“System leaves junior staff overseeing the most acutely ill”

The importance of the recent report on the management of in-hospital cardiac arrest by the National Confidential Enquiry into Patient Outcome and Death should not be underestimated. *Time to Intervene* is the first significantly detailed review of the situation patients who are acutely ill can be in. It found a succession of system and performance failures that compromised patient safety and wellbeing throughout the care pathway.

During initial assessments, there were omissions in the recognition of illness severity and delays in the escalation of care to senior clinicians. Early warning systems failed to track the deterioration of vital signs effectively and trigger an emergency response. Even when a response did occur, there were shortcomings in the very difficult circumstances of whether to start or withhold cardiopulmonary resuscitation and a worrying, blatant disregard of do not attempt resuscitation (DNAR) orders.

The report makes for disturbing reading and nursing has to shoulder some of the responsibility for these failures.

In most cases (77%), very junior doctors were the first clinicians to assess acutely ill patients; only 3% were seen by consultants. The report almost accepts this as inevitable, although it led to serious compromises in care. Despite the widespread adoption of early warning systems and rapid response teams, there were major care deficiencies, exemplified by a failure to act upon adverse clinical signs that were documented before cardiac arrest in 75% of cases.

Resuscitation status is an area of great concern. Only 22% (122) of patients had resuscitation status recorded in their notes. Of these, 43% (52) had a DNAR order – five at the patients’ request. Inexplicably, all 52 received CPR. The advisers to the project concluded that CPR was deemed necessary in 34 of 230 cases. As with immediate pre-arrest care, most decisions around resuscitation were made by very junior doctors, a point that was largely missed by the media.

Kathleen Murphy, chief executive of the Patients Association, said: “There is a huge degree of confusion about the way DNACPR orders are being handled.... The Patients Association supports NCEPOD’s call for consistent decision making and better communication. Patients need to feel they can trust the DNACPR system, and this report shakes that trust considerably.”

We must take heed of these words and the report and seek and embrace the views and opinions of patients and, where appropriate, their loved ones so we can comprehend and respond to critically ill, chronically ill and terminally ill patients in what is an extremely complex mix of social, ethical, moral and spiritual challenges.

This report may have exposed an impasse that merits serious consideration of a care model that exposes our most vulnerable patients with complex needs to the most inexperienced, least skilled and least knowledgeable nursing and medical staff. I urge you to read it and consider how it affects your everyday practice. **NT**

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**SPOTLIGHT**

Target smoking cessation advice at teenagers

Messages about the dangers of smoking can’t have passed many teenagers by, yet alarming numbers still take up the habit. A complex set of interconnected factors are at play – not least among them the wish to rebel and hang around with the “cool” kids. There is also the belief widely held in the under-20s that death is something that happens to other people.

But whatever starts teenagers smoking, the message reported in our discussion is that they can become addicted far more quickly than adults (page 12). This makes it vital that smoking cessation interventions are effective if we are to reduce the health burden of tobacco.

Health professionals need interventions that are designed specifically for this age group. Adult-focused interventions don’t work on those who see adults as an alien, and terminally boring, species.