Mid Essex Hospital Services NHS
NHS Trust

Resuscitation Policy and Standards of Care	**Policy** **Register No: 05111** **Status: Public**

Developed in response to:	UK Resuscitation Council Guidelines NHSLA Risk Management Standards
Contributes to CQC	Outcomes 1 & 4

Consulted With	**Post/Committee/Group**	**Date**
Dr Ben Maddison, Dr Nick Wilson	Consultant Anaesthetists	23.9.16
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Professional Approval of the updated 8.1	Dr Bob Ghosh, Cathy Geddes	October 2016

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Author/Contact for Information	Dr Katherine Rowe
Policy to be followed by (target staff)	All health care professionals
Distribution Method	Intranet & website
Related Trust Policies (to be read in conjunction with)	Adult Do Not Attempt cardiopulmonary resuscitation Policy Mandatory Training Policy (including Training Needs Analysis) Do Not Attempt Resuscitation Policy for Children Children's Observation Policy Care of the Critically ill child Guideline For Neonatal Resuscitation Guideline For Resuscitation In Pregnancy Supporting staff involved in a traumatic incident, complaint and claim Adult Patient Observations Policy Infection Prevention policies

Document Review/Approval History

Version No	**Authored/Reviewed by**	**Active Date**
1.0	Resuscitation Committee	
2.0	Resuscitation Committee	
3.0	Approved by CDAG	October 2005-August 2008
5.0	L Seager	8th September 2008
6.0	L Seager,	4th March 2011
7.0	L Seager	7th May 2013
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8.1	Dr Katherine Rowe	20th October 2016

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1. Purpose

1.1 This policy focuses on the staffing and equipment necessary for effective and responsive cardiopulmonary resuscitation should a patient suffer a cardiac arrest – (their heart has stopped beating) within MEHT.

1.2 This policy covers all patient groups for all areas (both clinical and non clinical) within MEHT except for those who are pregnant which is covered by the resuscitation in pregnancy policy.

1.3 Members of the public who deteriorate within MEHT will be moved to the emergency department where possible and appropriate and with admission if necessary.

1.4 Due to the complexity of the Do Not Resuscitate decisions that need to be made, there is a separate Do Not Attempt Resuscitation Cardiopulmonary resuscitation Policy (DNACPR).

1.5 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

2. Scope

2.1 This policy applies to the management of cardiopulmonary arrest and should be adhered to by all staff employed by the Trust.

2.2 This policy **excludes**:

- Guidance for staff on the recognition of patients at risk of deteriorating. Refer to the Adult Patient Observations Policy and the Children's Observation Policy
- Detailed guidance for staff on Do Not Attempt cardiopulmonary Resuscitation orders. Please refer to the Do Not Attempt cardiopulmonary Resuscitation Policy and the Children's Do Not Attempt Resuscitation Policy for additional information
- Guidance on resuscitation in pregnancy, refer to 04247 Resuscitation in Pregnancy

3. Responsibilities

3.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that the Trust provides an effective resuscitation service.

3.2 The Director of Patient Safety

The Director of Patient Safety is responsible for ensuring that resources and mechanisms are in place for the implementation, monitoring and review of this policy.

3.3 Deteriorating Patient Group (DPG)

The Trust's DPG is responsible for all resuscitation issues within the hospital including monitoring the implementation and effectiveness of this policy and should ensure:

- That current Resuscitation Council (UK) and other relevant national guidance is taken into account during the annual review of the Resuscitation policy.
- The availability of training and equipment for resuscitation is monitored.
- The regular review of the National Early Warning Score (NEWS) and Children's Early Warning Score System and cardiac arrest audit findings.
- Information from the Children & Young People Urgent & Emergency Care Group, which looks specifically at problems relating to children will be reported to the DPG and the Integrated Governance committee
- There is an appropriate response to lessons learnt following the review of incidents.
- A report is submitted annually to the Integrated Governance Committee.

3.4 Clinical Lead for Resuscitation

- To chair the Deteriorating Patient Group and take responsibility for the implementation of the Deteriorating Patient Group's recommendations.
- To liaise with the Director of Patient Safety to ensure that all aspects of resuscitation practice match national standards.
- To ensure the resuscitation policy is reviewed on a regular basis and updated as necessary.

