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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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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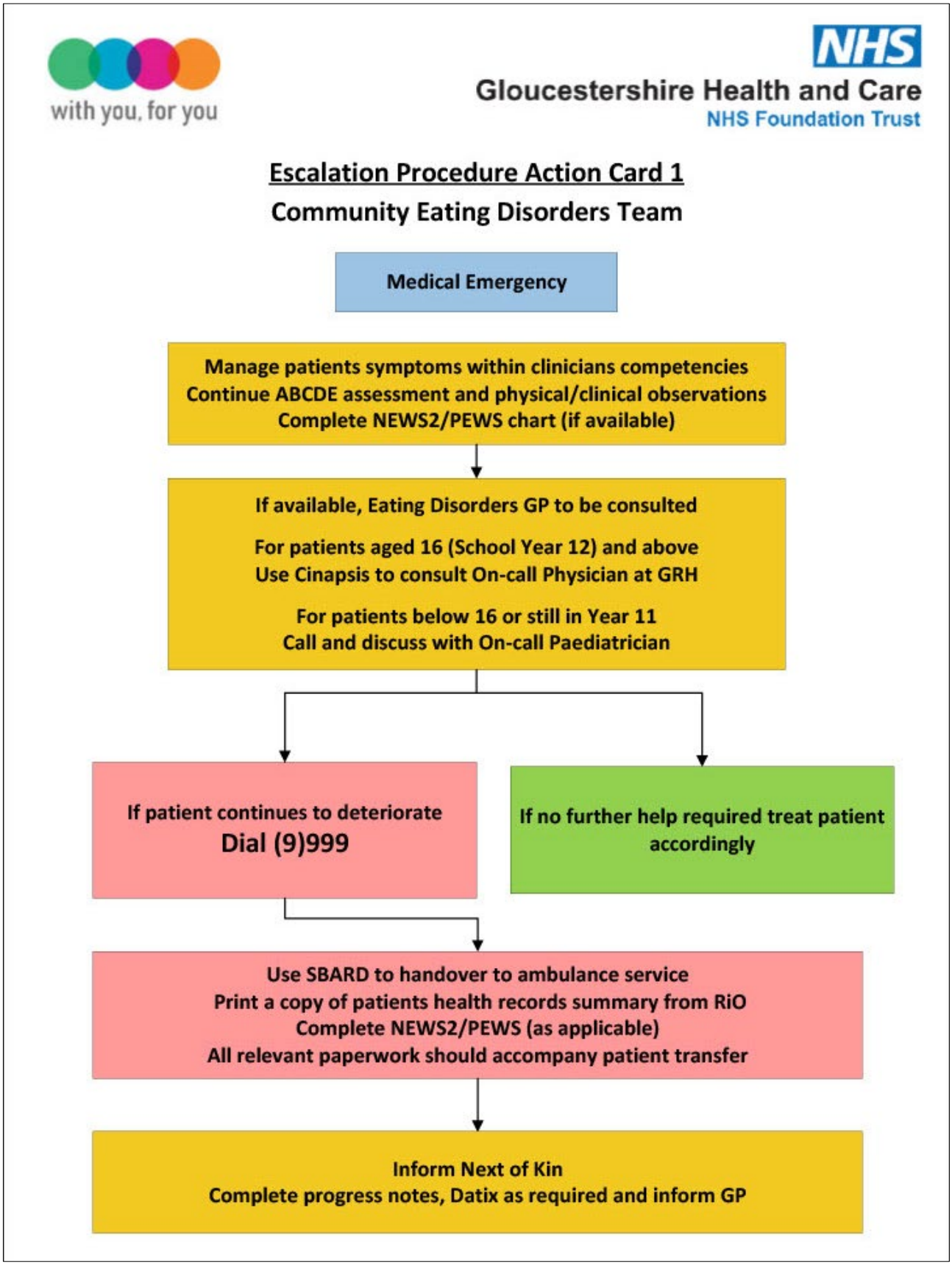
Attachments	Restore 2 Mini attachments	

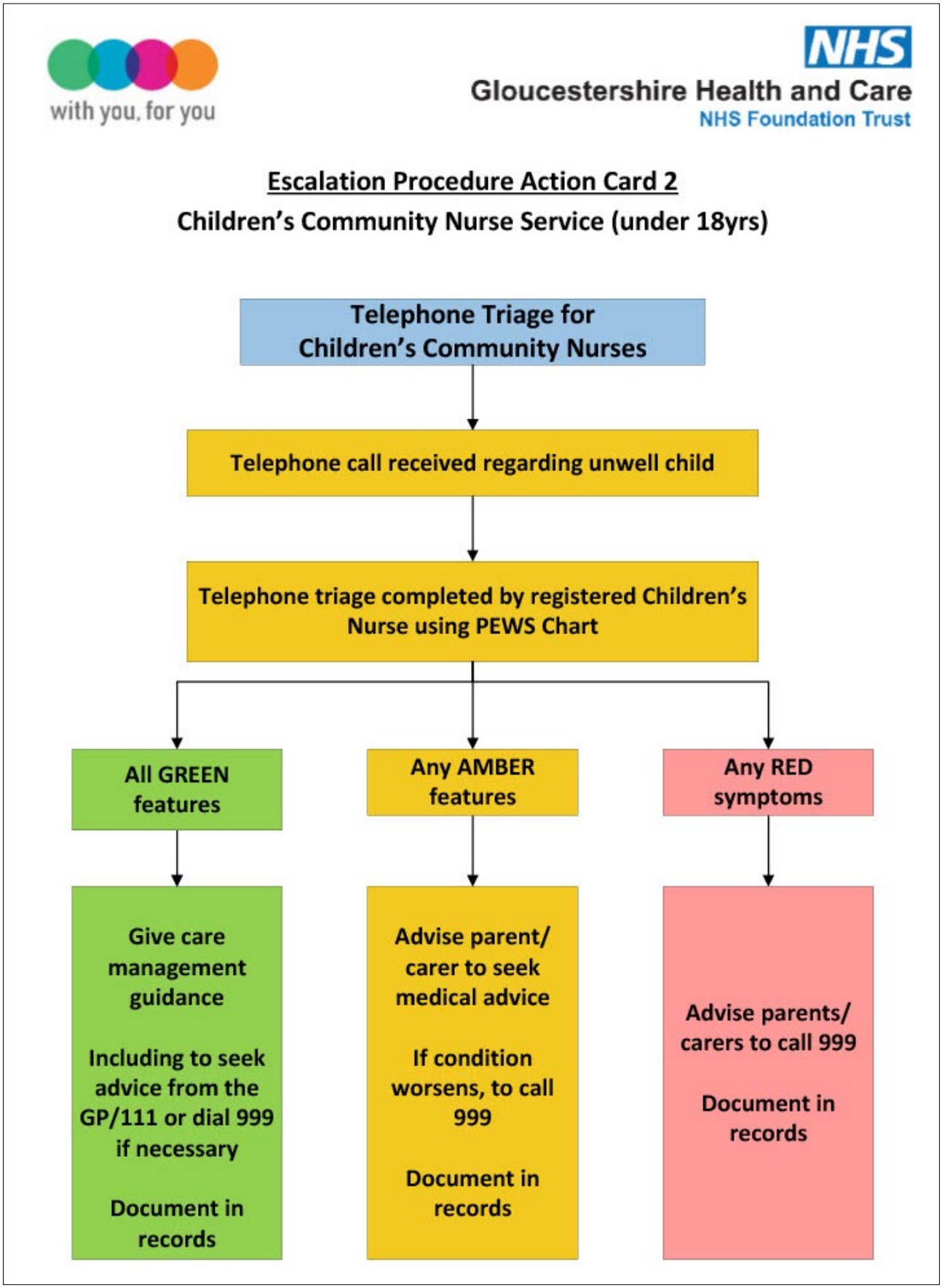
ABBREVIATIONS

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

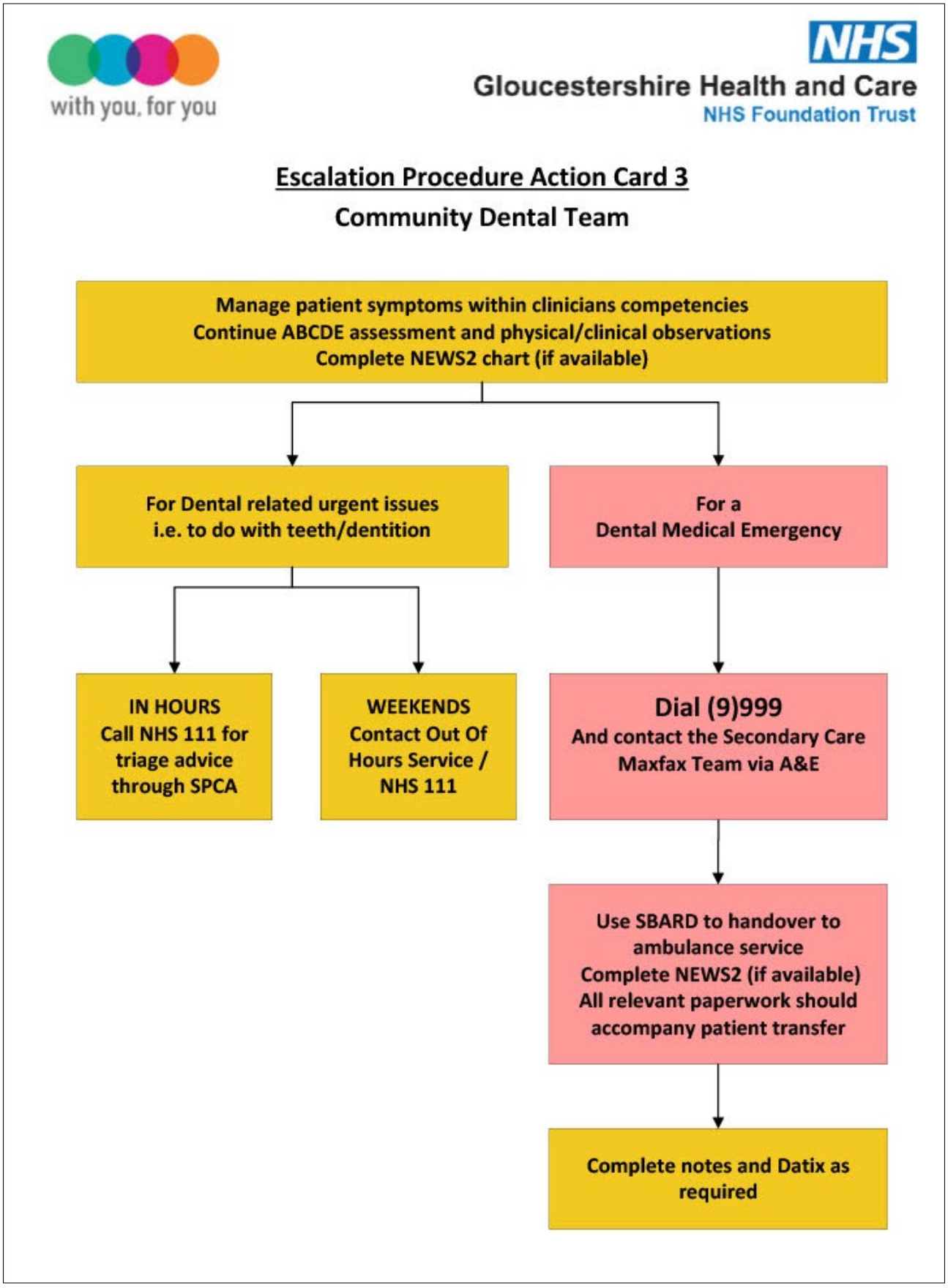
Escalation Procedure Action Card 1 - Community Eating Disorders Team



