NCEPOD Time to Intervene.

Hospital Number _____

Patient population, initial assessment and first consultant review

Recommendations	Data collection tool	Response		Action required
Standards of clerking/examination and recording thereof should be improved. Each hospital should ensure that the detail required in clerking and examination is explicit and communicated to doctors-in-training as part of the induction process. A regular (6-monthly) audit of performance against these standards should be performed and reported through the clinical governance structure of the organisation.	Q9a – Data taken from	Refer to audit tool		
	Q9b – Time of initial assessment	Refer to audit tool		
	Q9b – Date of initial assessment	Refer to audit tool		
	Q9c – Grade of clinician that carried out the initial assessment	Refer to audit tool		
	Q9d – Specialty of clinician that carried out the initial assessment	Refer to audit tool		
	Q10 – Did the initial assessment cover:			
	a) The presenting complaint	Yes	No	
	b) The history of presenting complaint	Yes	No	
	c) Past medical history	Yes	No	
	d) Drug history	Yes	No	
	e) Social history	Yes	No	
	f) Assessment of ADL	Yes	No	
	g) Physical assessment of the following symptoms			
	i. Cardiovascular	Yes	No	
	ii. Respiratory	Yes	No	
	iii. CNS	Yes	No	
	iv. Gastro-intestinal	Yes	No	
	v. Genito-urinary	Yes	No	
	Q11 – Did the initial assessment provide:			
	a) Differential diagnosis	Yes	No	
	b) Investigation plan	Yes	No	
	c) Physiological monitoring plan	Yes	No	
	d) Treatment plan	Yes	No	

Hospitals must ensure appropriate supervision for doctors-in-training. Delays in escalation to more senior doctors due to lack of recognition of severity of illness by doctors in training are unacceptable and place patients at risk.	Q12 – Did the doctor performing the initial clerking appreciate the severity of the situation?	Yes	No	
	Q14 – Did the doctor performing the initial clerking escalate to a more senior doctor in a timely fashion?	Yes	No	
	Q26 – In the 48 hours prior to cardiac arrest please grade the following on a scale of 1-9 , where 1 = very poor and 9 = excellent			
	a) Organisational aspects of care	6-9	1-6	
	b) Clinician's knowledge	6-9	1-6	
	c) Appreciation of clinical urgency	6-9	1-6	
	d) Supervision of junior staff	6-9	1-6	
	e) Advice from senior doctors	6-9	1-6	
Each Trust/Hospital must provide sufficient critical care capacity or pathways of care to meet the needs of its population.	Q15a – To what level of care was the patient admitted?	Refer to audit tool		
	Q15b – In your opinion, to what level of care should the patient have been admitted?	Refer to audit tool		
	Q16a – Were there any delays in admitting the patient?	Yes	No	
	Q16b – If YES, please provide details	Refer to audit tool		
	Q16c – If YES, did they affect the outcome?	Yes	No	
Each entry in a patient's case notes must contain date, time, location of patient and name and grade of staff and their contact details. It must also contain information on the most senior team member present during that patient contact (name and grade).	Q17a – How many entries are there during the 48 hours prior to cardiac arrest in the case notes?	Refer to audit tool		
	Q17b – How many included:			
	i. The date of review	100%	0-99%	
	ii. The time of review	100%	0-99%	
	iii. The location of the patient at the time of review	100%	0-99%	
	iv. The name of the clinician undertaking the review	100%	0-99%	
	v. The grade of clinician undertaking the review	100%	0-99%	
	vi. The contact details of the clinician undertaking the review	100%	0-99%	
	vii. The name of the most senior team member present during the patient review	100%	0-99%	
	viii. The grade of the most senior team member present during the review	100%	0-99%	

As previously recommended by NCEPOD and the RCP, all acute admissions must be reviewed at consultant level within 12 hours of admission. Earlier consultant review may be required and arrangements should be in place to ensure that this is available. A regular (6-monthly) audit of performance against this standard should be performed and reported through the governance structure of the organisation.	Q18a – Can you identify the first consultant review? Q18b – If YES, what was the time of the first review? Q18b – If YES, what was the date of the first review? Q19 – What was the time from arrival to first consultant review? Q20 – In your opinion, was the consultant review obtained in an appropriate time frame?	Yes Refer to audit tool Refer to audit tool <12 hours Yes	No >12 hours No	
CPR status must be considered and recorded for all acute admissions, ideally during the initial admission process and definitely at the initial consultant review when an explicit decision should be made and clearly documented (for CPR or DNACPR) . When, during the initial admission, CPR is considered as inappropriate, consultant involvement must occur at that time.	Q13 – During the initial admission process, was resuscitation status: a) Considered b) Discussed c) Documented Q21 – During the first consultant review, was resuscitation status: a) Considered b) Discussed c) Documented Q22 – If a decision was made that CPR was inappropriate, was a consultant involved with making this decision?	 Yes Yes Yes Yes Yes Yes Yes	 No No No No No No No	