3.5 Resuscitation Team Officers

- Responsible for the provision of resuscitation and NEWS system training within the Trust in accordance with the Trust's Training Needs Analysis (Mandatory Training Policy).
- Will offer specialist advice in all appropriate aspects of resuscitation.
- May act as the Team Leader and administer drugs used in a cardiac arrest, in accordance with National Guidelines.
- Will ensure deficiencies in compliance with this policy are identified and reported to the Deteriorating Patient Group for advice, dissemination or action as appropriate.
- Will organise external resuscitation courses as required

3.6 **All clinical staff – inpatients and outpatients.**

- To read this policy and understand their role in resuscitation procedures.
- To ensure, where appropriate, that they are familiar with the resuscitation equipment on the ward/unit.
- To inform their manager of any constraints regarding their ability to perform resuscitation procedures.
- To attend mandatory resuscitation training and updates in accordance with the Trust's Training Needs Analysis (Mandatory Training Policy).

4.0 Key Issues

4.1 This policy supports the recommendations for clinical practice and training from the UK core Skills Training Framework Statutory/Mandatory Subject Guide Version 1.3 'skills for Health Core Skills March 2016, as well as the Acute care – Quality standards from the Resuscitation Council (UK) November 2013.

4.2 These standards have been reviewed and adapted to local needs with advice and input from ED, paediatrics, critical care and anaesthesia.

4.3 This policy focuses on the staffing and equipment necessary for effective and responsive cardiopulmonary resuscitation in the event of a cardiac arrest.

4.4 The level of resuscitation skills required and expected by nursing and medical staff at MEHT has been based upon the individuals expected role should a patient suddenly deteriorate when the staff member is involved in their day-to-day duties.

4.5 In the event of a cardiac arrest, patients have a right to expect:

- Consideration to be given to their privacy and dignity, with respect for them as individuals at all times
- For the clinical staff on duty, who are responsible for the patient, to be aware of their resuscitation status and be confident and competent in performing them
- Immediate recognition of cardiac arrest on assessment of airway, breathing and circulation
- Immediate effective basic life support and quick, accessible and reliable ability to summon more specialist help.
- Prompt access to appropriate resuscitation equipment that is in full working order and which has been checked against the standardised MEHT checklist.
- Reliable and prompt access to specialist help to aide in the continuing resuscitation attempt

4.6 The management of an emergency clinical situation will vary depending on the patient group

4.7 There are three identifiable patient groups within MEHT 1) adult 2) paediatrics 3) maternity**.** For all matters concerning the maternity population please refer to the resuscitation in pregnancy guideline.

4.8 Medical and nursing staff, depending on their clinical duties will have responsibility and involvement in the care of one, two or all of these groups. Staff caring for each groups are expected to have an appropriate level of skill in resuscitating for each group whom they may be involved with in an emergency situation.

4.9 The specialist help requires team members who are competent in intermediate life support and also a team leader who can effectively lead this team and ensure that the appropriate level of advance life support for the patient is on going.

4.10 There are three levels (or tiers) of resuscitation skills recognised by the UK core skills training framework guide. This policy has used this framework and added a fourth more specialist tier such that all aspects of resuscitation can be incorporated within one clinical guideline.

4.11 The competencies advised by this policy will be matched to each staff members mandatory training such that each individual has clear and open access to the expected level of resuscitation skill required for their on going clinical duties.

5.0 The first responder (see appendix 1)

5.1 The first responder if the member of the nursing or medical staff who first arrives to a unresponsive patient.

5.2 The first responder will be expected to rapidly assess the patient and follow the in-hospital resuscitation algorithm (appendix 1 – in-hospital resuscitation algorithm).

5.3 Unless a Do Not Attempt cardiopulmonary Resuscitation (DNACPR) statement has been made, a patient in cardiopulmonary arrest should receive cardiopulmonary resuscitation (CPR) and the cardiac arrest call should be put out.

5.4 If the arrest occurs within a level 2 or 3 environment (ICU or theatres) it may not be necessary to put a cardiac arrest call out if practitioners (medical and nursing) with advanced critical care competencies are already present.