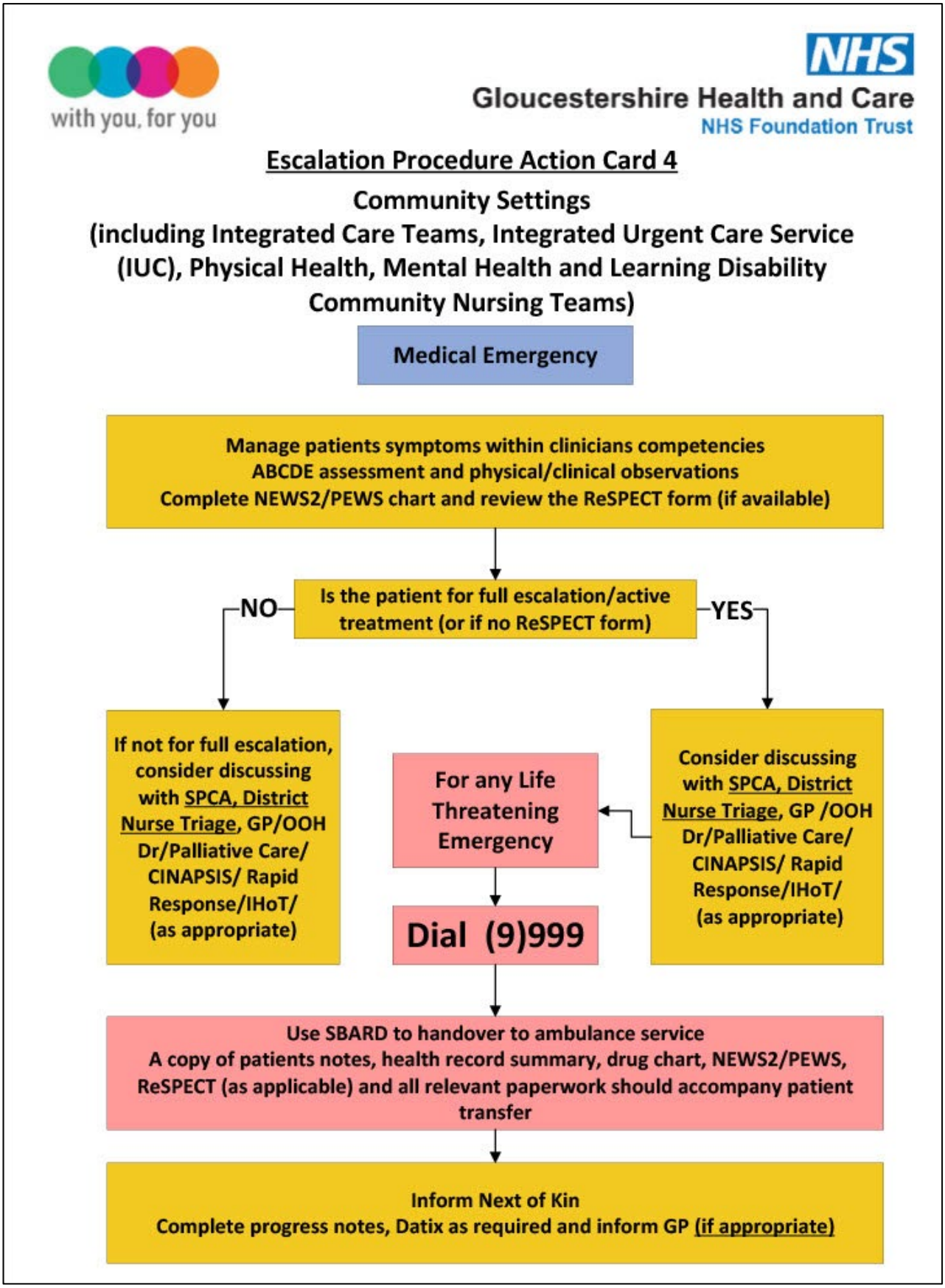
Escalation Procedure Action Card 2 - Children's Community Nurse Service



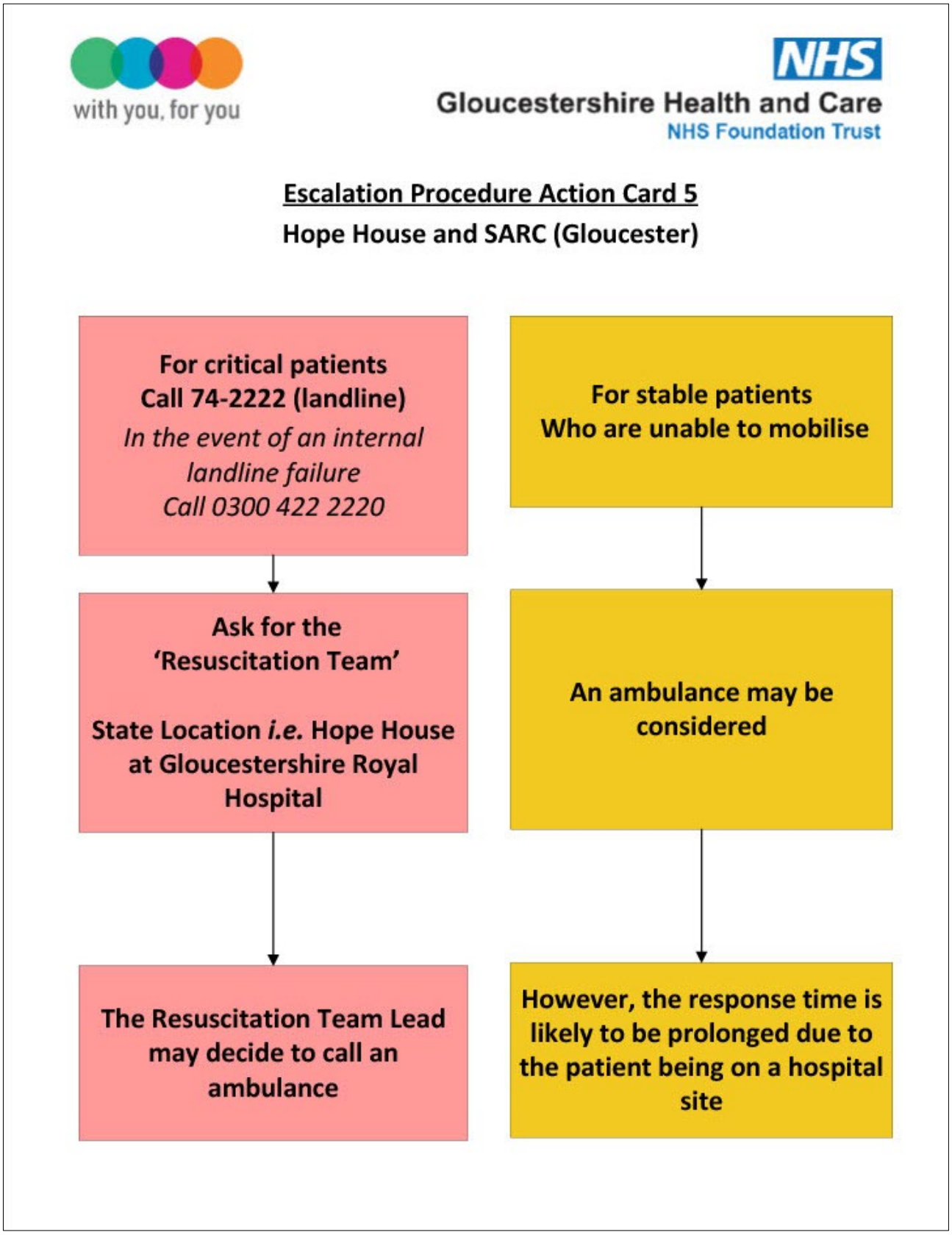
Escalation Procedure Action Card 3 - Community Dental Team



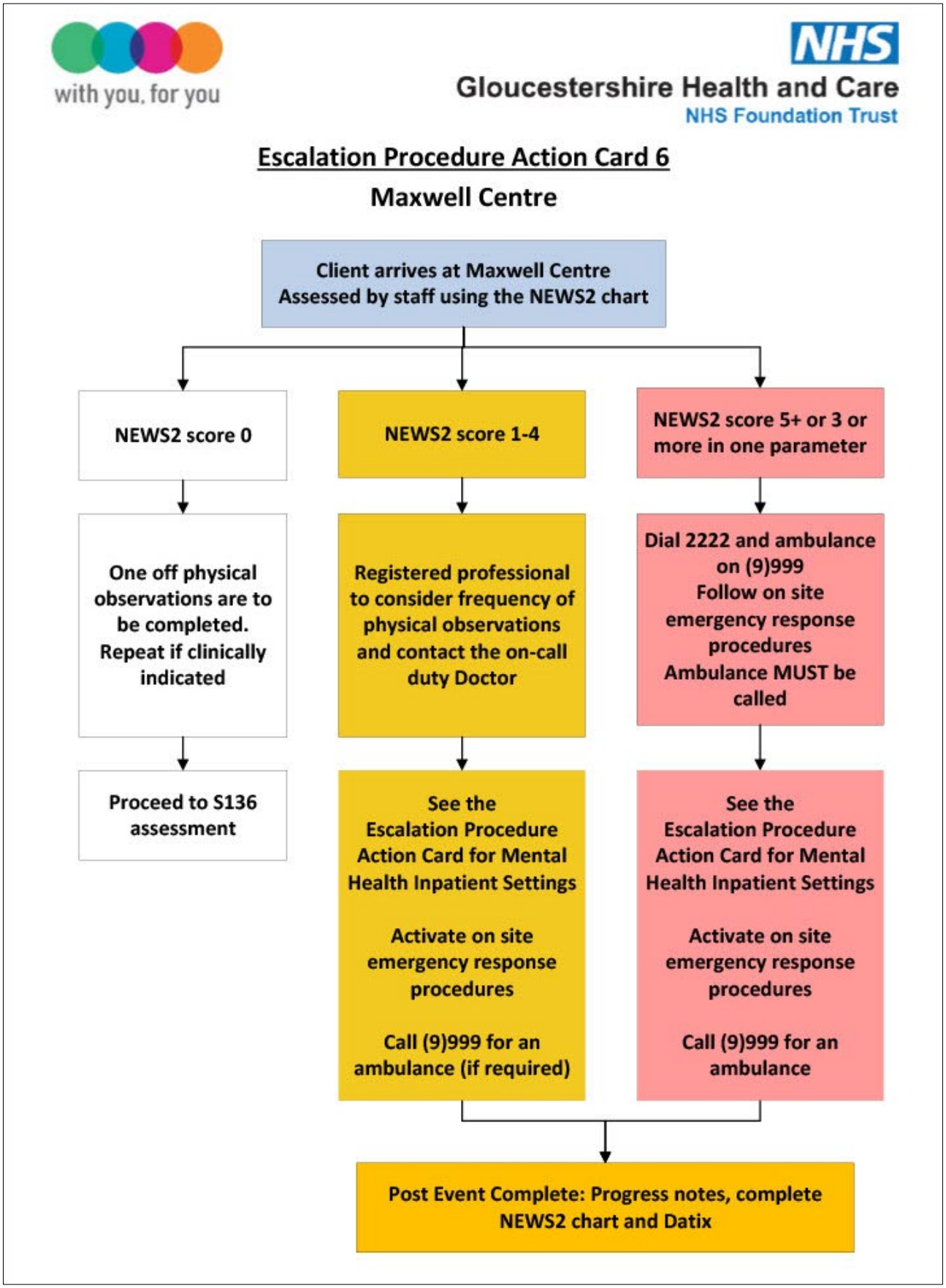
Escalation Procedure Action Card 4 - Community Settings including Integrated Urgent Care (IUC)



