1 Introduction

The Newcastle upon Tyne Hospitals NHS Foundation Trust (hereafter the Trust) recognises the need for, and is committed to, providing a high standard of Cardiopulmonary Resuscitation. It is Trust policy to provide immediate and effective Cardiopulmonary Resuscitation (CPR) at the site of a cardio-respiratory arrest, when indicated. In order to achieve this aim, the Trust recognises the requirement to provide a high standard of CPR training appropriate to the needs of different staff groups.

2 Scope

- Roles and responsibilities of the Trust, Resuscitation Committee, arrest team members and staff
- Arrest procedure for all age groups who may require resuscitation
- Mandatory and recommended levels of resuscitation training
- Mechanisms for identifying patients at risk and procedures that should be followed.
- Resuscitation equipment provision and checking procedures
- Safe transfer procedures

3 Roles and Responsibilities

Roles and Responsibilities of the Trust, Directorates, the Resuscitation Committee, Resuscitation Officers (ROs) and staff.

3.1 The Trust will ensure adequate provision of training and resources.

3.2 The Resuscitation Committee

The Committee has overall responsibility for the implementation, evaluation and monitoring of the cardiopulmonary resuscitation strategy throughout the Trust.

The Resuscitation Committee shall:
- Meet formally on a quarterly basis to review Resuscitation issues throughout the Trust.
- Keep the Trust board informed, via the risk management committee, of the necessary requirements to maintain a high standard of CPR training and facilities necessary to provide effective, basic to advanced life support.
• Designate one meeting a year, to plan the coming year’s Resuscitation service and training intentions/requirements. This will be held in October, to enable any necessary cases of need to be put to the Trust for business planning.
• Ensure that the cardiac arrest team can provide Basic and Advanced Life Support, if indicated. If the resuscitation attempts are successful, the team is responsible for arranging the patient’s appropriate post-arrest care and safe transfer.
• Audit resuscitation services.

The composition of the Resuscitation Committee is stated in the Terms of reference

3.3 The Resuscitation Officers

The Resuscitation Officers are responsible for:
• Overseeing training (adult & paediatric) of:
  • Basic Life Support
  • Automated External Defibrillation
  • Intermediate Life Support
  • Advanced Life Support
  • Equipment training
  • Training and updating Cascade trainers
  • Monitoring / audit of cardiopulmonary arrest outcomes
  • Co-ordinating the provision of resuscitation equipment in conjunction with the Resuscitation Committee.
  • Periodical audit of resuscitation equipment
  • Implementation of the Resuscitation Committee decisions.

Contact details for Resuscitation Officers are available on the Resuscitation Training intranet site.

3.4 Speciality managers / Clinical Directors are responsible for:
• All resuscitation issues within their directorate
• Ensuring that staff are provided with adequate time to attend training
• Providing time out for directorate cascade trainers
• Maintaining appropriate records of staff training
• Auditing the use of “Do not attempt CPR”.  
  • orders within their directorate

3.5 All staff are aware of the procedure for summoning the arrest team / ambulance.

3.6 Clinical staff
• Attend annual resuscitation training in accordance with the training grid (see section 4.14)
• Ensure the availability of resuscitation equipment, as stipulated by the resuscitation committee, and ensure that it is in working order and checked as per policy (see section 6)
• Be familiar with the location of the nearest automated external
defibrillator (if applicable) and resuscitation equipment as available.
• Be familiar with the location of the next nearest resuscitation equipment
within acute Trust sites

4 Resuscitation Training

4.1 Yearly adult Basic Life Support (BLS) training is mandatory for clinical staff
caring for any age group of patient.
  • This is a requirement of “Cardiopulmonary Resuscitation, Standards for
    Clinical Practice and Training” page 10, A Joint Statement from;
  • The Royal College of Anaesthetists
  • The Royal College of Physicians of London
  • The Intensive Care Society
  • The Resuscitation Council (UK)

This document has been endorsed by:
  • The Council for Professionals as Resuscitation Officers
  • The National Patient Safety Agency
  • The Royal College of Physicians of Edinburgh
  • The Royal College of Physicians and Surgeons of Glasgow
  • The Royal College of Surgeons of England
  • The Royal College of Surgeons of Edinburgh
  • The Royal College of Paediatrics and Child Health
  • The Royal College of Nursing
  • The Faculty of Accident and Emergency Medicine Published October

4.1.1 ‘Clinical staff’ are taken to mean Doctors; Nurses; Healthcare
  Assistants; Professions allied to medicine; helpers and assistants to
  the afore mentioned; Pharmacists; Physicists and other persons who
  have some direct care of patients, (CNST, 2003)

4.2 Yearly neonatal life support training is mandatory for all clinical staff who
  attend women in childbirth and/ or the immediate postnatal period.
  “Clinical staff” are taken to mean midwives, doctors and neonatal nurses.

