAL REQUIRED? 3 AGREE AND DOCUMENT ONGOING MANAGEMENT PLAN (INCLUDING OBSERVATION FREQUENCY AND PLANNED SECOND REVIEW)
If 3-6 months, temperature 39°+ NO AMBER FLAGS = ROUTINE CARE RED FLAG BUNDLE: DIAL 999 AND ARRANGE BLUE LIGHT TO SELVE TRANSIT STATES AVAILABLE & TRANSIT STATES AND THE SITE OF THE S	COMMUNICATION: Ensure communication of 'Red Flag Sepsis' to crew. Advise crew to pre-alert as 'Red Flag Sepsis'. Where persible a written bandouse is
Age (years) Tachypnoea (breaths per minute) Tachycardia (beats per minute)	THE UK SEPSIS TRUST UKST 2024 1.0 PAGE 1 0F 1 The controlled copy of this document is maintained by The UK Sepsis Trust. Any copies of this document held outside of that area, in whatever format (e.g., paper, email attachment) are considered to have passed out of control and should be checked for currency and validity. The UK Sepsis Trust registered charity number (Fingland & Walles) 1158843 (Scotland) SCOS0277. Company registration

SEPSIS SCREENING TOOL COMMU	NITY CARE Age 5	-11
RISK FACTORS FOR SEPSIS INCLUDE:	HILD LOOKS UNWELL, IF PARE GY IS ABNORMAL e.g. PEWS dwelling lines / IVDU / broken skin	NT
COULD THIS BE DUE TO A LIKELY SOURCE: Respiratory Urine Skin / joint / would Brain Surgical Other	CONSID	LY, ER
ANY RED FLAGS PRESENT? Mental state or behaviour is acutely altered Doesn't wake when roused / won't stay awake Looks very unwell to healthcare professional Sp02 <90% on air or increased 02 requirements Severe tachypnoea (see chart) Severe tachycardia (see chart) Bradycardia (<60 bpm) Non-blanching rash / mottled / ashen / cyanotic	RED FLAG SEPSIS	
ANY AMBER FLAGS PRESENT? IF IMMUNITY IMPAIRED TREAT AS RED FLAG SEPSIS Not behaving normally Reduced activity / very sleepy Parental or carer concern Moderate tachypnoea (see chart) Moderate tachycardia (see chart) Sp02 <92% on air or increased 0₂ requirement Nasal flaring Capillary refill time ≥ 3 seconds Reduced urine output (<1ml/kg/h if catheterised) Leg pain / cold extremities Immunocompromised Temperature <36°	1 SAME DAY ASSESSMENT BY GP / TEAM LEADER 2 IS URGENT REFERRAL TO HOSPITAL REQUIRED? 3 AGREE AND DOCUMENT ONGOING MANAGEMENT PL (INCLUDING OBSERVATION FREQUENCY AND PLANNED SECOND REVIEW)	AN
NO AMBER FLAGS = ROUTINE CARE RED FLAG BUNDLE: DIAL 999 AND ARRANGE BLUE LIGHT T IF PRESCRIBER AVAILABLE & TRANSI >1HR GIVE IV ANTIBIOTICS	COMMUNICATION: Ensure communi of 'Red Flag Sepsis' to crew. Advise to pre-alert as 'Red Flag Sepsis'. Whose partition bendered	crew is
Age (years) Tachypnoea (breaths per minute) Tachycardia (beats per minute) Severe Moderate Severe Moderate 5 ≥29 24-28 ≥130 120-129 6-7 ≥29 24-26 ≥120 110-119 8-11 ≥25 22-24 ≥115 109-114		es of this doc- are considered JK Sepsis Trust ny registration