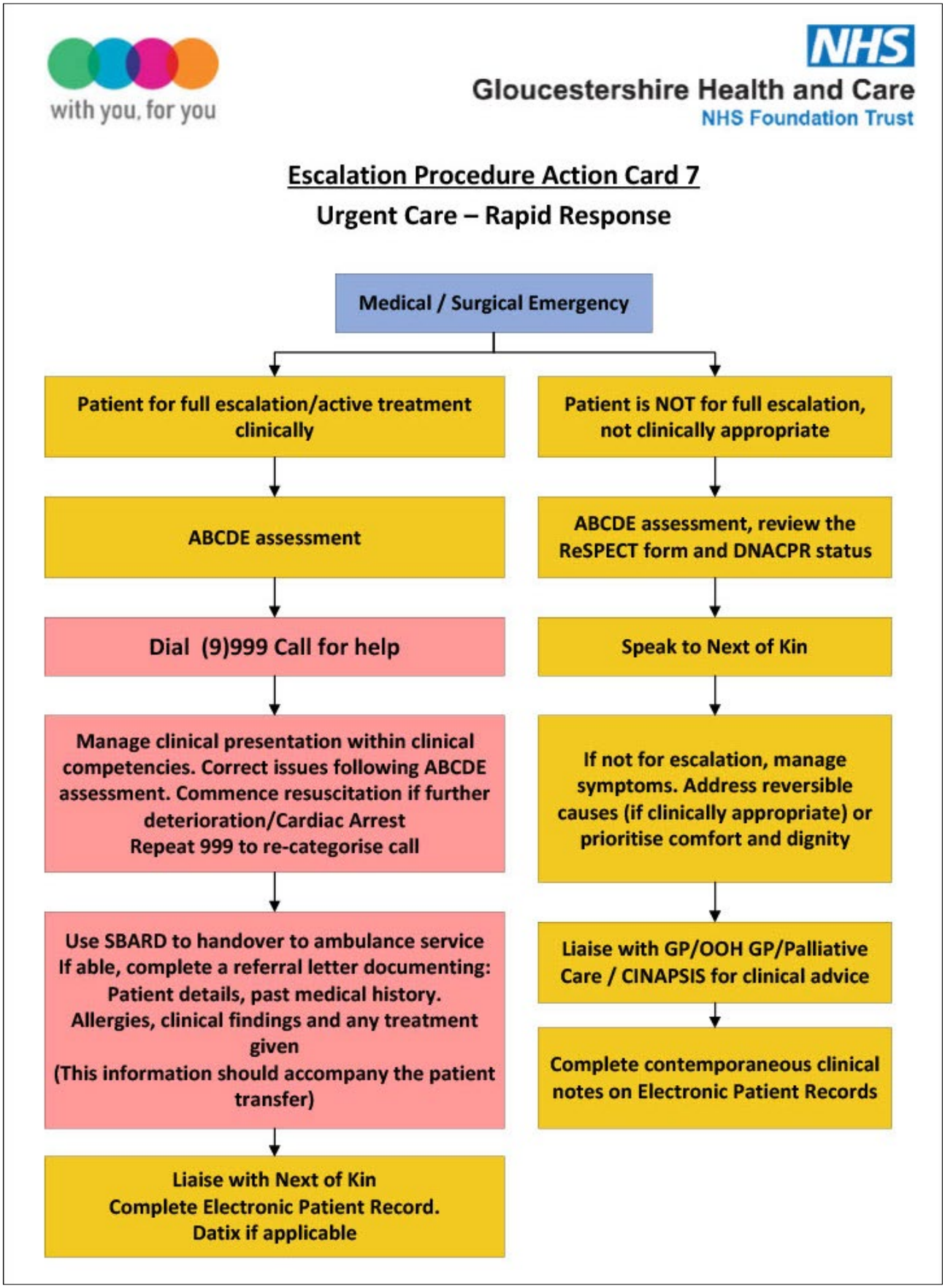
Escalation Procedure Action Card 5 - Hope House and SARC



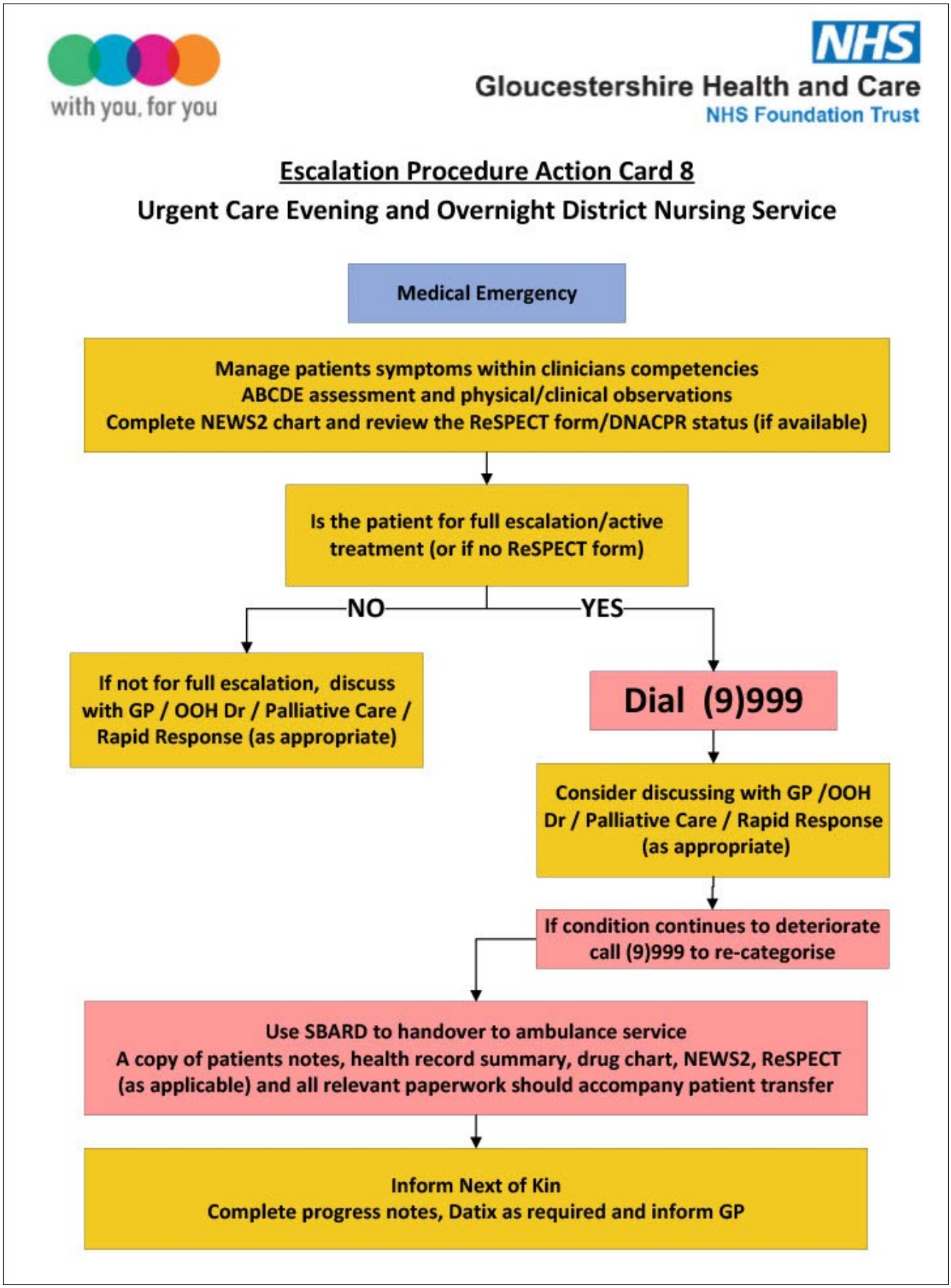
Escalation Procedure Action Card 6 - Maxwell Centre



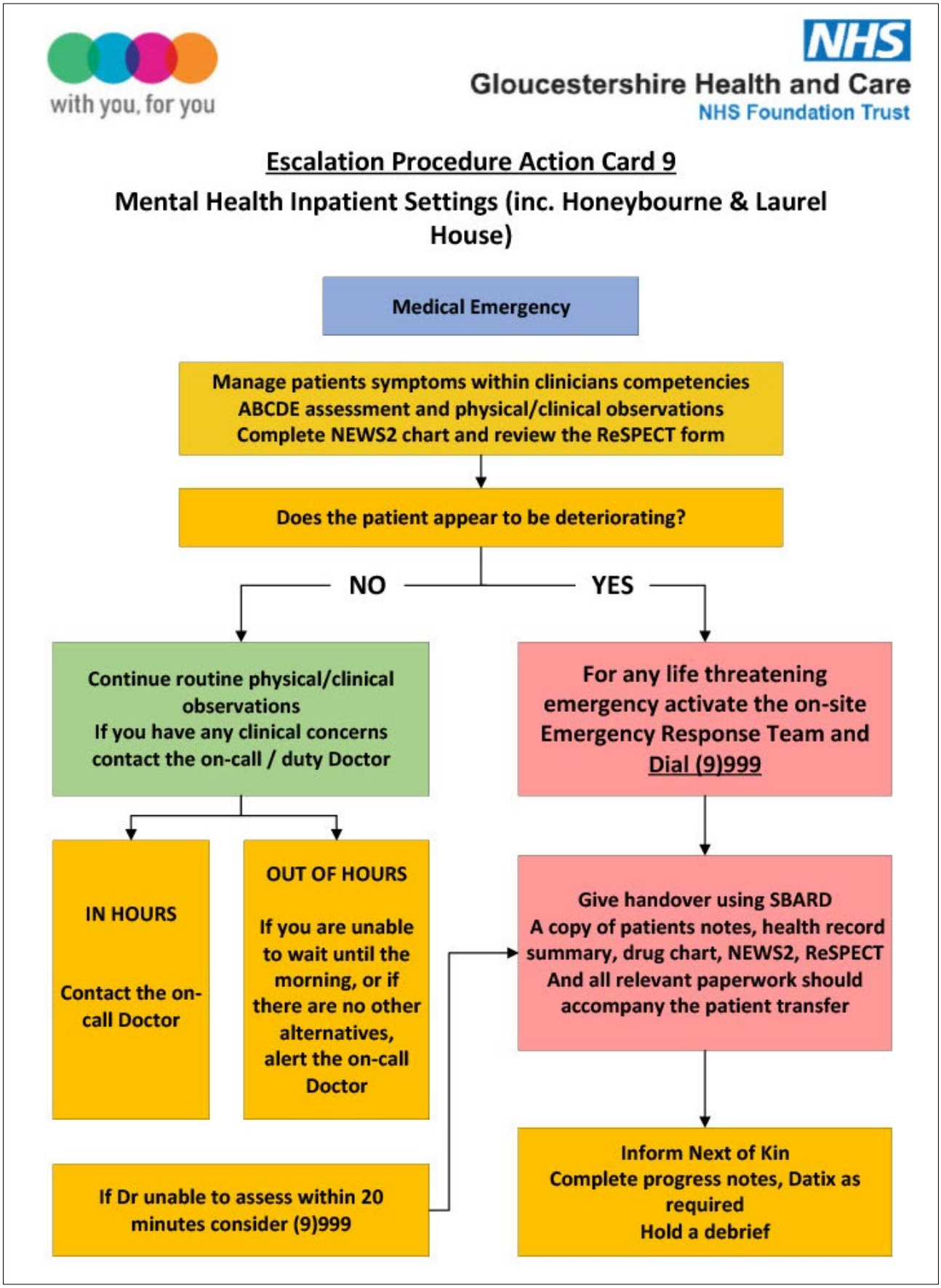
Escalation Procedure Action Card 7 - Urgent Care Rapid Response