4.3 Additional, annual paediatric life support training is mandatory for clinical staff
caring for children.

4.4 Basic Life Support training will be provided by:
  • The Resuscitation Officers
  • BLS (Adult & Paediatric) trainers identified and trained throughout the
    Trust. These individuals will be known as BLS Cascade Trainers and
    will receive initial and continued training from the ROs.
  • Specified, named Medical / Dental staff.
  • Neonatal BLS trainers are identified and monitored by the Women’s
    Services Directorate
- BLS with AED training will be provided by RO's and competent named community staff.

4.5 The Newcastle Patient at Risk Course (NPARC) is run regularly within the Trust and there is teaching provided by Outreach teams to recognise and initially manage the critically ill. This includes the early identification of patients likely to deteriorate to cardiac arrest.

4.6 The Training for Transfer course runs regularly within the North East and Cumbria Critical Care Network and is open to any qualified staff member involved in the transfer of the critically ill.

4.7 BLS training for non-clinical staff throughout the Trust is advisory.

4.8 All training provided will follow the current Resuscitation Council (UK) guidelines.

4.9 There should be a maximum ratio of one trainer to six trainees at each practical life support session, to provide adequate opportunity to demonstrate and practice resuscitation skills, (ERC, 1992)

4.10 Cardiopulmonary Resuscitation training to trainee doctors will be incorporated into a training programme, which satisfies the requirements of the Postgraduate Institute for Medicine and Dentistry and the Colleges of various specialities.

4.11 Cardiopulmonary Resuscitation training to Medical and Dental students will usually be provided.

4.12 The Resuscitation Officers will evaluate the training provided.

4.13 Cardiopulmonary resuscitation training will be carried out throughout the Trust in suitable venues, which allow space for the allocated number of students, trainers and equipment.

4.14 Mandatory training for clinical staff (with patient contact)

The grids in this policy differ slightly from the Mandatory training policy to allow guidance on more advanced courses. The groups of staff requiring BLS and or PBLS are the same.

4.15 Staff who have a disability, health condition or other issues that impinge on and the implications for their role with their line manager. The resuscitation officers or line manager (most appropriate) will be informed of any member of staff who are unable to start or complete the training in relation to these issues, to ensure a risk assessment is carried out if appropriate and any necessary action plan formulated.
### Staff working only in adult patient areas

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Adult BLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff (with patient contact)</td>
<td>✓</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>✓</td>
</tr>
<tr>
<td>District Nursing staff</td>
<td>✓</td>
</tr>
<tr>
<td>Health Visitors</td>
<td>✓</td>
</tr>
<tr>
<td>Podiatrists</td>
<td>✓</td>
</tr>
<tr>
<td>Nursing Assistants; Health care assistants (Aux/N; S/W;HCA)</td>
<td>✓</td>
</tr>
<tr>
<td>Dentist (all grades)</td>
<td>✓</td>
</tr>
<tr>
<td>Dental Nurses</td>
<td>✓</td>
</tr>
<tr>
<td>Technicians in dentistry (with patient contact)</td>
<td>✓</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>✓</td>
</tr>
<tr>
<td>Physiotherapy assistants / helpers</td>
<td>✓</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>✓</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>✓</td>
</tr>
<tr>
<td>Occupational Therapy assistants / helpers</td>
<td>✓</td>
</tr>
<tr>
<td>Portering Staff / Operating department orderlies</td>
<td>✓</td>
</tr>
<tr>
<td>Plaster Technicians</td>
<td>✓</td>
</tr>
<tr>
<td>Cardiac &amp; Nuclear Technicians</td>
<td>✓</td>
</tr>
<tr>
<td>Operating department practitioners</td>
<td>✓</td>
</tr>
<tr>
<td>Operating Department Technicians and Anaesthetic Assistants (nursing)</td>
<td>✓</td>
</tr>
<tr>
<td>Radiographers/ Radiography practitioners</td>
<td>✓</td>
</tr>
<tr>
<td>Radiographer assistants / helpers</td>
<td>✓</td>
</tr>
<tr>
<td>Dieticians</td>
<td>✓</td>
</tr>
<tr>
<td>Any staff member who regularly cares for / deals with patients</td>
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</tr>
</tbody>
</table>

