Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Resuscitation Policy

This procedural document supersedes: PAT/EC 1 v.8 - Resuscitation Policy

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Author/reviewer: (this version)	Nicola Vickers – Resuscitation & Manual Handling Lead
Date written/revised:	September 2017
Approved by:	Patient Safety Review Group
Date of approval:	6 October 2017
Date issued:	10 November 2017
Next review date:	September 2020 **– extended to February 2022**
Target audience:	Trust wide

Amendment Form

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

Version	Date Issued	Brief Summary of Changes	Author
Version 9	10 November 2017	• References updated • Appendix 1 Terms of reference for Patient Safety Review Group (PSRG) added • Monitoring compliance updated • Equipment Grab Bags information added • Appendix 2 Resuscitation Teams updated • Appendix 3 Equality Impact Assessment added	Nicola Vickers Jonathan Allen
Version 8	March 2014	• References updated • Terms of reference updated • Test bleep procedure added • Procedure for calling for an ambulance in an emergency at MMH/Retford hospital OR outside of the main hospital complex • Monitoring compliance updated • Appendix 3 PAWS charts included • Appendix 4 Resuscitation Teams updated	Lisette Caygill Jonathan Allen
Version 7	November 2010	• **Major changes throughout - PLEASE READ IN FULL.**	Lisette Caygill
Version 6	August 2007	• Page 4 – Objectives • Pages 5, item 1 – Immediate Action • Pages 5/6, item 2 – Members of the Cardiac Arrest Team • Page 6/7, item 3 – Resuscitation Equipment • Pages 7-10, item 4 – Training • Page 10, item 6 – Audit • Pages 11-14, items 7/8 – Specialist Areas • Page 17, Appendix 2 • Pages 19-34, Appendix 4 – Algorithms • Page 35, Appendix 5 – Resuscitation Event Record • Page 36/37, Appendix 6 – Medical Equipment Training & Fault Reporting • Page 38, Appendix 7 – Cardiac arrest occurring in an area where a defibrillator is not currently available	Lisette Caygill

Contents

1. INTRODUCTION

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

2. PURPOSE

The purpose of the policy is to provide direction and guidance for the planning and implementation of a high-quality and robust resuscitation service to Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (here after referred to as the Trust). The strategy for resuscitation incorporates the current published guidelines for resuscitation (Resuscitation Council (UK), 2015).

3. DUTIES AND RESPONSIBILITIES

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

3.1 Duties within the Organisation

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

It is the responsibility of the Resuscitation Lead, Patient Safety Review Group and Policy Co-ordinator to ensure policy distribution, implementation and compliance throughout the organisation.

It is the responsibility of the Care Group Directors, Heads of Nursing, Midwifery & Therapies and Matrons to ensure that staff are provided with the opportunity to attend training appropriate to their role.

It is the responsibility of individual staff members to attend training appropriate to their roles.

3.2 Approval of the Resuscitation Policy

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

3.3 Scope of Policy

This policy applies to all staff who have direct patient contact.

4. PROCEDURE

4.1 The Early Warning System

Early warning systems have been established for use with all patients to identify those who are clinically deteriorating and require urgent intervention, which may prevent cardiopulmonary arrest. All clinical staff should be trained in the identification of critically ill patients and the use of appropriate observation charts to enhance decision-making and care escalation if required. For further detailed information please refer to the trusts early warning and escalation policies and procedures.

4.2 Composition of the cardiac arrest team

The composition of the respective emergency teams (Adult / Paediatric / Obstetric) is detailed within Appendix 2.

4.3 Cardiac Arrest Calls

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

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

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

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

4.3.1 Response to 2222 calls

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

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

4.3.2 Cancelling 2222 calls

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

4.3.3 Test Bleeps

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

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

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

4.5 Resuscitation Equipment

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

The expiry dates on all accessible items should be checked, including drugs and disposable items.

A list must be kept of equipment and a record signed stating ALL equipment is present and functioning correctly.

4.5.1 Cardiac Arrest Trolleys

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

Following the use of a cardiac arrest trolley, replacement equipment should be sought immediately. At DRI, BDGH and MMH sites a trolley exchange system is in place via main theatres. It is also the responsibility of ward/department staff to ensure that trolleys approaching expiry are exchanged and ideally this should be done one week before the final expiry date. All other Trust sites are responsible for the replenishment of used/expired equipment to ensure the immediate availability of a cardiac arrest trolley at all times.

4.5.2 Defibrillators

Defibrillators are serviced regularly by Medical Technical Services. If a defibrillator malfunctions, it should be reported immediately to Medical Technical Services, removed from service and temporarily replaced with a spare defibrillator located in the equipment library. If no replacement defibrillator is available, clinical areas should share defibrillators until the problem is resolved. Defibrillators should not be removed from the resuscitation training unit to replace malfunctioning machines. It is the responsibility of the nurse/person in charge to inform all relevant staff of the situation and ensure that they know the location of the defibrillator to be used in the event of cardiac arrest.