Care before the cardiac arrest

Recommendations	Data collection tool	Response		Action required
For all patients requiring monitoring, there must be clear instructions as to the type and frequency of observations required. Where 'Track and Trigger' systems are used the initial frequency of observations should be clearly stated by the admitting doctor.	Q23a – Was the patient monitored on a standardised 'Track and Trigger' chart?	Yes	No	
	Q23b – If YES, was the initial frequency of observation clearly stated by the admitting doctor?	Yes	No	
	Q23c – If no standard 'Track and Trigger ' chart was used to monitor the patient, please state the documented request for type and frequency of physiological observations to be made:			
	a) Pulse i. Frequency recorded	Yes	No	
	b) BP i. Frequency recorded	Yes	No	
	c) Respiratory rate i. Frequency recorded	Yes	No	
	d) Urine output i. Frequency recorded	Yes	No	
	e) Fluid balance i. Frequency recorded	Yes	No	
	f) CVP i. Frequency recorded	Yes	No	
	g) SpO^2 i. Frequency recorded	Yes	No	
	h) Other i. Frequency recorded	Yes	No	
	Q24 – Are there instructions to the nurses as to when to alert the medical staff in the event of deterioration in specific variables?	Yes	No	
Where patients continue to deteriorate after non-consultant review there should be escalation of patient care to a more senior doctor. If this is not done, the reasons for non-escalation must be clearly documented in the case notes.	Q25a – If the patient continued to deteriorate after non-consultant review, was there an escalation of care to a more senior doctor?	Yes/NA	No	
	Q25b – If NO, was the reason for non-escalation clearly recorded in the case notes?	Yes	No	

Hospitals should undertake a detailed audit of the period prior to cardiac arrest to examine whether antecedent factors were present that warned of potential cardiac arrest and what the clinical response to these factors was.	Q34a – In your opinion were there warning signs that the patient was at risk of deterioration and cardiac arrest? Q34b – If YES, were these signs: a) Recognised well enough? b) Acted upon adequately? c) Communicated to appropriate seniority of doctor?	Refer to audit tool Yes Yes Yes	 No No No	

Resuscitation status

Recommendations	Data collection tool	Response	Action required
An effective system for recording all decisions and discussions relating to CPR/DNACPR must be established, allowing all people who may care for the patient to be aware of this information.	Q27 – Is there a record of Resuscitation Status at any point after admission to the time of cardiac arrest?	Yes / No	
	Q28 – Was the patient for resuscitation?	Refer to audit tool	
	Q29 – Was the grade of clinician who MADE the decision recorded in the case notes?	Yes / No	
	Q30a – Is there a record in the case notes that the decision was discussed with the patient?	Yes / No	
	Q30b – If YES, what grade of clinician had the discussion?	Refer to audit tool	
	Q31a –Is there a record in the case notes that the decision was discussed with the relatives?	Yes / No	
	Q31b – If YES, what grade of clinician had the discussion?	Refer to audit tool	
	Q32 – Where a DNAR decision has been made, in your opinion does it comply with the following: a) Effective recording on a form that will be recognised by all those involved with the care of the patient? b) Effective communication and explanation of DNAR decision with the patient (where appropriate) c) Effective communication and explanation of DNAR decision with patient's family, friends and other representatives?	 Yes / No Yes / No Yes / No	

Resuscitation attempt

Recommendations	Data collection tool	Response		Action required
All CPR attempts should be reported through the Trust/Hospital critical incident reporting system. This information should be reported to the Trust/Hospital Board on a regular basis.	Q35 – Was the cardiac arrest reported through the Trust/Hospital critical incident reporting system?	Yes	No	

Period after the cardiac arrest

Recommendations	Data collection tool	Response		Action required
Each hospital should audit all CPR attempts and assess what proportion of patients should have had a DNACPR decision in place prior to the arrest and should not have undergone CPR, rather than have the decision made after the first arrest. This will improve patient care by avoiding undignified and potentially harmful CPR during the dying process.	Q27 – Is there a record of Resuscitation Status at any point after admission to the time of cardiac arrest?	Yes	No	
	Q28 – Was the patient for resuscitation?	Refer to audit tool		
	Q33 – If there was no decision documented or the patient was documented as being 'For Resuscitation', should the patient have had a DNACPR decision made prior to their arrest?	Yes	No	
Consultant input is required in the immediate post arrest period to ensure that decision making is appropriate and that the correct interventions are undertaken.	Q37 – In your opinion, was the clinical care in the immediate (up to first hour) post arrest period:	Good/ Adequate	Poor	
	Q38a – In your opinion, was the decision making in the immediate (up to first hour) post arrest period:	Good/ Adequate	Poor	
	Q38b – If less than GOOD were there problems in: a) Speed of decision making? b) Seniority of decision making? c) Clarity of care required? d) Other	 Yes Yes Yes Yes	 No No No No	
	Q39a – Was the responsible consultant/on-call consultant aware that the patient had suffered a cardiac arrest and resuscitation?	Yes	No	
	Q39b – If YES, was this:	Immediat-ely	Delayed	
	Q40 – Can you identify the time of consultant review after cardiac arrest for: a) Responsible consultant? b) On-call consultant? c) ICU consultant d) Other consultant?	 Yes/NA Yes/NA Yes/NA Yes/NA	 No No No No	

Coronary angiography and PCI should be considered in all cardiac arrest survivors where the cause of cardiac arrest is likely to be primary myocardial ishcaemia.	Q36a – In your opinion, was the aetiology of this arrest likely to be cardiovascular? (i.e. Myocardial ischaemia or primary rhythm problem) Q36b – If YES to 36a, was consideration given to coronary angiography? Q36c – If YES to 36a, was discussion undertaken with cardiology? Q36d – If YES to 36a, was angiography +/- intervention CONSIDERED? Q36e – If YES to 36d, was angiography +/- intervention PERFORMED?	Refer to audit tool Yes Yes Yes Refer to audit tool	No No No	
Organ donation should be considered in every case where life sustaining therapies are being withdrawn.	Q41 – If active life sustaining therapies were withdrawn, was organ donation CONSIDERED? Q41b – In your opinion, was the patient a potential organ donor? Q41c – If YES, was the patient referred to a specialist nurse for organ donation?	Yes Refer to audit tool Yes	No No	