6. Procedure for putting out a cardiac arrest call (see appendix 2)

6.1 Broomfield clinical area

- Dial Switchboard: 2222, they will be responsible for putting out the call.
- State the nature of emergency (e.g. cardiac arrest, trauma call).
- Accurately describe the location.

- Basic/Advanced Life Support should be started as appropriate.

6.2 Remote and non-clinical areas on Broomfield

- Access an outside line 999 and ask for an ambulance
- In addition Dial 2222
- State the nature of emergency (e.g. trauma call – Broomfield site ONLY cardiac arrest)
- Accurately describe the location
- Basic/Advanced Life Support should be started by staff trained to do so
- Emergency Equipment will be made available from the Accident & Emergency Department. In the event of this coinciding with a major incident, the arrest will be managed by the local ambulance service. This will be collected by the porter carrying the cardiac bleep

6.3 Other MEHT sites, the first responder must:

- Access an outside line (dial '9'), dial 999 and ask for an ambulance
- State the nature of emergency (e.g. cardiac arrest)
- Accurately describe the location
- Instigate Basic Life Support whilst awaiting the arrival of the ambulance
- Where an appropriately trained member is available an Automated External Defibrillator (AED) should summoned and applied whilst awaiting the arrival of an ambulance
- Once stabilized, the patient should be transferred to A&E by ambulance.

7 Resuscitation Team attending a cardiopulmonary arrest call

7.1 For an adult cardiopulmonary arrest the medical staff that hold the cardiac arrest bleep 24/7 and are expected to attend an adult cardiac arrest include an anaesthetist, a critical care doctor and a core medical trainee/F2.

7.2 For a paediatric cardiopulmonary arrest the medical staff that hold the paediatric cardiac arrest bleep 24/7 and are expected to attend an adult cardiac arrest include an anaesthetist, a critical care doctor a paediatric registrar and a paediatric F2.

7.3 Depending on the ward and clinical situation there may be medical staff who are not carriers of the cardiac arrest bleep who can be an active member of the arrest team and leading on the resuscitation if they have the required competencies.

7.4 Non- essential medical staff should not impede the resuscitation attempt and may be asked to leave.

7.5 Registered nursing staff on the ward are expected to be an active member of the resuscitation attempt.

7.6 Other staff to attend include a Resuscitation Training Officer, Operating Department Practitioner and a porter.

7.7 A Team Leader will be identified at all resuscitation attempts. The Team Leader will direct the team in accordance with National Guidance and is generally the most senior member of medical staff present.

7.8 Any nurse who is a member of a cardiac arrest team, and who is in possession of a current relevant Advanced Life Support certificate, may assume the role of the Team Leader until medical staff arrive.

7.9 The Resuscitation Officer is permitted to act as Team Leader and administer drugs used in a cardiac arrest, in accordance with National Guidelines, until medical staff arrive.

7.10 Resuscitation will be carried out to the standards of the Resuscitation Council (UK). Staff in possession of a current ALS or ILS certificate (or equivalent as per section 12.5) should be encouraged to perform all aspects of resuscitation. This includes CPR, defibrillation, drug administration and basic airway skills.

8.0 Cardiac arrest special circumstances

8.1 Neck Breathers

8.11 All neck breathers within MEHT will be recognised as such by the large National Tracheostomy Safety Project (NTSP) 'Airway Breather' sign displayed behind their bed on the wall. This will illustrate whether they have a laryngectomy or a tracheostomy.

8.12 A blue box will be available for each of these patients which contains all the necessary extra equipment for airway resuscitation including calorimetric capnography.

8.13 If necessary and appropriate the airway practitioner (anaesthetist or ICU doctors) will secure the stoma site with the necessary tracheal tube. Ongoing resuscitation will follow national guidelines.

8.14 For further information please see the MEHT tracheostomy policy.

9.0 Attendance at the Resuscitation Attempt by Patients Close Relative or Friend

9.1 Individuals with a close affinity to the patient may, where appropriate, attend the resuscitation attempt if:

- There is a nurse dedicated to supporting them.

- They understand that they must not interfere in the process of resuscitation, including the decision to discontinue resuscitation.