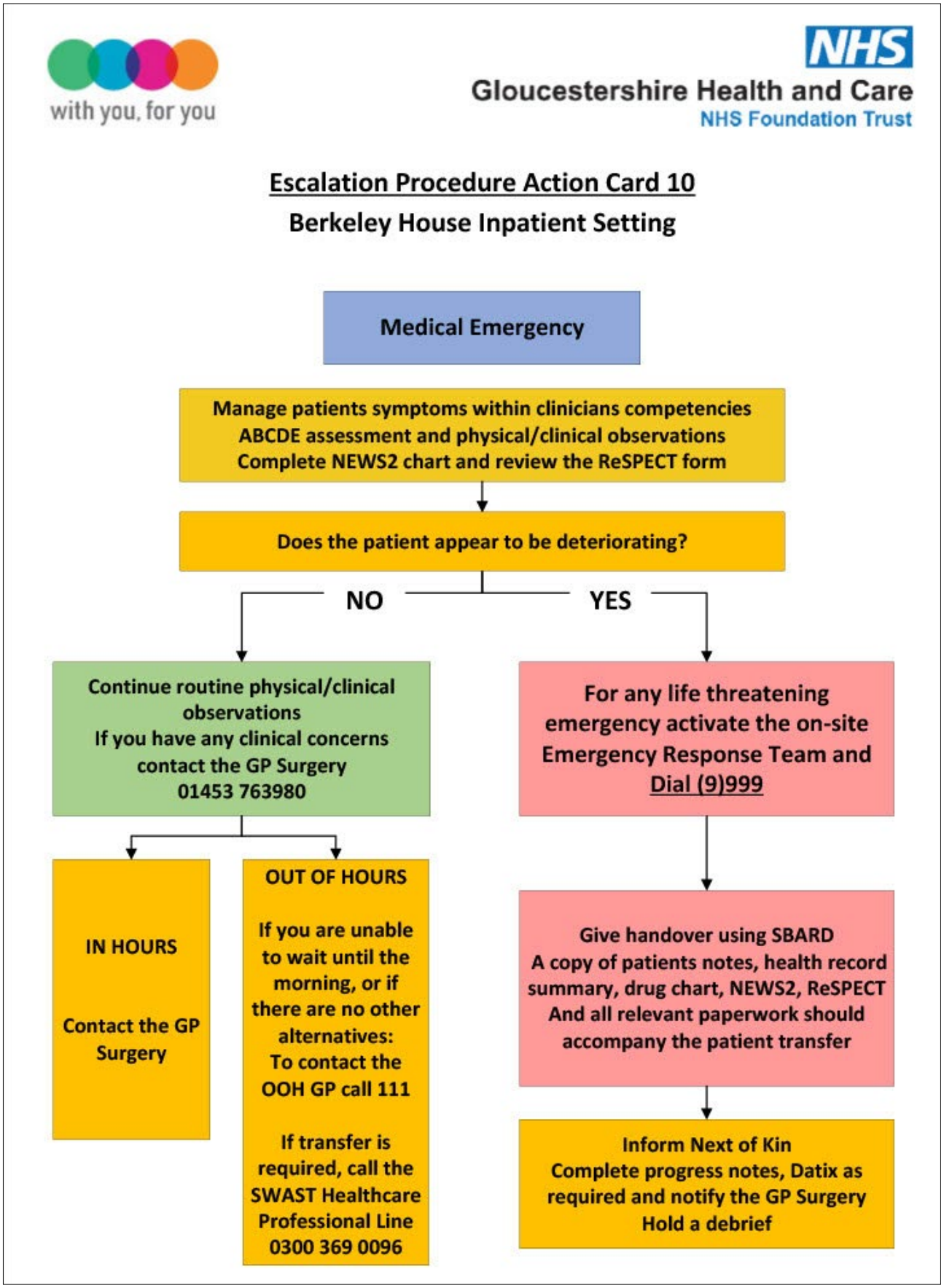
Escalation Procedure Action Card 8 - Urgent Care and Overnight District Nursing Service



Escalation Procedure Action Card 9 - Mental Health Inpatient Settings



Escalation Procedure Action Card 10 – Berkeley House



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

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Escalation Procedure Action Card 11

Charlton Lane and Wotton Lawn Hospital

What to do when there is a delay in an ambulance arriving for a patient outside the expected time frame and you are concerned

To escalate to SWAST ambulance service, ring the HCP SWAST escalation line on 0300 369 0096

IN HOURS?

Also inform the senior manager present at Wotton Lawn or Charlton Lane Hospital

OUT OF HOURS?

Contact the mental health clinical on-call manager via switchboard or pager 07623 911832

If there are any medical concerns,
Discuss with the duty doctor on call at any time

There are two ways to contact duty doctor:

Via on call mobile on 07826 874906
Or
Duty doctor pager on 07623 908410

If you are having trouble getting through to the duty doctor, escalate to mental health clinical on-call manager as above

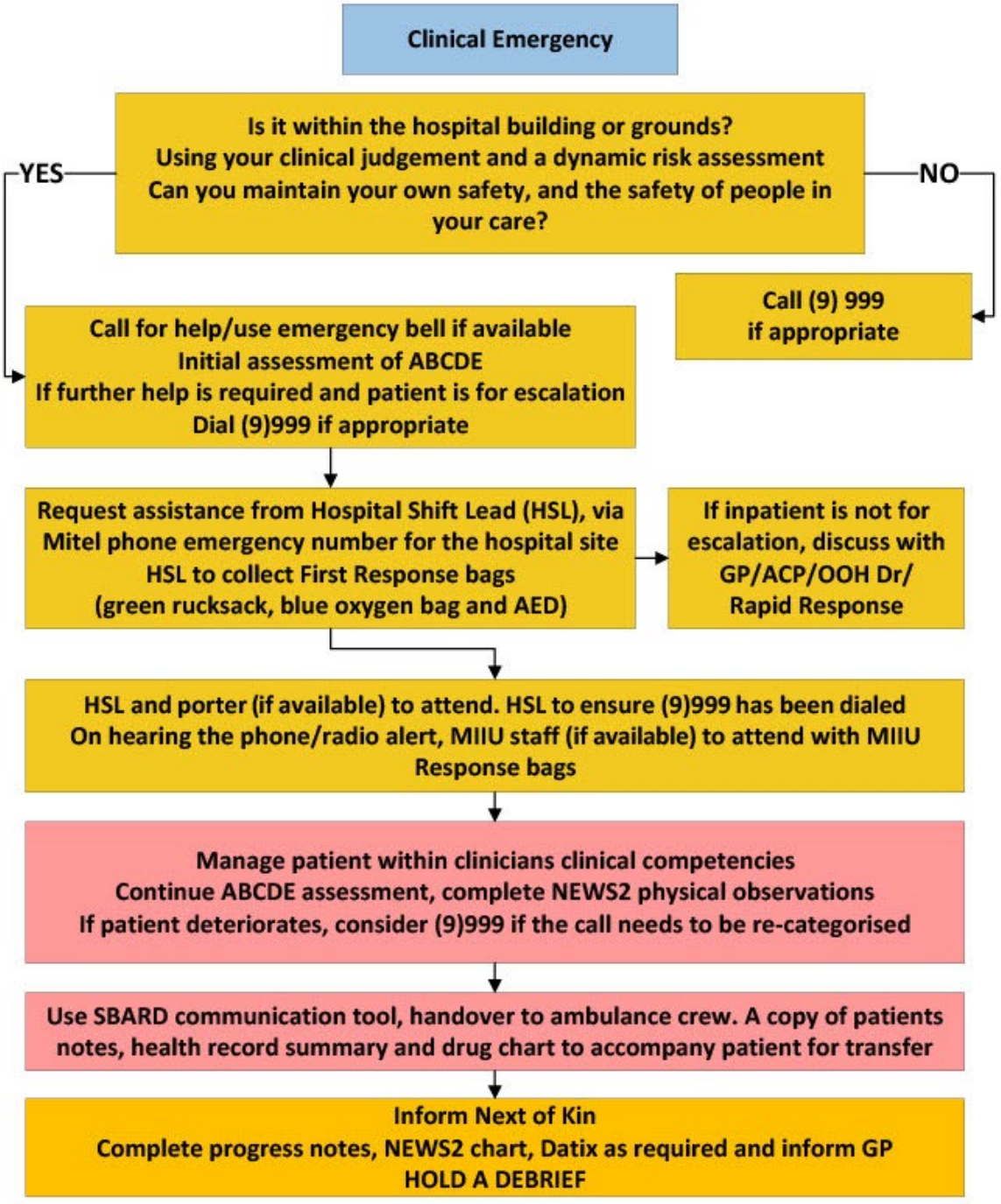
Escalation Procedure Action Card 12 - Physical Health Community Hospital Sites

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Escalation Procedure Action Card 12

Physical Health Community Hospitals Site Escalation



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

Escalation Procedure Action Card 13 - PEWS – GHC MIiU Escalation Level

ESCALATION LEVEL		LOW (L)	MEDIUM (M)	HIGH (H)	EMERGENCY (E)
TRIGGER CRITERIA: Respond as per the highest level based on CHANGE in ANY ONE of these criteria	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 'Pain' or 'Unresponsive' OR abnormal pupillary response
	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 that 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**
Remove clothing (rash), consider Urinalysis/fluid intake/urine output and check blood glucose					
Communication and Response • Situation • Background • Assessment • Recommendation • Decision		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**
Review Timings / Observations		Nurse/clinician must reassess within 60 minutes (and document ongoing plan)	Within 30 minutes	Within 15 minutes	Continuous monitoring
FOR EMERGENCY OR LIFE-THREATENING SITUATIONS: CALL (9) 999					

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

5.1 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.

6.2 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 line with national, regional, trust or local requirements?	YES

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 Duty of Candour Policy 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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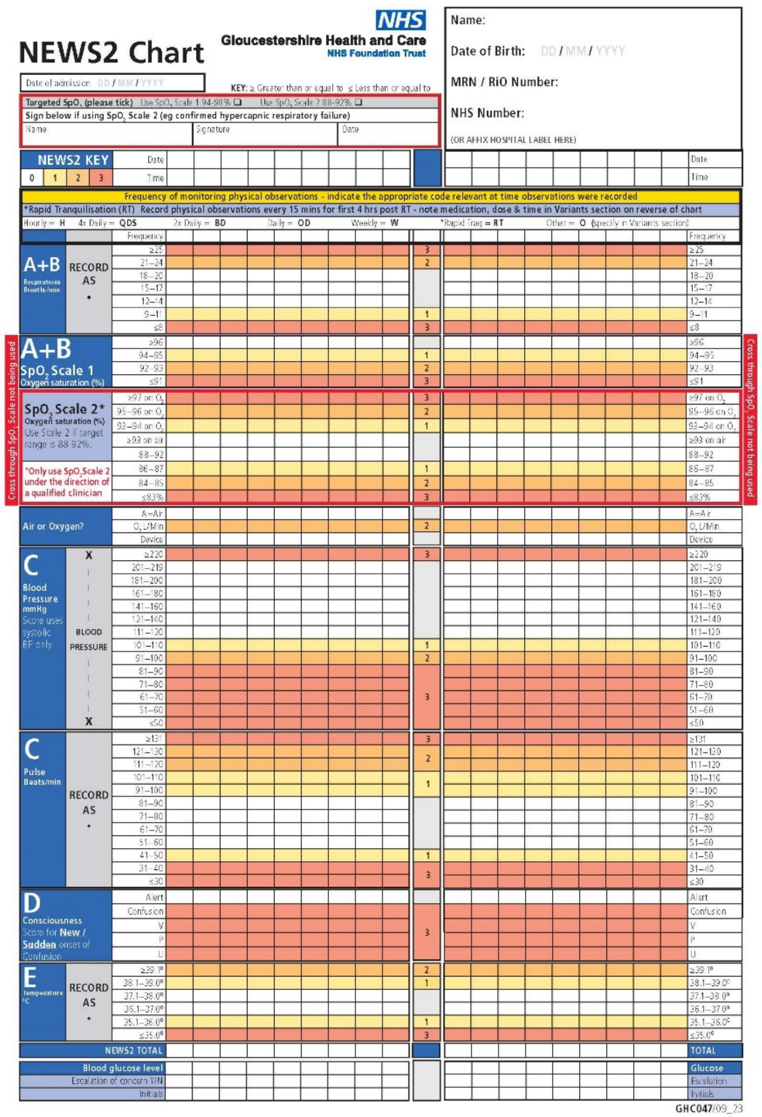
12. ASSOCIATED DOCUMENTS

- 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 NEWS2	Please document action and further comments below (Give reason for any 'refusals')	Staff name



NEWS2 Score	Frequency of monitoring	Clinical response
LOW RISK 0	Continue with routine monitoring	Continue routine monitoring and observe for any clinical changes
Total 1-4 *Consider Sepsis*	Increase frequency of physical observations	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, Out Of Hours or Rapid Response-Red Team Lead (0300 421 6570). Use SBARD to handover
LOW-MEDIUM RISK 3 in single parameter *Consider Sepsis*	Increase frequency of physical observations to a Minimum 4 hourly Consider increasing frequency of physical observations as necessary.	Registered Practitioner to discuss with either: Medical Team, Out Of Hours or Rapid Response-Red Team Lead (0300 421 6570). Use SBARD to handover
MEDIUM RISK Total 5-6 Complete Sepsis Screening Tool	Increase frequency of physical observations to a Minimum 1 hourly SEPSIS REG FLAG SIGNS Slurred speech Extreme shivering/muscle pain Passing no urine (in a day) Severe breathlessness "I feel like I might die" Skin mottled/discoloured Refer to the Sepsis Screening Tool	Registered Practitioner to **immediately** seek urgent medical review/advice. If applicable refer to ReSPECT form. 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) Use SBARD to handover Initiate emergency response and call (9)999 if transfer of patient is required
HIGH RISK Total 7 or more	Continuous monitoring of patient's physical observations Refer to the Sepsis 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. 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) Use SBARD to handover

If a decision is made to deviate from the clinical response guidance above,this MUST be documented in the patient's progress notes and care plan with a rationale for the decision.