Appendix 10c - Sepsis Screening Tool Community Care Age 12-15

START THIS CHART IF THE YOUNG PERSON LOOKS IF PARENT IS CONCERNED OR HAS ABNORMAL e.g.	-
RISK FACTORS FOR SEPSIS INCLUDE: Impaired immunity (e.g. diabetes, steriods, chemotherapy) Recent trauma / surgery / invasive pr	PEWS
COULD THIS BE DUE TO AN INFECTION? LIKELY SOURCE: Respiratory Urine Skin / joint / wound Indwelling device Brain Surgical Other	SEPSIS UNLIKELY, CONSIDER OTHER DIAGNOSIS
ANY RED FLAGS PRESENT? Objective evidence of new or altered mental state Respiratory rate ≥ 25 per minute New need for 02 (40% or more) to keep Sp02 > 92% (>88%COPD) Systolic BP ≤ 90 mm Hg (or drop of >40 from normal) Heart rate > 130 per minute Not passed urine in 18 hours (<0.5ml/kg/hr if catheterised) Non-blanching rash / mottled / ashen / cyanotic	SIS
ANY AMBER FLAGS PRESENT? IF IMMUNITY IMPAIRED TREAT AS RED FLAG SEPSIS Family report abnormal behavior or mental state Reduced funtional ability Respiratory rate 21-24 Systolic BP 91-100 mmHg Heart rate 91-130 or new dysrhythmia Sp02 < 92% on air or increased 02 requirement Not passed urine in 12-18 hr (0.5ml/kg/hr to 1ml/kg/hr if catheterised) Immunocompromised Signs of infection including wound infection Temperature <36°C	ADER RRAL TO RED? IMENT EMENT PLAN ERVATION PLANNED
AND SAFETY-NETTING ADVICE: CALL 111 IF CONDITION CHANGES OR DETERIORATES. Passing no urine 'I feel I might die	ng or muscle pain (in a day)

Appendix 10d - Sepsis Screening Tool Community Care Age 16+

SEPSIS SCREENING TOOL COMMUNITY CARE	Age 16+
START THIS CHART IF THE PATIENT LOOKS UNWELL OR HAS ABNORMAL PHYSIOLOGY RISK FACTORS FOR SEPSIS INCLUDE: Age > 75 Impaired immunity (e.g. diatetes, steriods, chemotherapy) CONSIDER ANY ADVANCE DIRECTIVE / CAR Indwelling lines / IVDU / broken skin Recent trauma / surgery / invasive pro	
COULD THIS BE DUE TO AN INFECTION? LIKELY SOURCE: Respiratory Urine Skin / joint / wound Indwelling device Brain Surgical Other	SEPSIS UNLIKELY, CONSIDER OTHER DIAGNOSIS
ANY RED FLAGS PRESENT? Objective evidence of new or altered mental state Respiratory rate ≥ 25 per minute New need for 02 (40% or more) to keep Sp02 > 92% (>88%COPD) Systolic BP ≤ 90 mm Hg (or drop of >40 from normal) Heart rate > 130 per minute Not passed urine in 18 hours (<0.5ml/kg/hr if catheterised) Non-blanching rash / mottled / ashen / cyanotic	SIS
ANY AMBER FLAGS PRESENT? Family report abnormal behavior or mental state Reduced funtional ability Respiratory rate 21-24 Systolic BP 91-100 mmHg Heart rate 91-130 or new dysrhythmia Sp02 < 92% on air or increased 02 requirement Not passed urine in 12-18 hr (0.5ml/kg/hr to 1ml/kg/hr if catheterised) Immunocompromised Signs of infection including wound infection Temperature <36°C	DER RAL TO RED? MENT EMENT PLAN RVATION
RED FLAG BUNDLE: DIAL 999 AND ARRANGE BLUE LIGHT TRANSFER IF PRESCRIBER AVAILABLE & TRANSIT TIME >1HR GIVE IV ANTIBIOTICS Ensure communication of 'Red Flag Sepsis' to crew. Advise crew to pre-alert as	g or muscle pain (in a day)