### Staff working with paediatric patients - minimum requirements

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Adult BLS</th>
<th>Paed BLS</th>
<th>NLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff (with patient contact)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Nursing staff</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>District Nursing staff</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Health Visitors</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Nursing Assistants (Aux/N; S/W;HCA)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Dentist (all grades)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Dental Nurses</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Technicians in dentistry (with patient contact)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Physiotherapy assistants / helpers</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy assistants / helpers</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Portering Staff</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Plaster Technicians</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Cardiac &amp; Nuclear Technicians</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Operating department practitioners</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
### Staff Group

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Adult BLS</th>
<th>Paed BLS</th>
<th>NLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Department Technicians and Anaesthetic Assistants (nursing)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Radiographers Radiography practitioners</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Radiographer assistants / helpers</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Dieticians</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Any staff member who regularly cares for / deals with paediatric patients</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Advanced RCUK or ALSG courses are valid for a 4 year period, BLS is included and does not need to be repeated in the same year of successfully completing an advanced life support course if the Trust has a record of the advanced life support course.

### Staff attending women in childbirth and or the immediate post natal period

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Adult BLS</th>
<th>Paed BLS</th>
<th>NLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal Nursing staff</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Nursery Nurses</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Advanced RCUK or ALSG courses are valid for a 4 year period, BLS is included and does not need to be repeated in the same year of successfully completing an advanced life support course if the Trust has a record of the advanced life support course.

### Staff working in areas where there is access to Automated External Defibrillators (AEDs) and trained in its use

Staff are required to attend annual AED updates. All staff will be required to demonstrate their competence practically by using the resuscitation training aids and theoretically by viva.

4.16 **Advisory levels for more advanced training**

Augmented training is available for staff members who may be required to deliver early defibrillation and/ or lead the management of a critically ill patient.

Many staff are confident in this role and do not need to attend UK Resuscitation Council or local courses. However they should be able to demonstrate safe use of a defibrillator and have a current knowledge of resuscitation algorithms and drugs to the standard of an ILS course.

The tables below may assist directorates and individuals in assessing any additional training which may be required in their role.

**ILS includes** – Intermediate Life Support (in-house course) and Immediate Life Support course (Resuscitation Council (UK) accredited national courses ALS – Advanced Life Support course (or equivalent)
Staff working in adult patient areas

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>ILS</th>
<th>ALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Anaesthetists/ Emergency Physicians/ A&amp;E</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Spr’s, SHO’s; F1s</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>F2’s; arrest team leaders</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Spr’s in anaesthesia</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Nursing staff - On arrest team</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Nursing staff (CCU) on arrest team</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Cardiac &amp; Nuclear Technicians</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Operating Department Practitioners (on arrest team)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Potential BLS Cascade trainers</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Non-medical staff wishing to extend their role in manual defibrillation</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>(at the discretion of each Directorate / department)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: ILS course completion is not necessary if you have a valid ALS provider or instructor certificate

This does not exclude other groups of staff undertaking intermediate or advanced life support courses at the discretion of the line manager / Directorate Manager

Staff working with paediatric patients

As noted above, staff may not want to attend UKRC courses however they should be able to demonstrate a working knowledge of the appropriate resuscitation algorithms along with safe use of equipment, to a level equivalent to the courses outlined below.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Paed ILS / 1day PLS</th>
<th>APLS / EPLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Anaesthetists/ Accident and Emergency</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Spr’s, SHO’s; F2’s</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Spr’s &amp; Consultant anaesthetist (if appropriate to their role)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Nursing staff - On arrest team</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Operating Department Practitioners (on paediatric arrest team)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Potential BLS Cascade trainers</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Note: Paed ILS or PLS course completion is not necessary if you have a valid APLS or EPLS provider or instructor certificate

This does not exclude other groups of staff undertaking intermediate or advanced life support courses at the discretion of the line manager / Directorate Manager

Qualified staff working in Obstetrics

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>In-house Clinical Skills day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td>✓</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>✓</td>
</tr>
</tbody>
</table>
5  BLS training for new staff / training at induction

All new staff are offered induction places by the training department, which includes an introduction to arrest procedures within the Trust. The following day clinical staff are allocated Adult BLS training.