Nothing in this scheme should prevent a Practitioner making an appropriate response based upon their clinical judgement.

Variants:	Registered Practitioner to detail any variation in specific NEWS2 parameters:

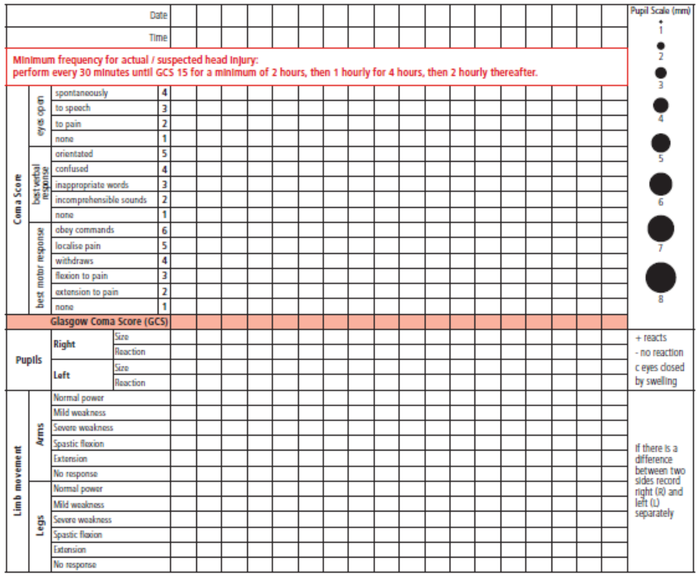
Print name	Signature	Date	Review date
		DD / MM / YYYY	DD / MM / YYYY

SBARD - Situation, Background, Assessment, Recommendation, Decision	
Situation	State name, position and location. patients details, reason for calling
Background	Any recent relevant events, eg: MHA status, date & reason for admission, medical history, medications, investigations/treatments
Assessment	NEWS2 score, ABCDE assessment, clinical concerns
Recommendation	Be specific, explain what you need, make suggestions, clarify expectations
Decision	Record what has been agreed in the patients progress notes

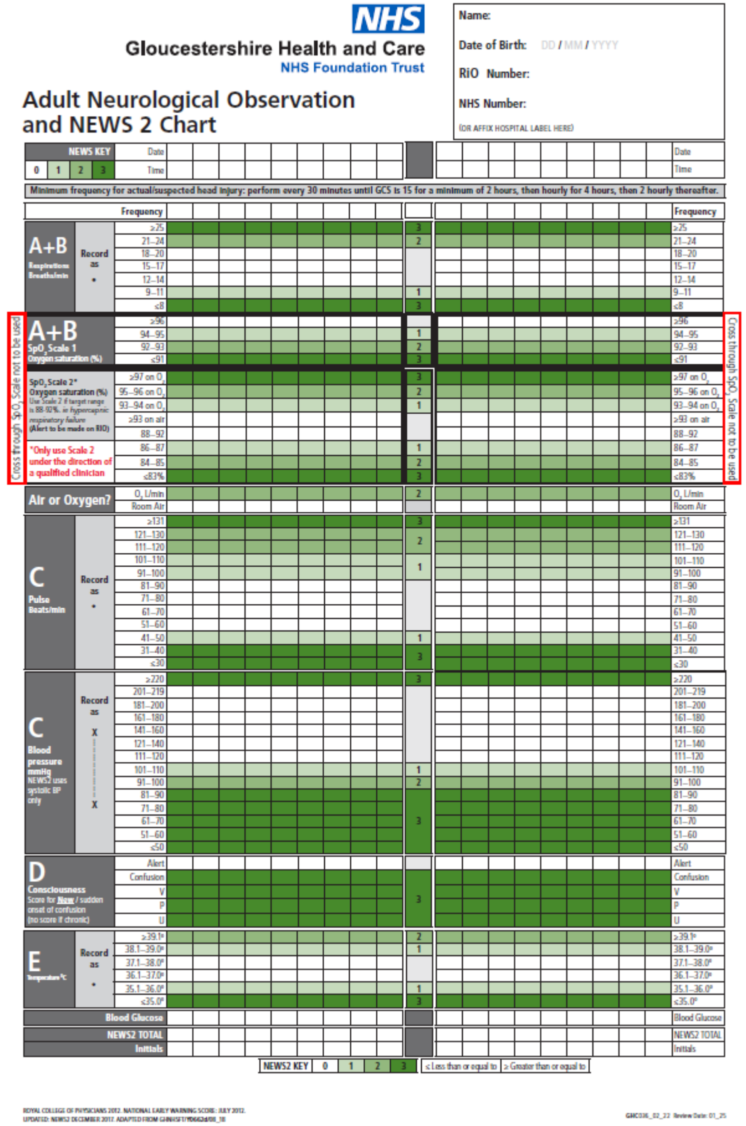
Physiological Parameter	3	2	1	0	1	2	3
Respiration rate	≤8		9-11	12-20		21-24	≥25
SpO, Scale 1	≤91	92-93	94-95	≥96			
SpO, Scale 2	≤83	84-85	86-87	88-92 ≥93 on air	93-94 on oxygen	95-96 on oxygen	≥97 on oxygen
Air or Oxygen		Oxygen		Air			
Systolic BP (mmHg)	≤90	91-100	101-110	111-219			≥220
Pulse	≤40		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 document action and further comments below (Give reason for any 'refusals')	Staff name

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



NEWS2 Score	Frequency of monitoring	Clinical response
LOW RISK 0	**Continue with routine monitoring**	Continue routine monitoring and observe for any clinical changes
Total 1-4 *Consider Sepsis*	**Increase frequency of physical observations**	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, Out Of Hours or Rapid Response-Red Team Lead (0300 421 6570). **Use SBARD to handover**
LOW-MEDIUM RISK **3 in single parameter** *Consider Sepsis*	**Increase frequency of physical observations to a <u>Minimum 4 hourly</u>** Consider increasing frequecy of physical observations as necessary.	Registered Practitioner to discuss with either: Medical Team, Out Of Hours or Rapid Response-Red Team Lead (0300 421 6570). **Use SBARD to handover**
MEDIUM RISK **Total 5-6** **Complete Sepsis Screening Tool**	**Increase frequency of physical observations to a <u>Minimum 1 hourly</u>** SEPSIS REG FLAG SIGNS Slurred speech Extreme shivering/muscle pain Passing no urine (in a day) Severe breathlessness "I feel like I might die" Skin mottled/discoloured Refer to the Sepsis Screening Tool	Registered Practitioner to **immediately** seek urgent medical review/advice. If applicable refer to ReSPECT form. 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) **Use SBARD to handover** Initiate emergency response and call (9)999 if transfer of patient is required
HIGH RISK **Total 7 or more**	**<u>Continuous monitoring</u> of patient's physical observations** Refer to the Sepsis 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. 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) **Use SBARD to handover**



Appendix 3 – GHC055 Non-Contact Physical Observations

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Non-Contact Physical Observations

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

Name:	Date of birth:

If any statement from the red box is true, raise the alarm and DO NOT leave the patient

Airway
- Airway obstructed? Silence? Coughing? Swelling? Gurgling?
- Risk of vomiting.
  Consider moving onto their side into the recovery position and carry out constant observations to prevent choking.

Breathing
- Noisy or difficult breathing even with an open airway.
- Breathing rate is more than 20 breaths per minute.
- Breathing rate is less than 12 breaths per minute.
  Consider: COPD hypercapnic respiratory failure, asthma, heart failure

Circulation
- Change in ability to mobilise.
- Pale or flushed, clamming, sweating, cold, swollen, blue tinge to skin.
- Dehydrated and / or malnourished.
- Trauma / bleeding.

Disability
- Unresponsive.
- Unexpected sleepy/drowsy, confusions, fitting.
- Pain, only responds to physical stimulus.
  Consider checking all observations including blood glucose level and epilepsy.

Airway
- Talking (not just moans and groans).
- Airway clear.

Breathing
- Breathing is quiet and regular.
- Breathing between 12-20 breaths per minute.
  Breathing causes no extra effort of difficulty e.g. no wheezing or gurgling.

Circulation
- Mobility normal.
- Presenting as normal.
- Warm, pink skin, comfortable presentation.

Disability
- Alert and orientated.
- Responsive to voice responding to voice could indicate a decrease in level of consciousness.
- Drinking & eating.
- Active.

Exposure
- Monitor and record findings and visual observations using the non-contact physical observations.
  Consider additional monitoring for asthma, diabetes, epilepsy, intoxication etc., medication side effects.

working together | always improving | respectful and kind | making a difference

Patient Name .... DOB .... NHS No		If any RED statements are triggered overleaf, tick the relevant A, B, C, D or E box below. Note your concerns to red trigger in larger box provided (include escalations, support, monitoring and outcomes)						Name, Signature and Role
		A	B	C	D	E		
Date / Time	All green statements? (Circle if true)							
Date / Time	All green statements? (Circle if true)							
Date / Time	All green statements? (Circle if true)							
Date / Time	All green statements? (Circle if true)							
Date / Time	All green statements? (Circle if true)							
Date / Time	All green statements? (Circle if true)							
Date / Time	All green statements? (Circle if true)							
Date / Time	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.**

		Key prompts / decisions
S	**Situation** e.g. what's happened? How are they? NEWS2 score if available	
B	**Background** e.g. what is their normal, how have they changed?	
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)	

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

RESTORE2™ mini

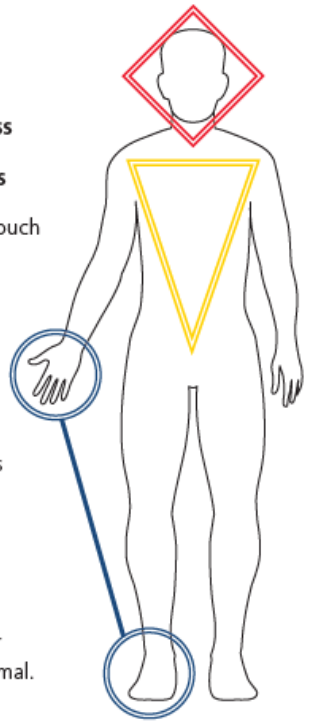
Recognise Early Soft Signs, Take Observations, Respond, Escalate

Ask your resident – how are you today?