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

4.5.3 Drugs

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

4.5.4 Grab Bags

Some specialised resuscitation equipment is not held in every clinical area so will be brought to all cardiac arrest calls in a grab bag by the Operating Department Practitioner who is carrying the cardiac arrest bleep. The contents of the grab bags will include portable waveform capnography and intraosseous access devices in line with current Resuscitation Council (UK) guidelines for the treatment of cardio respiratory arrest.

4.6 Post Resuscitation Care

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

4.6.1 Patient transfer

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

4.7 Manual Handling

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

4.8 Cross Infection

Although the risk of infection transmission from patient to rescuer during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. It is therefore advisable that direct mouth-to-mouth resuscitation be avoided.

All clinical areas should have immediate access to airway devices so that mouth-to-mouth ventilation is not necessary. In situations where airway protective devices are not immediately available, continuous chest compressions should be performed whilst awaiting an airway device.

4.9 Anaphylaxis

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

4.10 Procurement

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

4.11 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

The Trust's DNACPR Policy (PAT/EC 2) complies with the guidance issued by the BMA / RCN / Resuscitation Council (UK) (2016), the General Medical Council's guidance on 'Treatment and care towards the end of life: good practice in decision making' (2010) and the Resuscitation Council (UK) Quality standards for cardiopulmonary resuscitation practice and training- acute care (2013).

5. TRAINING/ SUPPORT

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

Training should explicitly incorporate the identification of patients at risk from cardiac arrest and a strategic approach to implement preventative measures such as Early Warning Systems.
The Trust will provide sufficient and appropriate resuscitation training for each staff group.
Levels of training responsibility are detailed in the Trust Statutory and Essential Training (SET) Policy (CORP/EMP 29) and specific levels of resuscitation training appropriate to role are detailed on the trust intranet under SET.

The approach to teaching is one of positive encouragement and proven educational efficacy which follows the recommendations for resuscitation teaching advocated by the Resuscitation Council (UK) (Mackay-Jones & Walker, 1998).

5.1 Training recommendations

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

5.1.1 Clinical Staff

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

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

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

Clinical staff should have at least annual updates.

5.1.2 Non-clinical Staff

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

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

5.2 Training Records

Training and Education are responsible for updating individual staff records of attendance at resuscitation training (delivered by Resuscitation Officers or trainers within the trust) on the Oracle learning management (OLM) system. Individual staff members must inform Training and Education of all certified resuscitation training that has been successfully completed at an external course centre so this can also be recorded.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
All Cardiac Arrests where a 2222 call is placed	Resuscitation Services	Twice weekly	Participation in the National Cardiac Arrest Audit (NCAA) with six monthly reports to the Patient Safety Review Group along with the review of all datix entries following these events
Cardiac Arrest reviews of management & escalation	Resuscitation Services will conduct a minimum of three reviews as part of the trust review of mortality process	Monthly	Reviews completed as part of the mortality case note review group with six monthly reports to the Patient Safety Review Group
Equipment Audit	Resuscitation Services	Annually with re audit for non compliance	Reported during audit to ward/department managers followed by a formal report annually to the Patient Safety Review Group

7. DEFINITIONS

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

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

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

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

Defibrillation
Defibrillation is the passage of electrical current across the myocardium to depolarise a critical mass of the cardiac muscle simultaneously to enable the natural pacemaker to resume control.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
A formal decision not to commence cardiopulmonary resuscitation.

8. EQUALITY IMPACT ASSESSMENT

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

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified, see Appendix 3.

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy (adults and young people aged 16 years and over) - PAT/EC 2

Manual Handling Policy - CORP/HSFS 4

Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) - PAT/PA 19

Physiological Observations and prevention of deterioration in the acutely ill adult - PAT/T 33

Physiological Observations for Paediatric Patients (excluding Neonates) - CW01

Early Recognition of the severely ill Antenatal/ Postnatal Woman Using the Modified Obstetric Early Warning Score - MSG166

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

Privacy and Dignity Policy - PAT/PA 28

Standard Infection Prevention and Control Precautions Policy - PAT/IC 19

Statutory and Essential Training (SET) Policy - CORP/EMP 29

Fair Treatment for All Policy – CORP/EMP 4

Equality Analysis Policy – CORP/EMP 27

10. REFERENCES

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

MacKay - Jones, K. and Walker, M. (1998) Pocket Guide to Teaching for Medical Instructors. BMJ Books. London

Mental Capacity Act 2005 Department of Health

Resuscitation Policy. Health Services Circular (HSC) 2000/028. London. Department of Health

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

Resuscitation Council (UK) (2016) Decisions Relating to Cardiopulmonary Resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.

Resuscitation Council (UK) Resuscitation Guidelines (2015) www.resus.org.uk

Resuscitation Council (UK) (2013) Quality Standards for Cardiopulmonary Resuscitation Practice and Training- Acute Care.