Other speciality specific BLS must be arranged via their own department/ Directorate.

6  Resuscitation Equipment

6.1 Resuscitation equipment must be checked at least daily (working days), (Resuscitation Council (UK), 2000).

- The Resuscitation Committee will provide recommendations regarding essential equipment (including standardisation).
- In the case of neonatal resuscitation equipment, recommendations will be made by Trust Neonatologists.
- The Trust will ensure regular checks and maintenance are carried out in accordance with relevant manufacturer’s guidelines.
- Managers of all areas with resuscitation equipment will ensure that daily checks are carried out, as below.

6.2 Pocket masks / masks & filters should be readily available in all adult clinical areas e.g. toilets, bathrooms, dayrooms, cubicles, & 6 bedded bays, etc.

It is the responsibility of the person in charge of each clinical area to ensure that these are in place

It is the responsibility of staff working in the clinical area to familiarise themselves with the location of all resuscitation equipment.

6.3 Specified resuscitation trolley / red or green airway bag contents (including emergency drug boxes), particular to each individual hospital, must also be checked daily and after each use.

The following action must be taken when checking a trolley/ bag / equipment

Check the trolley, ensuring all the specific contents are present; in working order and have not expired.

- Only items on the designated list, should be in/on the trolley/bag. Any other items must be authorised by the resuscitation committee. Avoid clutter.
- A Trust record book must be signed and dated to confirm that checks have been performed. Any necessary action required, must be documented, carried out as soon as possible and signed for on completion.

6.4 If a trolley is shared between areas, the areas concerned must arrange a checking rota between them to ensure familiarity with the equipment.
6.5 Any resuscitation equipment must be renewed as soon as possible following use. All used disposable equipment must be replaced from an appropriate source.

6.6 All non-disposable equipment must be cleaned and replaced in accordance with the manufacturer’s recommendations and the Infection control policy.

6.7 Defibrillators, suction and oxygen equipment must be checked at least daily (working days) and preferably each shift, to ensure that they are in full working order. The member of staff checking the equipment must complete and sign the relevant checking book. A record should be made of any replacements, or faults and any action required. Any action taken must be documented, carried out as soon as possible and signed for on completion.

6.8 If any fault is found with resuscitation equipment, either during use or following daily checks, this should be reported immediately to the relevant maintenance department. If a fault occurred during use, a critical incident form should be completed.

6.9 Defibrillators on each site must be positioned appropriately in preparation for immediate use. If a defibrillator is shared by more than one area, it must be housed in an area of easy access to all areas concerned. All clinical staff must be aware of the whereabouts of the nearest defibrillator covering their area. Each new clinical area will be assessed, to ensure that a defibrillator can be brought to the bedside within 2 minutes.

6.10 All qualified nursing staff, with access to a manual defibrillator, should be able to set up a defibrillator ready for use, be aware of any appropriate accessory equipment required for their area of work (e.g. internal paddles, ECG cables etc.) and know how this equipment is used.

Only medical staff and appropriately trained nursing staff / cardiac technicians are allowed to carry out manual defibrillation.

6.11 The Trust aims to provide semi automated defibrillators to reduce the time to defibrillation in outlying areas. These can be used by staff, who have successfully completed appropriate training.

6.12 In the event of resuscitation equipment already being in use, all clinical staff must ensure they are familiar with the position of the nearest alternative equipment within their area (RVI, FH & CAV), particularly a defibrillator.

6.13 Emergency drugs are provided in case of cardiac arrest and are housed on all resuscitation trolleys (with the exception of critical care areas). A replacement box must be obtained immediately after use, or if the seal/ box appears to have been tampered with, or if it is approaching expiry.

6.14 If the contents of a drug box have been tampered with, or the box is missing, report the incident to the Pharmacy department and complete an untoward incident form.

6.15 Additional ‘second line’ emergency drugs should be provided at the scene of a cardio-pulmonary arrest from a designated source, specific to the FH, RVI and NGH. These drugs should be checked on a weekly basis and after each use. They should be replaced if used, or near their expiry date.
7 Cardiopulmonary Arrest (CPR) prevention

7.1 Within the Trust a Track and Trigger early warning system is used for in-patients to recognise patients with abnormal physiological observations.

7.2 This Modified Early Warning System (MEWS) contains recommendations relating to augmented monitoring and calling criteria.