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

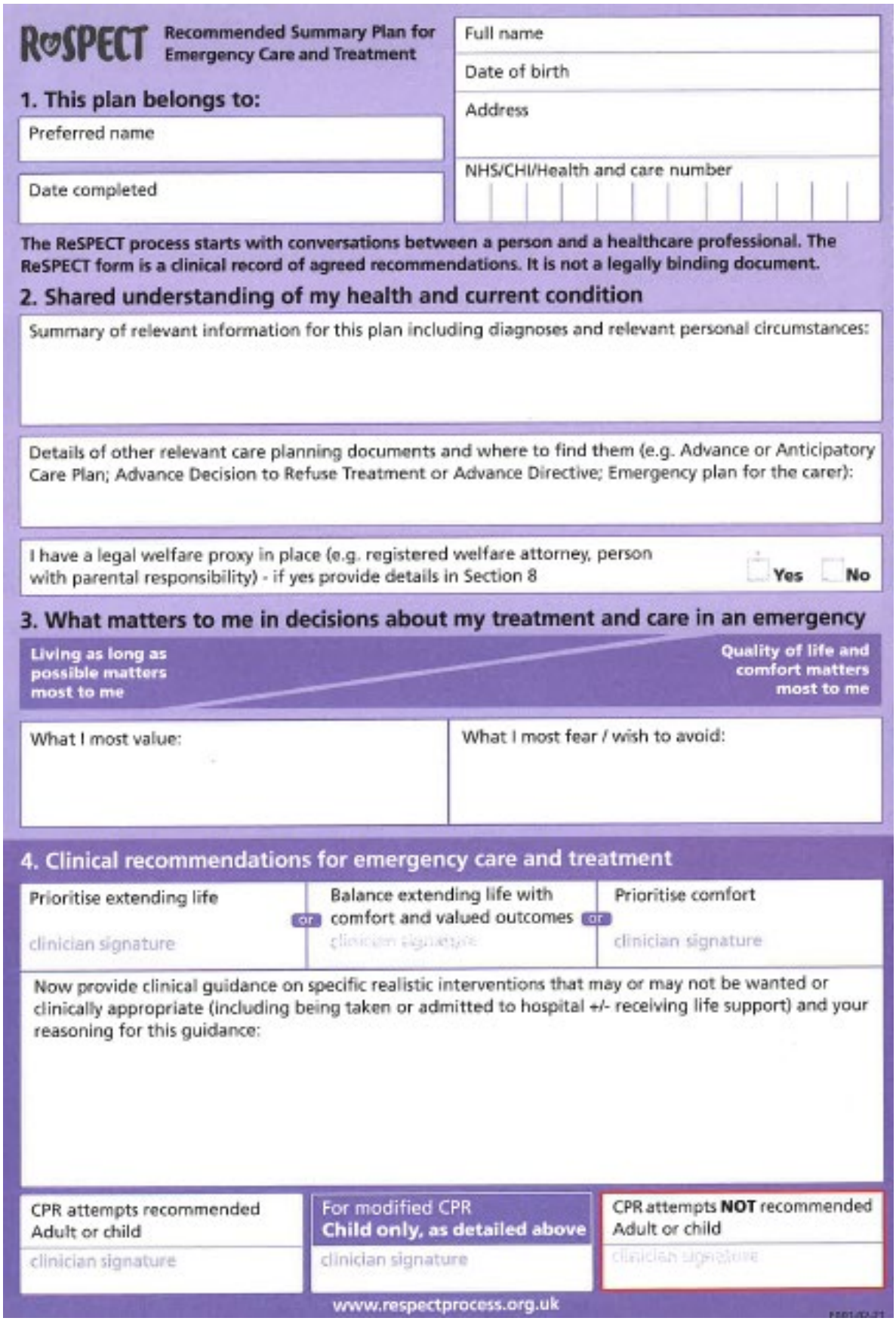
- Increasing **breathlessness** or **chestiness**
- Change in **usual drinking / diet habits**
- A **shivery fever** – feel **hot or cold** to touch
- Reduced mobility – **'off legs'** / less co-ordinated
- New or increased confusion/ agitation / anxiety / pain
- Changes to usual level of **alertness / 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.



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

Appendix 5 - ReSPECT V3



ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name

Date of birth

Address

NHS/CHI/Health and care number

1. This plan belongs to:

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 Anticipatory 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 ☐ Yes ☐ No

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me / **Quality of life and comfort 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

clinician signature

or

Balance extending life with comfort and valued outcomes

clinician signature

or

Prioritise comfort

clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

CPR attempts recommended
Adult or child

clinician signature

For modified CPR
Child only, as detailed above

clinician signature

CPR attempts **NOT** recommended
Adult or child

clinician signature

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5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? Document the full capacity assessment in the clinical record.	☐ Yes ☐ No →	If no, in what way does this person lack capacity? If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.

☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

If this page is on a separate sheet from the first page: **Name:** **DoB:** **ID number:**

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Appendix 6 - SBARD Communication Tool

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S	SITUATION Identify self, environment and person using services. What is happening? Give a concise statement of the problem.
B	BACKGROUND State the pertinent information relating to the situation. What data will help to clarify? – Observations – Early Warning Score – Relevant history
A	ASSESSMENT what do you think is going on? What is your clinical opinion? What are you concerned about?
R	RECOMMENDATION What is your request or recommended action and when is it required?
D	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/ashen/ 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 ill 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 • Oxygen 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: – >160 beats/minute, age <12 months – >150 beats/minute, age 12–24 months – >140 beats/minute, age 2–5 years • CRT ≥3 seconds • Dry mucous membranes • Poor feeding in infants • Reduced urine output	• 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 ≥38°C* • Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures

CRT, capillary refill time; RR, respiratory rate

* Some vaccinations have been found to induce fever in children aged under 3 months

This traffic light table should be used in conjunction with the recommendations in the NICE guideline on fever in under 5s.

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: PEWS – 0 to 11mths National Paediatric Early Warning System Observation and Escalation Chart (GHC071) Sample Copy

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

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

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

Appendix 9 - GHC Page for Age MIiU

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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 **Cardiac arrest** 10 mcg kg^{-1} (or 0.1mL kg^{-1}) 1 in 10:000 solution	**50mcg (0.5ml) 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 (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	**100ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) **Cardiac Arrest** **5mg/kg**	**25mg (0.8ml) after 3rd & 5th 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 3rd & 5th 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 **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**	**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)

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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 ***Cardiac arrest*** 10 mcg kg^{-1} (or 0.1mL $kg^{-1)}$ 1 in 10:000 solution	**70mcg (0.7ml) 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	**140ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) **Cardiac Arrest** 5mg/kg	**35mg (1.2ml) after 3rd & 5th 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 3rd & 5th 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 **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)

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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 ***Cardiac arrest*** 10 mcg kg^{-1} (or 0.1mL kg^{-1}) 1 in 10:000 solution	**90mcg (0.9ml) 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	**180ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) **Cardiac Arrest** 5mg/kg	**45mg (1.5ml) after 3rd & 5th 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 3rd & 5th 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 **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

Page for Age – V3 October 2023 (Chief Pharmacist)

with you, for you

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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 ***Cardiac arrest*** 10 mcg kg^{-1} (or 0.1mL kg^{-1}) 1 in 10:000 solution	**100mcg (1.0ml) 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	**200ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) **Cardiac Arrest** 5mg/kg	**50mg (1.4ml) after 3rd & 5th 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 3rd & 5th 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 **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) 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 – V3 October 2023 (Chief Pharmacist)

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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 ***Cardiac arrest*** 10 mcg kg^{-1} (or 0.1mL kg^{-1}) 1 in 10:000 solution	**110mcg (1.1ml) 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	**220ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) **Cardiac Arrest** 5mg/kg	**55mg (1.8ml) after 3rd & 5th 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 3rd & 5th 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 **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) 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 – V3 October 2023 (Chief Pharmacist)

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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 ***Cardiac arrest*** 10 mcg kg^{-1} (or 0.1mL kg^{-1}) 1 in 10:000 solution	**1200mcg (1.2ml) 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	**240ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) **Cardiac Arrest** 5mg/kg	**60mg (2.0ml) after 3rd & 5th 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 3rd & 5th 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 **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) 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 – V3 October 2023 (Chief Pharmacist)

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 ***Cardiac arrest*** 10 mcg kg^{-1} (or 0.1mL kg^{-1}) 1 in 10:000 solution	**140mcg (1.4ml) 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	**280ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) pfs **Cardiac Arrest** 5 mg/kg	**70mg (2.3ml) after 3rd & 5th 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 3rd & 5th 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 **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) 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 – V3 October 2023 (Chief Pharmacist)

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 ***Cardiac arrest*** 10 mcg kg^{-1} (or 0.1mL kg^{-1}) 1 in 10:000 solution	**160mcg (1.6ml) 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 (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	**320ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) pfs **Cardiac Arrest** 5 mg/kg	**80mg (2.7ml) after 3rd & 5th 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 3rd & 5th 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 **A**irway/ **B**reathing/ **C**irculation 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 – V3 October 2023 (Chief Pharmacist)

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)

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 ***Cardiac arrest*** 10 mcg kg^{-1} (or 0.1mL kg^{-1}) 1 in 10:000 solution	**180mcg (1.8ml) 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 (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	**360ml** Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs **Cardiac Arrest** 5 mg/kg	**90mg (3ml) after 3rd & 5th 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	**90mg (1.8ml) after 3rd & 5th 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 **A**irway/ **B**reathing/ **C**irculation 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 – V3 October 2023 (Chief Pharmacist)

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)

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 3rd & 5th 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 3rd & 5th 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 **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**	**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 – V3 October 2023 (Chief Pharmacist)

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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 0r 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 (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	**460ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) **Cardiac Arrest** 5 mg/kg	**115mg (3.8ml) after 3rd & 5th 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 3rd & 5th 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 **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**	**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 – V3 October 2023 (Chief Pharmacist)

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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 (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	**500ml** Given over less than 10 minutes
Amiodarone I.V (300mg/10ml) **Cardiac Arrest** 5 mg/kg	**130mg (4.3ml) after 3rd & 5th 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 3rd & 5th 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 **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**	**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 – V3 October 2023 (Chief Pharmacist)

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)

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 ***Cardiac arrest*** 10 mcg kg^{-1} (or 0.1mL kg^{-1}) 1 in 10:000 solution	**270mcg (2.7ml) 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	**500ml** Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs **Cardiac Arrest** 5 mg/kg	**145mg (4.8ml) after 3rd & 5th 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 3rd & 5th 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 **A**irway/ **B**reathing/ **C**irculation problems persist
Glucagon I.M (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**	**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 – V3 October 2023 (Chief Pharmacist)

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 (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	**500ml** Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs **Cardiac Arrest** 5 mg/kg	**150mg (5.0ml) after 3rd & 5th 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 3rd & 5th 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 **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**	**1mg 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) 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 – V3 October 2023 (Chief Pharmacist)

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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)

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 (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	**500ml** Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs **Cardiac Arrest** 5 mg/kg	**175mg (5.8ml) after 3rd & 5th 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	**175mg (3.5ml) after 3rd & 5th 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 **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**	**1mg as a single dose** 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 – V3 October 2023 (Chief Pharmacist)

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)

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 (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	**500ml** Given over less than 10 minutes
Amiodarone I.V 300mg/10ml pfs **Cardiac Arrest** 5 mg/kg	**190mg (6.3ml) after 3rd & 5th 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 3rd & 5th 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 **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**	**1mg 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) 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 – V3 October 2023 (Chief Pharmacist)

with you, for you

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Page for Age over 12 years of age

(Drug doses are based on Resuscitation 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 **Suspected/confirmed anaphylaxis**	**If child is small pre-pubertal give: 300mcg (0.3ml)** **If child not small give: 500mcg (0.5ml)** 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**	**1mg as a single dose** 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