- The resuscitation team are able to competently perform their duty

10. Post Resuscitation Care

10.1 The Trust makes provision for safe continuity of care and where necessary, safe transfer following resuscitation of the patient. This may involve the following steps:

- Referral to a critical care specialist;

- Full and complete hand-over of care;

- Preparation of equipment, oxygen, drugs and monitoring systems;

- Intra-hospital or inter-hospital transfer;

- Liaison with the Ambulance Services;

- Staff involvement in patient retrieval and transfer;

- Informing relatives.

10.2 When the transport of children is involved, staff should liaise with CATS, Childrens Acute Transport Service.

10.3 Immediately after resuscitation the patient is likely to need transferring from a ward to a higher level of care such as intensive care or coronary care. The cardiac arrest team leader will oversee this and they should liaise with the appropriate department along with support from the anaesthetist and intensive care doctor.

11.0 Mandatory competencies for MEHT staff

11.1 This policy supports the recommendations for clinical practice and training from the UK core Skills Training Framework Statutory/Mandatory Subject Guide Version 1.3 ‘skills for Health Core Skills March 2016, as well as the Acute care – Quality standards from the Resuscitation Council (UK) November 2013.

11.2 These standards have been reviewed and adapted to local needs with advice and input from ED, paediatrics, critical care and anaesthesia.

11.3 This policy focuses on the staffing and equipment necessary for effective and responsive cardiopulmonary resuscitation.

11.4 The level of resuscitation skills required and expected by nursing and medical staff at MEHT has been based upon the individuals expected role should a patient suddenly deteriorate when the staff member is involved in their day-to-day duties.

11.5 This training requires the person to be within the validity date that the certification holds and to have an annual refresher appropriate to their clinical duties and is specified based on their recognised tier. The refresher course needs to be within 15 months of the certified course.

11.6 The relevant resuscitation course organisers will record attendance and pass this information on to Training and Development such that they have accurate records of certification and compliance with mandatory requirements. Individuals should also maintain their own records of attendance.

12.0 Skill levels required depending on clinical duties

12.1 Team leaders (Tier 4)

12.1.1 The Team Leader will direct the Resuscitation team in accordance with national guidance and is generally the most senior member of medical or nursing staff present in possession of the appropriate advanced Life Support Course for their patient group (as per section 12.5).

12.1.2 This includes those that carry the cardiac arrest bleep during their day-to-day work, but also those senior doctors or senior nurses in departments with high acuity who are the senior clinician or charge nurse within their department who be expected to run an emergency situation such as a cardiopulmonary arrest.

12.1.3 Team Leaders must hold appropriate qualifications to undertake this role and be expected to competently lead the care of the deteriorating patient for the specific type of patient they care for

12.1.4 Wards and areas of high acuity within MEHT are :

Phoenix, PHDU, PAU
Burns ITU
Wizard ward
Critical Care (GICU/GHDU)
ED
SEW, EAU
Theatres and recovery

12.1.5 The Team Leader is responsible for ensuring the smooth running of the arrest and following a CPR attempt, may provide support for staff through the opportunity for a debrief such that staff may discuss matters of concern.

12.1.6 Further support is available for staff in accordance with the Supporting staff involved in a traumatic incident, complaint and claim Policy. The resuscitation officers can also be contacted in this setting.

12.1.7 Those caring for the under 18yrs olds are expected to have advanced skills in resuscitation in both the adult and paediatric resuscitation.

12.2 Staff expected to be involved in the resuscitation team (Tier 3)

12.2.1 This includes qualified individuals who have direct clinical contact with patients and are expected to participate as part of the resuscitation attempt either in the ward or in the out-patient setting.

12.2.2 These individuals would continue being part of the attempt even when the cardiac arrest bleep holder arrives.

12.3 Staff with direct clinical care responsibilities including all qualified healthcare professionals (Tier 2)

12.3.1 This includes doctors and nurses who have direct clinical contact with patients who would be expected to be a first responder but not have an on-going role within the resuscitation attempt.

12.4 Any clinical or non-clinical staff, dependent upon local risk assessment (Tier 1)

12.4.1 This tier incudes all health care assistants who have contact with inpatients or outpatients who would be expected to be part of the initial resuscitation attempt until the resuscitation team arrived.