7.3 Critical Care Outreach teams (adults only) are available at the RVI and Freeman Hospitals.

7.4 The NPARC (Newcastle Patient At Risk Course) and CCrISP (Care of The Critically Ill Surgical Patient) are both run within the Trust along with regular critical care teaching.

8 Cardiopulmonary arrest call system

8.1 Each main hospital in the Trust RVI; Dental; FH has access to a fast response multidisciplinary team in the event of a cardiopulmonary arrest occurring. (Arrest team)

The Centre for Life relies upon a paramedic response (semiautomatic defibrillators are on site).

Campus for Aging and Vitality (CAV) (formally the NGH) Clinical areas on this site rely upon a paramedic response; they have access to AED’s

The Medical School is an independent organisation and also relies upon a paramedic response.

Community based services reply on a paramedic response.

8.2 Adult and Paediatric arrests (areas with access an arrest team)

In case of a cardio-pulmonary arrest, the person calling the team must dial 2222 from the nearest internal telephone, this will put them directly through to the switchboard operator.

The following team members will be urgently called to the scene via the Dect system

- Anaesthetist / General ITU resident
- Anaesthetic nurse / ODP or intensive care nurse
- Medical registrar (RVI)
- Coronary Care Unit nurse (RVI/ Dental / FH)
- F2 / SHO Medicine (RVI & FH)
- Cardiothoracic senior Registrar (cardio block, FH)
- Foundation year 1 doctor
- Porter
- Paediatric Registrar (Paediatric arrests)
• Paediatric SHO (Paediatric arrests)
• Paediatric Anaesthetic nurse (Paediatric arrests)
• Anaesthetist
• Dental nurse (Dental hosp)

Arrest of a pregnant woman
In the case of a pregnant lady arresting the person calling for the team should dial 2222 and inform the telephonist there is a maternal arrest.

8.3 Obstetric Emergencies (RVI only)

In case of an obstetric emergency, the person calling the team must dial 355 from the nearest internal telephone, this will put them directly through to the switchboard operator.

The following team members will be urgently called to the scene via the Dect system
• Obstetric Anaesthetist
• Obstetric Registrar
• Obstetric SHO
• Anaesthetic Nurse
• Senior Midwife
• Obstetric Consultant (When available)

8.4 Neonatal Emergencies (RVI only)

In case of a neonatal emergency, the person calling the team must dial 356 from the nearest internal telephone, this will put them directly through to the switchboard operator.

The following team members will be urgently called to the scene via the Dect system.
• Spr (Neonates)
• Delivery suite SHO
• Anaesthetic Nurse
• SHO (Covering Delivery suite)

<table>
<thead>
<tr>
<th>Adult &amp; Paediatric Arrests</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Site</strong></td>
</tr>
<tr>
<td>Freeman Hospital</td>
</tr>
<tr>
<td>Centre for Aging and Vitality</td>
</tr>
<tr>
<td>Royal Victoria Infirmary</td>
</tr>
<tr>
<td>Dental Hospital</td>
</tr>
<tr>
<td>Community based services</td>
</tr>
</tbody>
</table>


### Obstetric and Neonatal emergencies

<table>
<thead>
<tr>
<th>Site</th>
<th>Number</th>
<th>Area covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVI</td>
<td>355</td>
<td>Obstetrics</td>
</tr>
<tr>
<td></td>
<td>356</td>
<td>Neonatal</td>
</tr>
</tbody>
</table>

8.5 The person calling must give the following information:

- Confirm a cardiac arrest has occurred.
- Give a clear description of the location of the arrest Hospital site; the ward / department; wing and level
- Whether the arrest is adult; maternal; paediatric, or neonatal (Neonatal team available on RVI site only)
- Confirm which site / building they are calling from e.g. Freeman ; give post code if getting a paramedic response.
- Information given must be precise and the caller should stay on the line until the operator ends the call.

(For procedures relating to the DECT handsets please refer to appendix 1.)

8.6 The switchboard operator calls the cardiopulmonary arrest team for the area concerned, via the DECT handsets / bleep, transmitting a short verbal message, using the DAKS telephone / bleep system, giving the location of the arrest.

### Staff roles and responsibilities on finding a collapsed person and during Resuscitation

In the event of an emergency collapse on the ward or in the hospital area, each individual has a part to play to ensure that the casualty has the best chance of survival, by exercising their **individual responsibilities** to the best of their ability.