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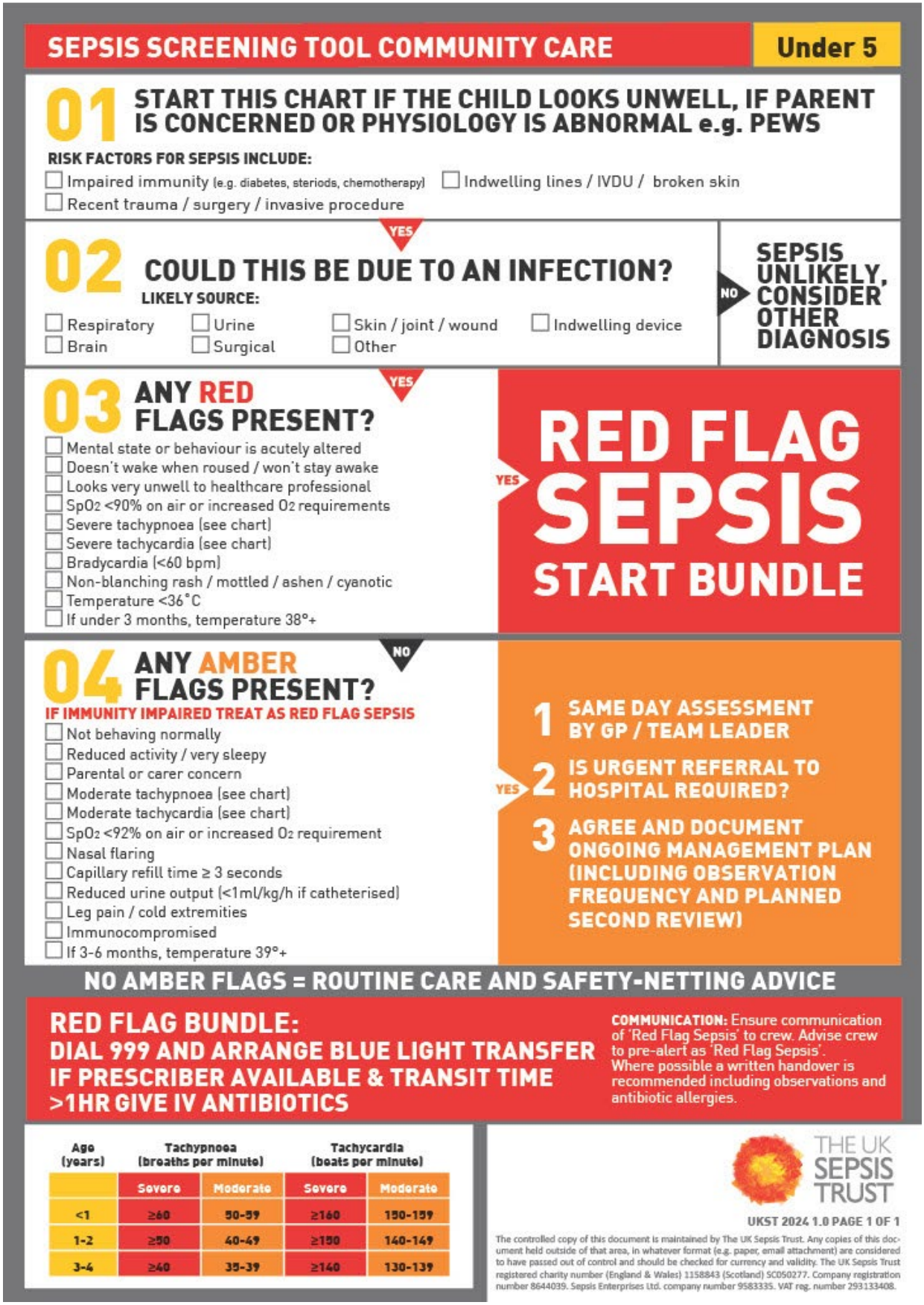
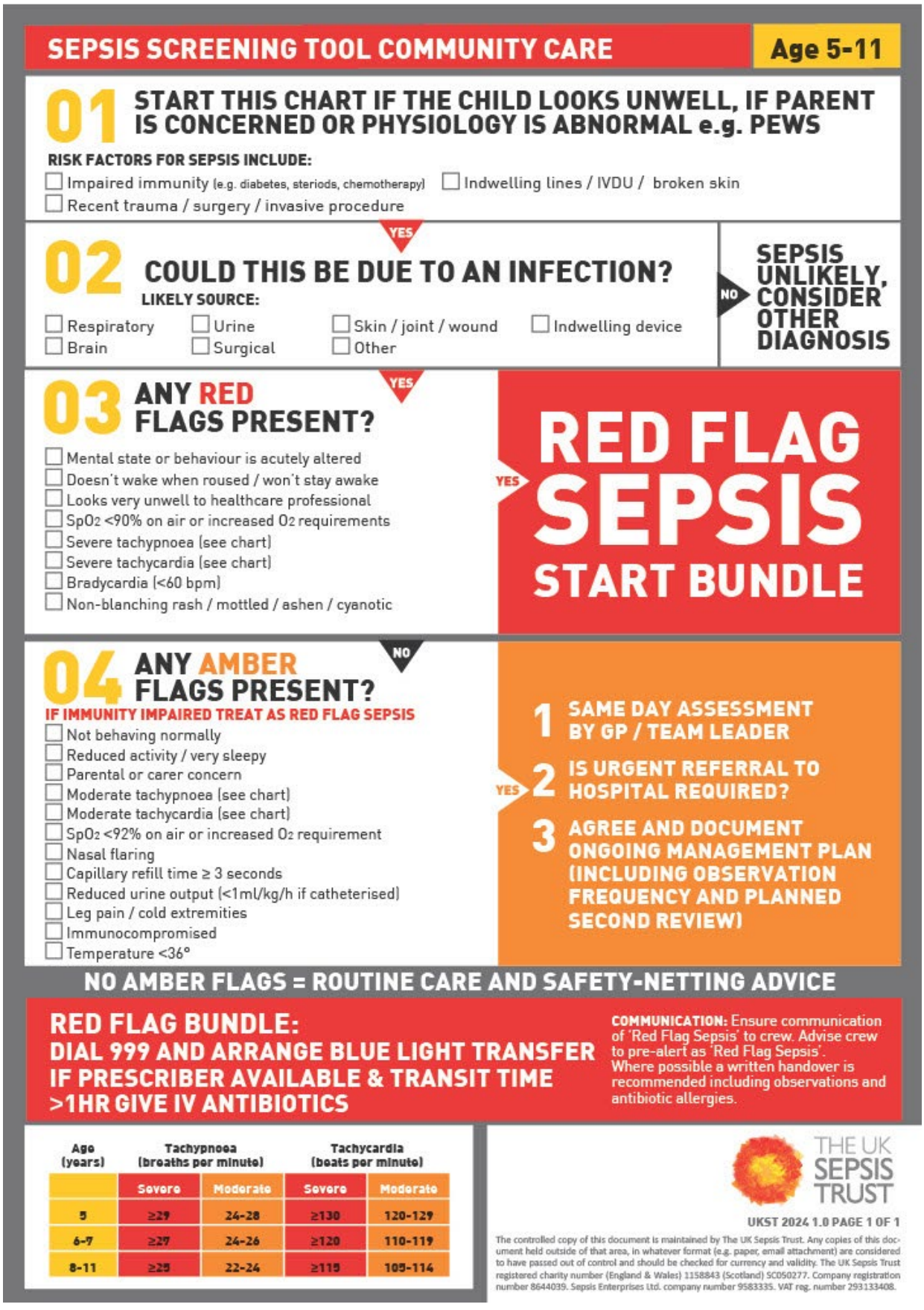
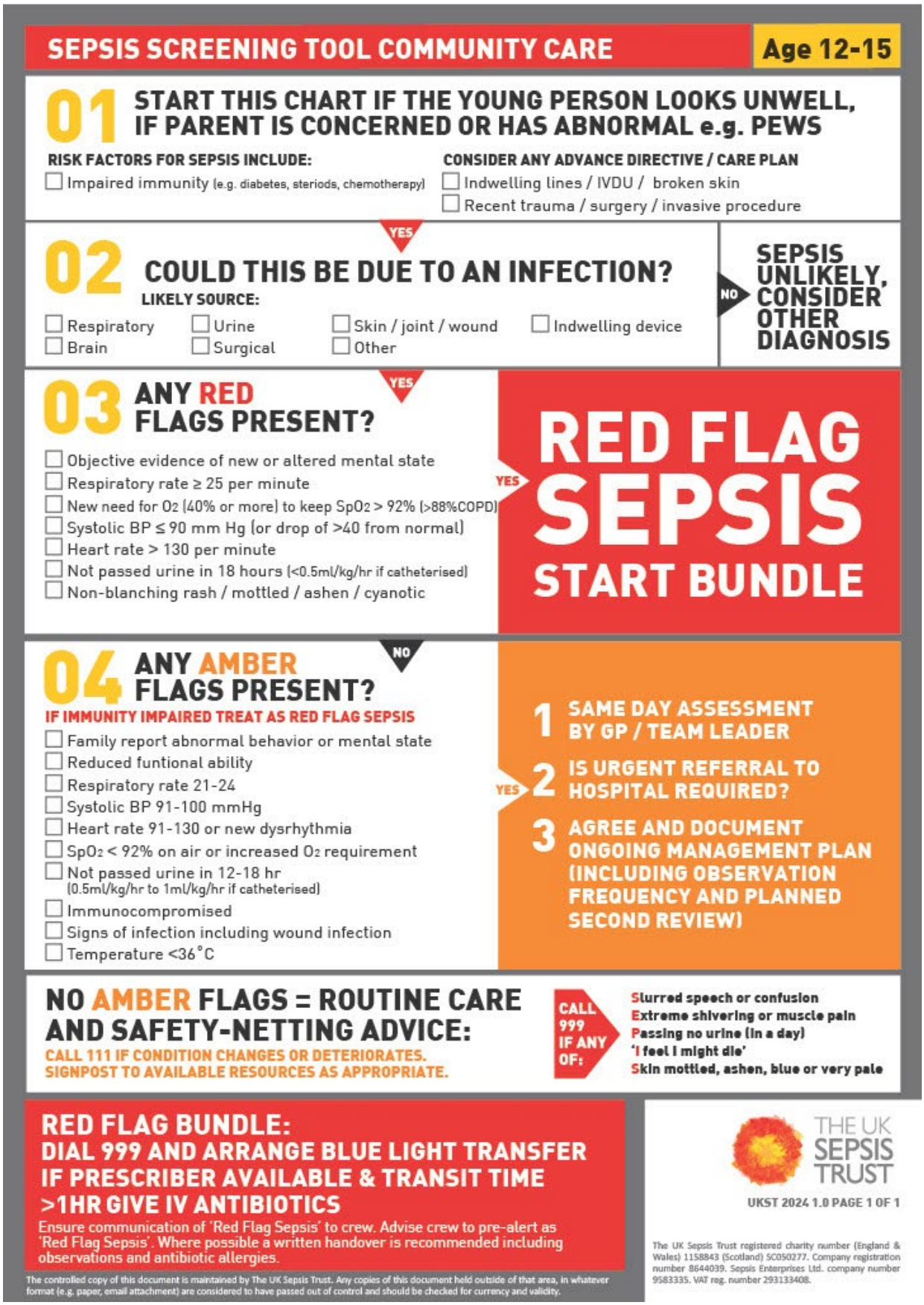
Appendix 10a – Sepsis Screening Tool Community Care for Under 5's



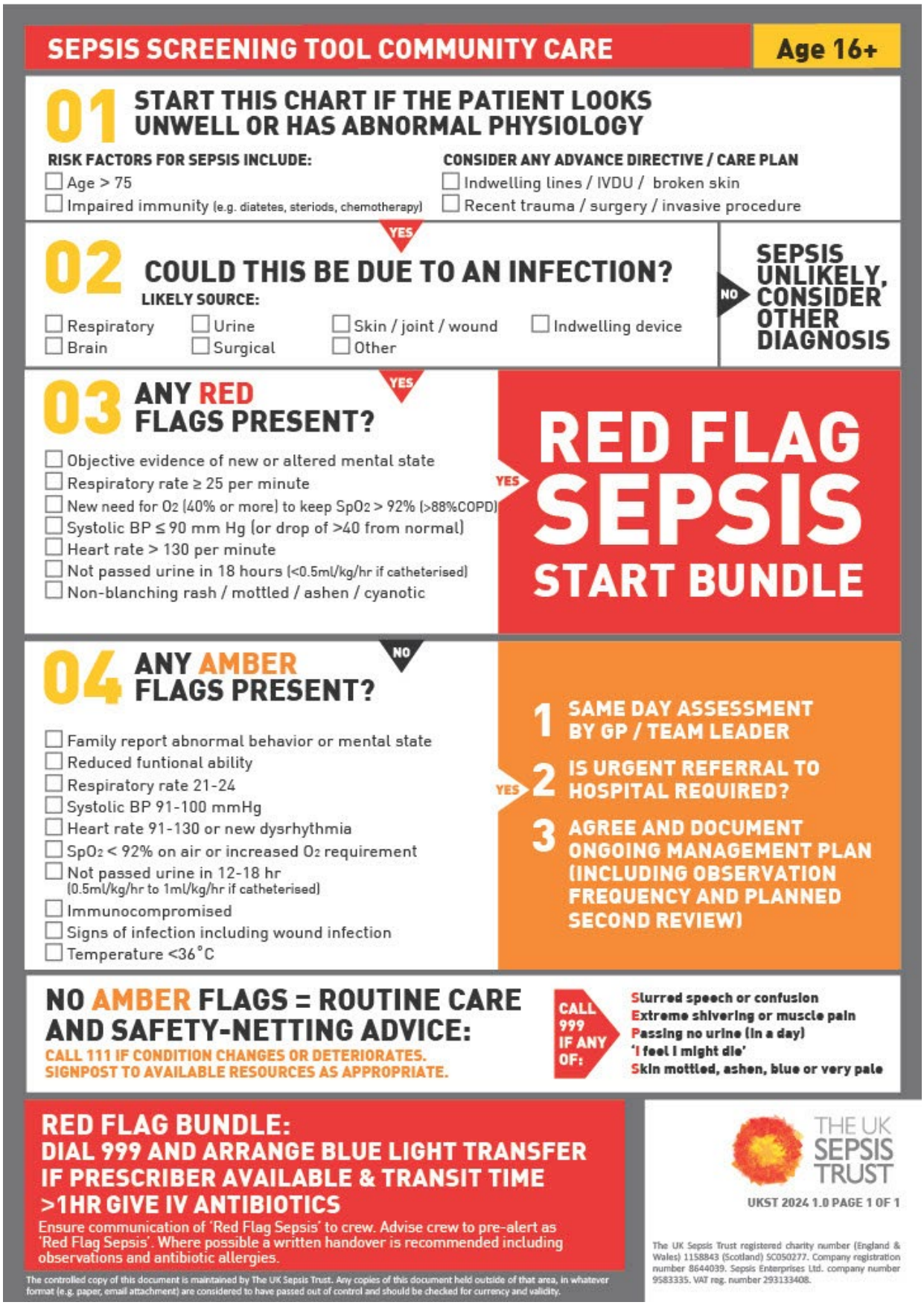
Appendix 10b - Sepsis Screening Tool Community Care Age 5-11