APPENDIX 1 – TERMS OF REFERENCE

Name	**Patient Safety Review Group (PSRG)**
Purpose	The purpose of the group is to ensure that there is continuous and measurable improvement in patient safety and that "the Board" is assured that the risks associated with clinical activity are appropriately managed. The group has the operational responsibility to ensure that the impact of clinical risk is minimised within the organisation and that learning is shared across Care Groups.
Responsible to	Clinical Governance Committee
Delegated authority	The group is authorised by the Clinical Governance Committee to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the group.
Duties and work programme	To receive, note and action where appropriate the following: • Datix Report Monthly • Claims highlighting organisational learning. • Inquests where learning identified. • Outcomes of formal investigations or enquiries from any of the above and relevant learning • Six Monthly Cardiac Arrest Report • Six Monthly DNACPR Report • Quarterly Safeguarding Report • Quarterly Child Death Overview Panel (CDOP) Learning Report • Alerts from CAS and MHRA (Quarterly) • Resuscitation Policies & Processes To consider the Introduction of new Clinical procedure/practices, approved by the Executive panel in accordance with the Protocol for Introducing New Clinical Procedures or practices CORP/RISK 3. The members of the group will ensure timely dissemination of information to their individual areas of responsibility and that discussions are evidenced in the minutes of Clinical Governance Groups. **The Patient Safety Review Group will invite case presentations on a monthly basis to report actions and/or recommendations taken from clinical incidents, complaints or claims. These reports will form a standard agenda item.** **An annual report will be submitted to the Clinical Governance Committee.**

Chair	The Deputy Medical Director for Clinical Standards shall be the Chair and the Deputy Director of Quality & Governance shall be the Vice-Chair
Membership	▪ Care Group Matrons ▪ Consultant Medical Staff ▪ Trainee representative ▪ Education Quality & Governance Manager ▪ Head of Patient Safety & Experience ▪ Named Nurse For Safeguarding Children ▪ Lead Nurse, Diabetes & Endo ▪ Legal Services Manager ▪ Director of Infection Prevention and Control/Lead Nurse infection Prevention & Control ▪ Medical Technical Services Manager ▪ Resuscitation & Manual Handling Lead ▪ Representative from the Drug & Therapeutics Committee ▪ Governor ▪ Pathology Quality Manager ▪ Clinical Therapy representative
In attendance	Secretary
Secretary	Committee Secretary, Risk & Legal Services
Quorum	The quorum is the Chair and/or Vice-Chair, 50% of bed holding Care Group representatives and 50% of consultant medical staff.
Attendance requirements	Attendance is required at all meetings. Members unable to attend should indicate in writing or by e-mail to the PSRG administrator in advance of the meeting (except in extenuating circumstances of absence). Members are advised to nominate a deputy to attend who is appropriately briefed to participate in the meeting. Members must attend at least **7** meetings throughout a Calendar year. The Chair will set the standards for the meeting and ensure the agenda is realistic in content, to achieve this by allocating fixed timescales for each item. In addition any items raised under 'any other business' will be identified at the start of each meeting to the Chair and/or Vice-Chair. The Chair and/or Vice-Chair will consider these items for inclusion on the agenda if there is sufficient time for discussion, or will defer these to the next meeting of the Group. Items for the agenda should be submitted to the Committee Secretary a minimum of 10 calendar days prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting. (This includes requests for policy approval) Progress against actions should be reported by those tasked at the subsequent meeting.

Frequency of meetings	The frequency of meetings shall be monthly, held on the first Friday of every month and will last no more than two hours.
Papers	Papers will be distributed 5 working days in advance of the meeting.
Permanency	The committee is a permanent committee.
Reporting committees	None.
Circulation of minutes	The minutes will be submitted to the Clinical Governance Co-ordinator for submission to the Clinical Governance Committee and the Chair will report on a monthly basis regarding the work of the committee and any matters needing action or improvement. The approved minutes will also be forwarded to Doncaster Clinical Commissioning Group for information.
Date approved by the committee:	*May 2017*
Date approved by the Clinical Governance Committee	*June 2017*
Review date:	*June 2018*

APPENDIX 2 – RESUSCITATION TEAMS

Adult Resuscitation Team members

DRI and BDGH

Anaesthetist (Core Trainee) (if available)
Medical Registrar & SHO on-call
Operating Department Practitioner (ODP)
Clinical Site Manager (nights)
Advanced Care Practitioners (days and Care Group specific)
Resuscitation Officer (when available)
Ward Staff

MMH & RETFORD HOSPITAL

No cardiac arrest team call 999

Paediatric Resuscitation Team Members

DRI

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

BDGH

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

Obstetric Emergency Team

DRI

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

BDGH

Bleep holders are contacted individually via switchboard.

APPENDIX 3 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Resuscitation Policy - PAT/EC 1 v.9	Resuscitation Services	Nicola Vickers	Existing policy	September 2017

1) Who is responsible for this policy? People & Organisational Development, Education, Resuscitation Services

2) Describe the purpose of the service / function / policy / project/ strategy? Ensure all aspects of resuscitation are in line with national guidance.

3) Are there any associated objectives? This policy reflects Resuscitation Council (UK) guidelines relating to cardiopulmonary resuscitation

4) What factors contribute or detract from achieving intended outcomes?

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** N/A

6) Is there any scope for new measures which would promote equality? N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: September 2020

Checked by: Nicola Vickers **Date: September 2017**