Appendix 10e - Sepsis Screening Tool - Acute Mental Health 16+

SEPSIS SCREENING TOOL - ACUT	E MENTAL HEALTH AGE 16+
1 START THIS CHART IF SE Factors prompting screening for se	PSIS IS SUSPECTED psis include:
 □ NEWS2 has triggered □ Carer or relative concern □ Recent chemotherapy/ risk of neutropenia Consider any advance directive or 	Patient looks unwell Evidence of organ dysfunction (e.g. lactate >2mmol/l) Assessment gives clinical cause for concern
CALCULATE NEWS2 SCORE Risk assess. Always interpret vital signs a medications, medical history and repons	10 March 2011 2011 2010 2010 2010 2010 2010 201
02 IS NEWS27 OR ABOVE? OR IS NEWS25 OR 6 AND ONE OF:	03 IS NEWS2 5 OR 6? OR IS NEWS2 1-4 AND ONE OF:
Any one NEWS2 parameter with score of 3 Mottled or ashen skin Non-blanching rash Cyanosis of skin, lips or tongue Patient looks extremely unwell Patient is actively deteriorating Risk of neutropenia (chemotherapy, immunosuppression)	Any one NEWS2 parameter with score of 3 Mottled or ashen skin Non-blanching rash Cyanosis of skin, lips or tongue Patient looks extremely unwell Patient is actively deteriorating Risk of neutropenia (chemotherapy, immunosuppression)
RED FLAG	1 SAME DAY ASSESSMENT BY GP/ TEAM LEADER 2 IS URGENT REFERRAL TO HOSPITAL REQUIRED?
SEPSIS START BUNDLE	3 AGREE AND DOCUMENT ONGOING MANAGEMENT PLAN (INCLUDING OBSERVATION FREQUENCY AND PLANNED SECOND REVIEW)
NO AMBER FLAGS OR UNLIKELY S other dia	
RED FLAG SEPSIS BUNDLE: THIS IS TIME-CRITICAL - IMMEDIATE ACTION REQUIRED: DIAL 999 AND ARRANGE BLUE LIGHT	COMMUNICATION: Ensure communication of 'Red Flag Sepsis' to crew. Advise crew to pre-alert as 'Red Flag Sepsis'. Where possible a written handover is recommended including observations and antibiotic allergies.

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Appendix 10f - Sepsis Screening Tool Community Care Pregnant or up to 4 Weeks Post Pregnancy

SEPSIS SCREENING TOOL COMMUNITY CARE	PREGNANT OR UP TO 4 WEEKS POST-PREGNANCY
START THIS CHART IF THE PATIENT LOOKS OR PHYSIOLOGY IS ABNORMAL RISK FACTORS FOR SEPSIS INCLUDE: Impaired immunity (e.g. diabetes, steriods, chemotherapy)	
COULD THIS BE DUE TO AN INFECTION? LIKELY SOURCE: Respiratory Urine Infected caesarean / perineal wound Breast abscess Abdominal pain / distension Chorioamnionitis / endometritis	SEPSIS UNLIKELY, CONSIDER OTHER DIAGNOSIS
Systolic BP ≤ 90 mmHg (or drop of >40 from normal) Heart rate > 130 per minute Respiratory rate ≥ 25 per minute New need for 02 (40% or more) to keep Sp02 > 92% (>88%COPD)	FLAG PSIS BUNDLE
Family report mental status change Respiratory rate 21-24 Heart rate 100-130 or new dysrhythmia Systolic BP 91-100 mmHg Has had invasive procedure in last 6 weeks Temperature < 36°C Has diabetes or impaired immunity Close contact with GAS CINCLUDING	D DOCUMENT MANAGEMENT PLAN G OBSERVATION Y AND PLANNED
AND SAFETY-NETTING ADVICE: CALL 111 IF CONDITION CHANGES OR DETERIORATES. CALL 111 IF CONDITION CHANGES OR DETERIORATES.	d speech or confusion ne shivering or muscle pain g no urine (in a day) might die' ottled, ashen, blue or very pale
RED FLAG BUNDLE: DIAL 999 AND ARRANGE BLUE LIGHT TRANSFER IF PRESCRIBER AVAILABLE & TRANSIT TIME >1HR GIVE IV ANTIBIOTICS	THE UK SEPSIS TRUST UKST 2024 1.0 PAGE 1 0F 1

CLP105 Deteriorating Patient Policy V3.9

Ensure communication of 'Red Flag Sepsis' to crew. Advise crew to pre-alert as 'Red Flag Sepsis'. Where possible a written handover is recommended including observations and antibiotic allergies.