These are:

9.1 **Staff finding a collapsed individual should follow the Resuscitation Council BLS arrest procedure** – (link To BLS; AED Algorithms At http://www.resus.org.uk/pages/guide.htm)

9.2 **The individual finding a collapsed person:**

- Assess the patient in accordance with Resuscitation Council (UK) current guidelines
- Call switchboard using the appropriate emergency number and give clear instructions relating to the location of the event.
- Initiate prompt competent Basic Life Support (link to Trust BLS Algorithms and http://www.resus.org.uk/pages/guide.htm) (Appendix 2 /3)
- Apply AED if available
- Get resuscitation equipment to the bedside
• Allow access for the team or direct the team to the incident
• Notify their own medical staff urgently
• Assist the team
• Care for relatives and or other patients.

(The order of events may vary depending on the number of staff present)

9.3 Medical Staff on the Ward
• To be competent in Basic Life Support
• To be familiar with the resuscitation equipment in their locality
• As in 8.2.

9.4 Medical Staff on the Arrest Team
• To have an effective knowledge of the site geography
• To have basic familiarity with defibrillators and the types of defibrillator in use on their site
• To carry an arrest dect phone in working order, and to ensure safe handover at shift-end.
• To respond to arrest calls promptly
• To have a working knowledge and be able to apply the current UK resuscitation guidelines for BLS (Adult, Paed, Neonatal) and ALS; EPLS/APLS/NALS (guideline appropriate for speciality)
• To arrange for continuing care of the patient and transfer to an appropriate area if required. Senior medical staff or specialists should be involved before transfer. Portable equipment for transfer is available from the Intensive care units or Coronary Care. Patient transfer usually includes appropriate medical escort and often involves the Outreach team.
• The team leader
• The team leader will usually be the Resident Medical Officer carrying the DECT phone, or the most senior / appropriately trained physician allocated to the team. S/He must be clearly identified on arrival and will supervise the resuscitation attempt.
• It is the team leader’s responsibility to ensure safe transfer of the patient, with appropriate portable equipment, unless this role has been appropriately delegated. The team leader should not leave the patient until safe handover to another clinical team.
• The team leader must ensure that the patient is transferred with appropriately trained staff
• The team leader must ensure that an arrest audit form is completed and returned to the appropriate department.
• The team leader must thoroughly document the event in the patient’s notes (including making a record of the key individuals present at the resuscitation episode).

9.5 The medical team currently responsible for the patient’s care are expected to attend, once notified of the event.
9.6 Secure (locked) areas must ensure that the cardiac arrest team members are able to gain access in the event of a cardiopulmonary arrest. Exceptionally this may require using “smash glass” access to prevent delays accessing such areas.

A relative (or significant other) may request to be present at any stage of the resuscitation attempt. The final decision is the responsibility of the team leader who must ensure the safety of all individuals present. A member of staff must be available to stay with the relative and liaise with the arrest team accordingly.

9.7 Emergency Situations in the community
If a person is discovered in a state of collapse it is the responsibility of an appropriately trained member of staff to assess the person’s level of responsiveness, airway, breathing and circulation. If a member of staff does not feel competent to undertake this assessment then it is their responsibility to get the assistance of someone who is.

9.7.1 Once cardiac/respiratory arrest has been identified a call should be made to the crash team (where available) or the Emergency Ambulance Service by dialling 999 and giving details to the emergency operator including what building and the postcode.

9.7.2 Undertake BLS/ILS measures and continue to do so until the crash team or the paramedics arrive and take charge of the situation. If necessary, the assistance of other staff members should be sought.

9.7.3 When the emergency is over there should be a written record made (if the victim is a patient) in the medical notes/nursing notes describing the:
- discovery of the collapsed person;
- assessment undertaken;
- subsequent action taken;
- treatment given;
- outcome of the resuscitation procedure

9.7.4 For all areas off the acute sites (RVI, FH, Dental), following the event the incident should be reported using the Trust Datix online form.

9.7.5 If an AED has been deployed a Resuscitation Council event form should also be completed and sent to Resuscitation services, at the RVI.

10 Decisions Relating To Cardiopulmonary Resuscitation

10.1 It is essential to identify the patients for whom cardiopulmonary arrest would be an appropriate terminal event, and for whom cardiopulmonary resuscitation would be inappropriate. This is addressed in the Trust’s Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy for Infants, Children and Young People.
10.2 Some patients may have a valid Advance Refusal of Treatment or “living will” and this should be acknowledged in respect of cardiopulmonary resuscitation. Any Advance Refusal or “living will” with reference to cardiopulmonary resuscitation should be considered as soon as possible on admission. In this event, both the Policy for Advanced decisions and the Do Not Attempt Resuscitation Policy should be consulted.