12.5 Essential Training - Table of requirements

12.5.1 ILS and PILS are both whole day courses led by the resus department. Refresher ILS (Ref-ILS) and refresher PILS (Ref-PILS) are half day courses.

12.52 COSBART is available to consultant anaesthetists only and contains. It is a high fidelity simulation course of emergency and critical incidents incorporating PILS and ALS algorithms. It is organised through the PMI, Anglia Ruskin University and the refresher is organised through the anaesthetic department or www.anglia.ac.uk/COSBART

	Paediatrics	Adult	Extra training necessary for Emergency department
Tier 4			
Valid Certification	EPALS/APLS or COSBART	ALS or COSBART	ATLS (medical) ATLS – (observer nursing)
Annual refresher	Ref – PILS or Ref- COSBART	Ref - ILS or Ref -COSBART	n/a
Tier 3			
Valid Certification	PILS	ILS	
Annual refresher	Ref - PILS	Ref – ILS	
Tier 2			
Valid Certification	BLS + CEWT	BLS	
Annual refresher	BLS + CEWT	BLS	
Tier 1			
Valid Certification	BLS + CEWT	BLS	
Annual refresher	BLS + CEWT	BLS	

13. Equipment

13.1 All clinical areas will have adult, and, where appropriate, paediatric resuscitation trolleys that are stocked according to a standardized MEHT checklist. A portable suction unit and a portable oxygen cylinder will also be available.

13.2 All clinical areas will have immediate access to an appropriate type of defibrillator.

13.3 The equipment to be kept on each cardiac arrest trolley will be identified by the Resuscitation Officers, decided by the DPG and reviewed each year. Provision of equipment should be to the Resuscitation Council (UK) guidelines. Provision of Paediatric equipment will follow regional guidelines.

13.4 The Resuscitation Trolley Checklist (appendix 2) identifies equipment that should be stored on the resuscitation trolley and stock levels. The top of trolley is to be

checked daily. This includes the oxygen cylinder (confirm expiry date and that cylinder is full), bag valve mask, suction unit and confirming that the defibrillator is charging (AED's do not require charging). If the trolley can be sealed shut the contents of the drawers can be checked weekly. MRX and Heartstart XL defibrillators should have a weekly test. Non sealed trolleys must be checked daily. Items are kept in drawers as marked on the checklist. Items marked in grey boxes can be located in the 'Resus Equipment Store, 24hr a day. This is located in the St Andrew's end of theatre (Entrance near E320). High risk areas not part of the scheme (A&E, ITU and Burns) should maintain adequate stock levels to restock the trolley following use.

13.5 All single use items should be stored in original packaging in accordance with infection control guidelines.

13.6 Wall mounted oxygen and suction units will be checked each day when the ward or department is in use and a record of this check made.

13.7 The person in charge of an area will be responsible for ensuring that an appropriately trained member of staff is assigned the above duties and that they have been carried out.

14.0 Resuscitation attempts

14.1 Accurate written records of the event are mandatory and are the responsibility of the senior doctor and nurse present.

14.2 After each resuscitation attempt, a Resuscitation Officer is responsible for ensuring that relevant information is collected for audit purposes.

14.3 If the resuscitation attempt is successful, the Team Leader is responsible for contacting the Intensive Care team to identify optimal post resuscitation care including patient destination, treatment plan and communication with relevant clinicians.

14.4 Following CPR attempts, debriefing by the Team Leader may be a useful way for staff to discuss matters of concern and offer support. Further support is available for staff in accordance with the Supporting staff involved in a traumatic incident, complaint and claim Policy.

15.0 Audit and monitoring

15.1 Audit of the availability of resuscitation equipment will be undertaken on an annual basis. The Resuscitation Department will audit the resuscitation trolleys in all areas to identify whether required equipment is available in accordance with the current resuscitation trolley checklist. Compliance with the requirement for local checking will also be audited. The audit findings will be reported to the DPG for review and action.