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Appendix 11 - I STUMBLE

"I STUMBLE" Algorithm for Falls (adapted from the West Midlands Ambulance Service) To be completed by registered nurse

Post Fall Assessment Tool To be completed by Registered nurse

Signed (staff mem Date of Fall Location of Fall: Primary Symptom prior to fall: (please	ber):							
Signed (staff mem Date of Fall Location of Fall: Primary Symptom prior to fall: (please tick one) Otto	able to identify					_		
Date of Fall Location of Fall: Primary Symptom prior to fall: (please tick one) Otto	able to identify				-			
Location of Fall: Primary Un Symptom prior to fall: (please tick one) Ott	sual impairment			Time o				
Primary Symptom prior to fall: (please tick one) Un Vis Ott	sual impairment				of Fall			
Symptom prior to fall: (please tick one) Vis	sual impairment							
to fall: (please tick one) Oti			Unwell		Behavioural change	2		
tion one)	her		Dizziness/loss of		Dementia (Usual st	ate)		
Accesementafinium			Details:					
Assessmentorinjury	1					Tick &	Initial	
	sponsive as normal							
consciousness	ss responsive than usual							
Un	responsive or unconscious		DIAL 999					
Pain/Discomfort No	evidence of pain/discomfor	rt						
Mil	ld pain/discomfort							
Se	vere pain/ discomfort							
Where is the Pain (if any)?								
Injury or wounds No	evidence of injury, bleeding	g or wo	unds					
Sli	ght or mild injury							
Ev	idence of significant swellin	g, bruis	ing, bleeding, or defor	mity of I	imbs			
Where is the injury?								
	le to move all limbs as nom	nal for t	he resident					
mobility Ab	le to move limbs but has pa	in on n	novement					
Un	able to move limbs or there	is a ma	ajor change in mobility					
Observations								
News score	Glasgow Coma Score		Blood sugar			Tick &	sign	
Conclusion of assess	ment					Tick &	Initial	
	ek or provide appropriate tr	eatmen	t					
injury or minor injury	mplete NEWS 2 score and act	on scor	e as appropriate					
Co	mmence neuro observations if ign of deterioration call for assis				n of trauma to head –			
Info	orm relatives							
Co	mplete incident form (recor	d Datix	(Number)					
Re	view Falls Assessment							
Major injury Giv	ve first aid/ resuscitate CALL	999 - 0	O NOT MOVE PATIE	NT				
	mplete NEWS2 score and act		as appropriate					
Co	mmence Neuro observation	5						
Infe	orm relatives							
Co	mplete Incident form (recor	d Datix	number)					
Re	peat falls assessment							_
INDICATE OUTCOME:	Continue to manage		Call for assistance		Call 999		Other:	

Call for assistance (Call Doctor)

Call 9-999

Appendix 12 - Sample copy of the SWARM – algorithm for post falls and reporting head injuries

	and Care ndation Trust			
At		Name:		
Risk of Falling		Date of Birth:	DD/MM/YYYY	
2	t Falls	MRN Number:		
Post Falls SWARM		NHS Number:		
344	AINI	(OR AFFIX HOSPITA	AL LABEL HERE)	
Date		Time		
Completed by Location of incident (ward/a	urea)	Job title		
Environmental Factors				
Specific location details Consider potential issues:				
Condition of floor?				
Furniture involved? Lighting?				
Other?				
Patient Factors Specific patient details	Delirium?		Sensory impairment?	
•	Y D N D		Y D N D	
	Cognitive in Y □ N □		UTI/LRTI? Y D N D	
Patient account			<u> </u>	
Witness account				
Consider other potential				
issues: Walking aid?				
Footwear?				
Post-op patient? /Anaesthetic block?				
Related to bathroom/toileting Falls Prevention Care Plan in				
place with completed actions?	?			
'At risk of falls' sign in place!	?			
Staff/Team Factors Specific ward details	Bed occupan	cy (%)		
Consider potential issues:				
Staffing ratios?				
OST FALLS SWARM FORM				
king together always	s improvina	respectful and	kind making a	
king together fathay.	o improving	respectiatana	rkina į making c	
117				
Where were staff? Other issues on ward?				
Nursing comments?				
Analysis and Plan Incident recorded on Datix?		Completed Safety	v Cross?	
Y □ N □		Y D N D	y C1055!	
Post Falls Protocol followed?		Reviewed Falls P	revention Care Plan?	
		Y D N D		
Y D N D		1		
Root Cause		Plan		
		Plan		
		Plan		
		Plan		