11 Inter-hospital Patient Transfer and Post-Resuscitation Care

11.1 Post resuscitation the patient’s condition is usually unstable and requires expert medical and nursing care. The patient should be as stable as possible prior to transfer. Although there may be situations where ongoing appropriate care is unavailable at the site of the collapse and the patient will need to be transferred rapidly to enable definitive treatment.

11.2 The person responsible for the safe and appropriate transfer of a patient, post resuscitation is the team leader. This role may be delegated to another appropriately trained member of staff, often the anaesthetist.

11.3 The team leader (unless the role has been appropriately delegated) will arrange for continuing care of the patient and transfer to an appropriate area if required.

11.4 Senior medical staff and nursing staff or specialists should be involved before transfer. Senior staff responsible for the receiving area should be contacted and authority for transfer agreed.

11.5 Portable equipment for transfer is available from the Intensive care units or Coronary Care Unit (if not at the scene of the collapse this should be collected for transfer). Oxygen for transfer can be obtained via the portering staff.

11.6 Patient transfer will include appropriate medical escort and often involves the Outreach team.

11.7 The team leader should not leave the patient until they have been accepted by another clinical team.

12 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.
## Monitoring and Review

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Method</strong></td>
<td><strong>By</strong></td>
</tr>
<tr>
<td>Attendance at training</td>
<td>Directorates will monitor attendance rates for BLS training (adult, paediatric, neonatal) and put in place action plans to rectify any problems. The staff development and training department will provide the Resuscitation Officers / Resuscitation Committee with quarterly reports on the BLS (adult &amp; paediatric) training figures.</td>
</tr>
<tr>
<td>Review of training courses</td>
<td>The Resuscitation Officers will monitor the training carried out by cascade trainers. This will include review of evaluation forms completed by attendees, attendance at a cascade update, (a minimum of one update a year) and by ensuring the trainers fulfil the other criteria for being a Trust trainer.</td>
</tr>
<tr>
<td>Adherence to resuscitation guidelines and equipment available</td>
<td>Resuscitation Officers will attend arrests when able (e.g. not training) to monitor the adherence to the resuscitation guidelines and equipment availability.</td>
</tr>
<tr>
<td>To monitor resuscitation throughout the Trust.</td>
<td>Audits of resuscitation equipment (including resuscitation trolleys).</td>
</tr>
<tr>
<td>Do not attempt resuscitation orders</td>
<td>Senior Resuscitation Officer / Clinical Governance &amp; Risk dept</td>
</tr>
</tbody>
</table>
14 Consultation and review

15 Implementation (including raising awareness)

16 References

- NHSLA Risk Management Standards for Acute Trusts
- Willis Corroon.
- European Resuscitation Council (1992)
- European Resuscitation Council
- Resuscitation Council (UK) (2010)
- www.resus.org.uk/pages/standard.html
Management of DECT handsets used by the cardiac arrest team members

The nominated members of staff carrying a cardiac arrest DECT handset at the time of the arrest are obliged to attend promptly.

Responsibilities of staff carrying DECT handsets

The arrest call system will be tested regularly, with team members getting at least one test call per day – the person holding the hand set must respond to the switch board. (Please refer to DECT user guide)

Team members who hold an arrest team cordless hand set should wherever possible ensure the handset they hand over at the end of their shift has had fully charged batteries inserted. In extreme cases when this is not possible the person handing over the hand set MUST inform the person receiving the hand set that it does not have a fully charged battery and the team member receiving the hand set MUST check the battery level and insert fully charged batteries as soon as possible.

Please ensure that only re-chargeable batteries are used in the DECT handsets and in the charging units. Do not attempt to put non-rechargeable batteries into the battery charger.

Those staff who have the small handsets, who are not on the team 24hrs, MUST ensure their handsets are put on their charger overnight and collected promptly the next day.

Any problems with the handsets must be reported immediately to switch board.