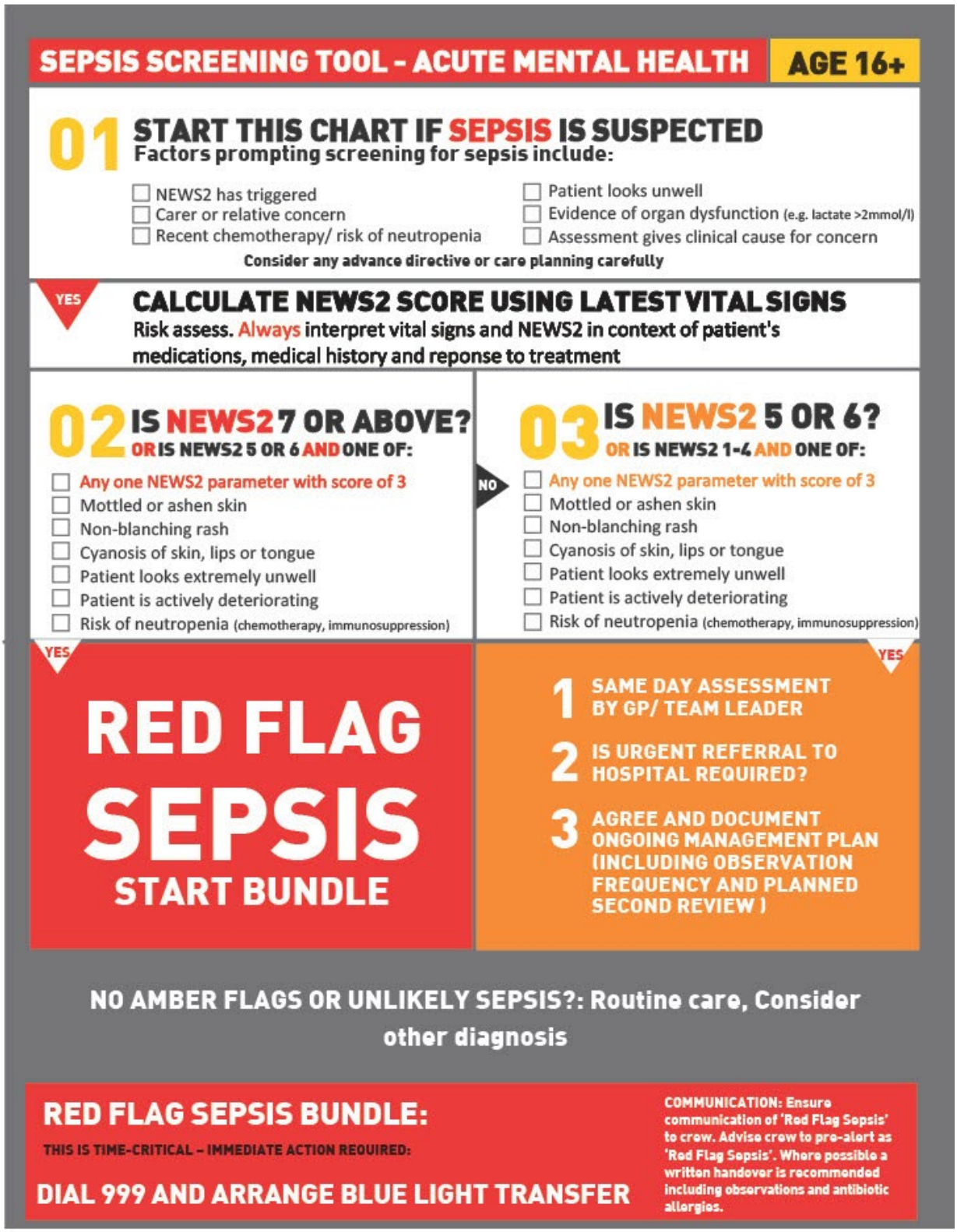
Appendix 10c - Sepsis Screening Tool Community Care Age 12-15



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



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



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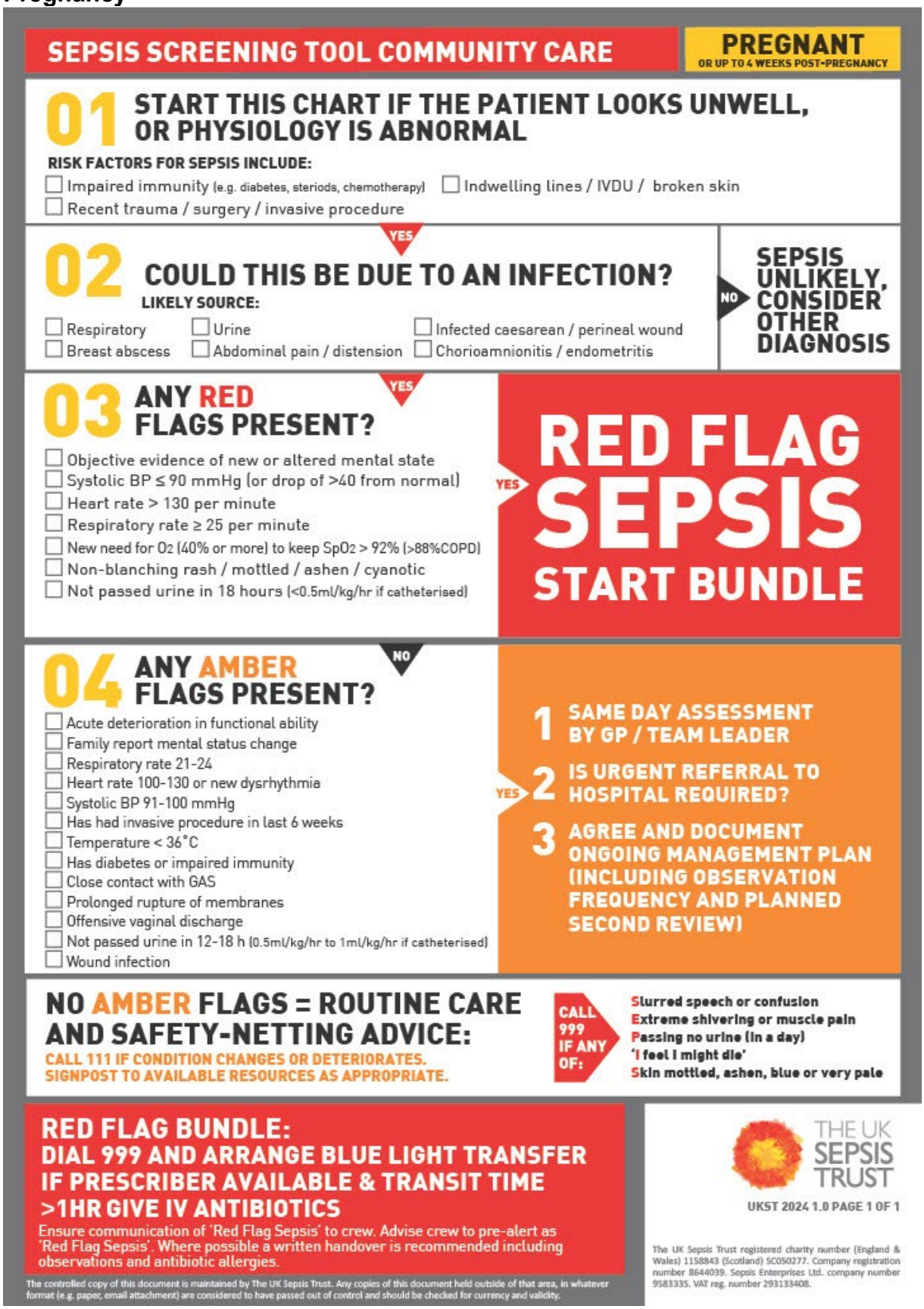
UKST MENTAL HEALTH 20241.0 PAGE 1 OF 1

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



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

Name of patient:..... NHS No:.....

Name of Registered Staff Member .....

Signed (staff member): .....

Date of Fall					Time of Fall				
Location of Fall:									
Primary Symptom prior to fall: (please tick one)	Unable to identify		Unwell		Behavioural change				
	Visual impairment		Dizziness/loss of		Dementia (Usual state)				
	Other		Details:						
Assessment of Injury								Tick & Initial	
Level of consciousness	Responsive as normal								
	Less responsive than usual								
	Unresponsive or unconscious DIAL 999								
Pain/Discomfort	No evidence of pain/discomfort								
	Mild pain/discomfort								
	Severe pain/ discomfort								
Where is the Pain (if any)?									
Injury or wounds	No evidence of injury, bleeding or wounds								
	Slight or mild injury								
	Evidence of significant swelling, bruising, bleeding, or deformity of limbs								
Where is the injury?									
Movement / mobility	Able to move all limbs as normal for the resident								
	Able to move limbs but has pain on movement								
	Unable to move limbs or there is a major change in mobility								
Observations									
News score		Glasgow Coma Score		Blood sugar				Tick & sign	
Conclusion of assessment								Tick & Initial	
No apparent injury or minor injury	Seek or provide appropriate treatment								
	Complete NEWS 2 score and act on score as appropriate								
	Commence neuro observations if on anticoagulants **even if** no obvious sign of trauma to head – if sign of deterioration call for assistance or, if out of hours, call 999								
	Inform relatives								
	Complete incident form (record Datix Number)								
	Review Falls Assessment								
Major injury	Give first aid/ resuscitate CALL 999 - DO NOT MOVE PATIENT								
	Complete NEWS2 score and act on score as appropriate								
	Commence Neuro observations								
	Inform relatives								
	Complete Incident form (record Datix number)								
	Repeat falls assessment								
INDICATE OUTCOME:		Continue to manage		Call for assistance		Call 999		Other:	

Continue to manage | Call for assistance (Call Doctor) | Call 9-999

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

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Post Falls SWARM

Name:	
Date of Birth:	DD/MM/YYYY
MRN Number:	
NHS Number:	
(OR AFFIX HOSPITAL LABEL HERE)	

Date		**Time**	
Completed by		**Job title**	
Location of incident (ward/area)			

Environmental Factors	
Specific location details	
Consider potential issues: *Condition of floor?* *Furniture involved?* *Lighting?* *Other?*	

Patient Factors		
Specific patient details	Delirium? Y☐ N☐	Sensory impairment? Y☐ N☐
	Cognitive impairment? Y☐ N☐	UTI/LRTI? Y☐ N☐
Patient account		
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 occupancy (%)	
Consider potential issues: *Staffing ratios?*		

working together | always improving | respectful and kind | making a difference

Where were staff? *Other issues on ward?* *Nursing comments?*	

Analysis and Plan	
Incident recorded on Datix? Y☐ N☐	Completed Safety Cross? Y☐ N☐
Post Falls Protocol followed? Y☐ N☐	Reviewed Falls Prevention Care Plan? Y☐ N☐
Root Cause	**Plan**

Signature:	Print Name	Designation	Date