15.2 Ongoing audit of cardiac arrests occurs through participation in the National Cardiac Arrest Audit (NCAA). A NCAA audit form is completed by a member of the Resuscitation Team for each cardiac arrest. Where failure to rescue is identified in

audit or Paediatric patients, a Root Cause Analysis is undertaken. This includes review of patient's NEWS history, consideration of DNAR orders and destination of patients successfully resuscitated. A summary of this activity will be submitted to the DPG on a quarterly basis for review and action where appropriate. The information will be disseminated to Clinical Directors and Divisional Managers who will be responsible for ensuring actions to address deficiencies are developed and implemented with progress reported to the DPG Group.

15.3 The resuscitation officers will make a record for each episode where a 2222 call has been put out.

15.4 Training attendance will be monitored in accordance with the Mandatory Training policy.

15.5 Details of audit and monitoring of compliance with this policy are described in the monitoring tool in appendix 2.

16.0. Review

16.1 This policy will be reviewed on an annual basis or sooner in response to local or national initiatives

17.0. Communication and Implementation

17.1 The policy will be available to staff and the public on the Trust's intranet site and website.

17.2 The policy will be sent to all Divisional directors.

18. References

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15. UK core Skills Training Framework Statutory/Mandatory Subject Guide Version 1.3 'skills for Health Core Skills March 2016