For battery type please refer to the dect telephone system on the trust intranet

Alkaline batteries must not be used in the dect handsets under any circumstances.
Appendix 2

BLS / CPR Guidelines 2010
For use in the UK (Basic Life Support / Cardio-Pulmonary Resuscitation)

S.A.F.E Approach

YES
Leave in recovery position (unless you suspect cervical spine injury)
GO for HELP

SHOUT for local help

Assess for RESPONSE

Victim RESPONDS?

NO

AIRWAY
Use Head Tilt & Chin Lift, (Jaw Thrust if head or neck trauma suspected).
Ensure mouth is clear. Finger sweep only if necessary

Are there SIGNS of NORMAL Breathing & / or Circulation?

Yes
Assess Patient
Get Advanced HELP
Treat appropriately

NO

NOT Breathing

Has signs of Circulation

Get Advanced HELP

Begin Rescue Breathing, Check every min for circulation

NO

Get HELP NOW!
Call 999 / 112 or Arrest Team on 2222

Begin 30 Chest compressions at rate of 100-120min

Give 2 attempts at Rescue Breathing (mouth to mouth) unless unable / unwilling to do so. Use a mask & filter/pocket mask if available

Continue at ratio of 30:2 until: 1 Help arrives, or 2 You are exhausted, or 3 Victim shows signs of life
**Check for Safety**

- Leave child in position (if in no further danger).
- Get help if needed.
- Reassess

**Check Responsiveness**

**No Response**

**Shout for Help**

**Open Airway.**
(Head tilt, chin lift / Jaw thrust)

**Check for Normal Breathing**
(look, listen & feel)

- Breathing abnormal / Absent
  - Remove obvious airway obstruction
  - Give 5 initial rescue breaths

- **Assess for signs of life +/- check pulse**

- No signs of life / Pulse < 60bpm / Unsure
  - *15 chest compressions : 2 breaths*

* Lone rescuers may use a ratio of 30:2, particularly if they are having difficulty with the transition between compressions and Ventilation.
Getting help

It is vital for rescuers to get help as soon as possible when a child collapses.

- When more than one rescuer is available, one should start resuscitation while the other goes for assistance.

- If only one rescuer is present, they should perform 1 minute of resuscitation before going for assistance. The only exception to performing 1 min of CPR before going for help is in the case of a child with a witnessed, sudden collapse when the rescuer is alone. In this case cardiac arrest is likely to be an arrhythmia and the child may need defibrillation. Seek help immediately if there is no one to go for you.

NB. It may be possible for you to take an infant or small child with you whilst summoning help.

Foreign Body Airway Obstruction

- Assess Safety
  - Assess Severity
    - Ineffective Cough
      - Shout / Send for help
    - Effective Cough
      - Encourage cough
        - Continue to check for deterioration to ineffective cough or relief of
      - Conscious
        - 5 Back Blows
          - 5 Thrusts (chest for infant < 1yr) (Abdominal for child >1yr)
          - After 1 minute, summon emergency services if not already done
    - Unconscious
      - Check & Open Airway
        - 5 Breaths
          - Start CPR
          - After 1 minute, summon emergency services if not already done
**Policy Title:** Cardiopulmonary Resuscitation (CPR) and Training Policy

<table>
<thead>
<tr>
<th>Yes/No?</th>
<th>You must provide evidence to support your response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)</td>
<td>This policy does not discriminate against any race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age or disability</td>
</tr>
<tr>
<td>Race *</td>
<td>No</td>
</tr>
<tr>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
</tr>
<tr>
<td>Gender *</td>
<td>No</td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
</tr>
<tr>
<td>Religion or belief *</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people *</td>
<td>No</td>
</tr>
<tr>
<td>Age *</td>
<td>No</td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health problems *</td>
<td>No</td>
</tr>
<tr>
<td>Gender reassignment *</td>
<td>No</td>
</tr>
<tr>
<td>Marriage and civil partnership *</td>
<td></td>
</tr>
</tbody>
</table>

2. Is there any evidence that some groups are affected differently?

3. If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?

4(a). Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).

4(b). If so can the impact be avoided?

4(c). What alternatives are there to achieving the policy/guidance without the impact?

4(d) Can we reduce the impact by taking different action?

**Comments:**

**Action Plan due (or Not Applicable):**

N/A

Name and Designation of Person responsible for completion of this form: Karen Rowell, (Senior Resuscitation Officer)

Date: 09/04/2013

Names & Designations of those involved in the impact assessment screening process: Karen Rowell (Senior Resuscitation Officer)

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Frances Blackburn, Head of Nursing, Freeman/Walkergate, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.