16. Quality standards from the Resuscitation Council (UK) November 2013.
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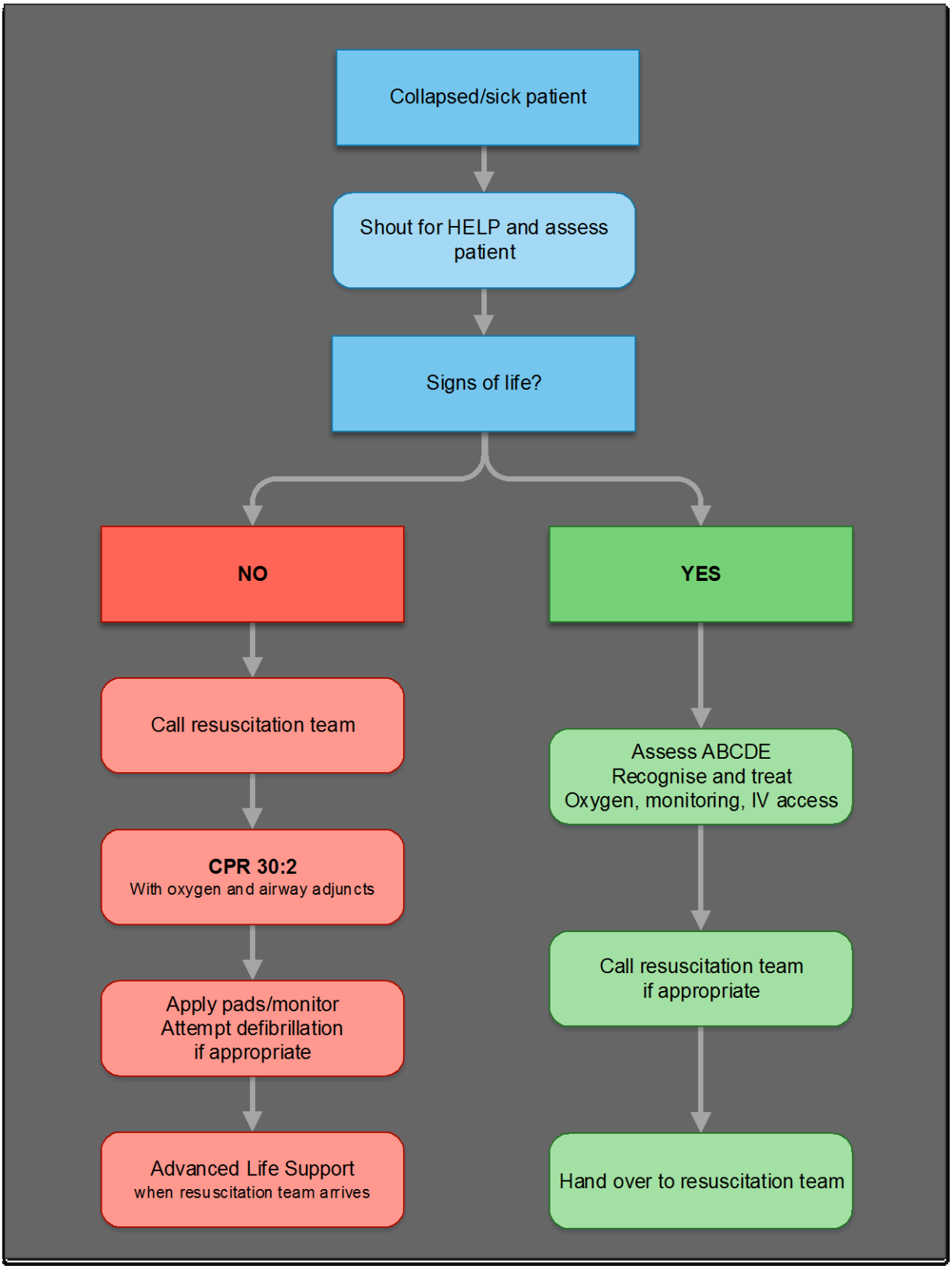
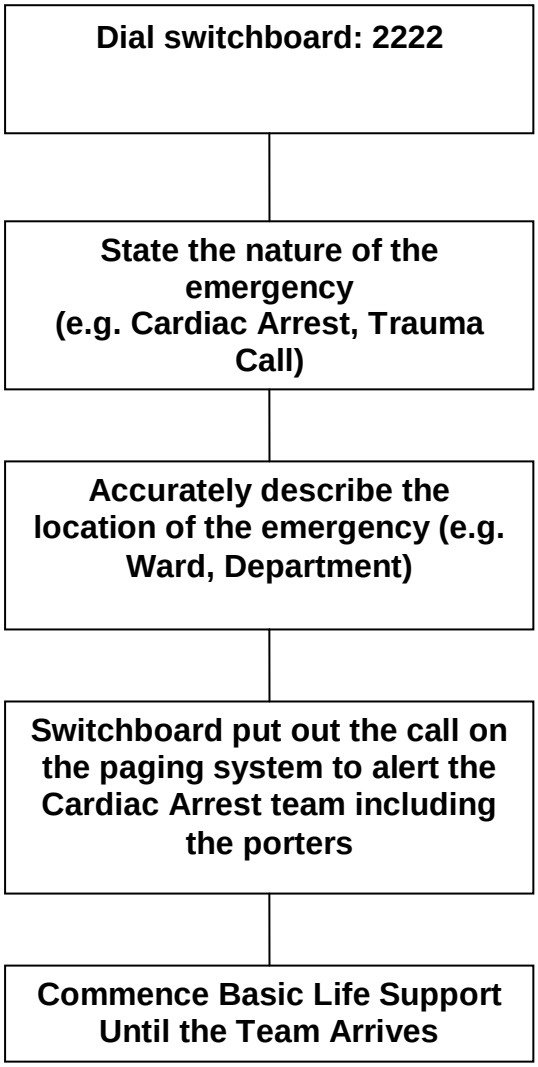
In-hospital Resuscitation



Appendix 2

Procedure for Calling the Teams



Appendix 3

Document Name: Resuscitation Policy and Standards of Care Policy **Policy Number: 05111**
Document owner: Lee Seager **Date of Review: November 2**
NHSLA Standard: 4.7

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements may include	Acting on recommendations and Lead(s) may include:	Change in practice and lessons to be shared
Duties	Nicola Boutilier Resuscitation officer	Ongoing review following up Cardiac arrest	Ongoing	Identified issues reported to DPG	Medical Directors Clinical Directors Divisional Managers Resuscitation Officers	Required changes in practice will be identified and actioned within a specified timeframe and lessons will be shared
Systems in place for the recognition of patients at risk of deterioration	Refer to Adult Patient Observations Policy and CEWT Guideline					
Resus trolley audit	Kate Johnson Resuscitation Officer	Resus trolley audit tool to assess compliance with key criteria	Annual audit	DPG Divisional Managers Director of Nursing	Kate Johnson with DPG to develop and approve action plan to address any deficiencies with identified leads and timescales. Leads may include: Medical Directors Clinical Directors Divisional Managers Resuscitation Officers	
Staff training	Cathy Lee	Refer to Mandatory Training Policy				