

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Cardiopulmonary Resuscitation (CPR) and Training Policy

Effective: February 2010

Review: February 2013

1. This policy covers:-

- 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

2. Introduction

- 2.1 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.
- 2.2 It is Trust policy to provide immediate and effective Cardiopulmonary Resuscitation (CPR) at the site of a cardio-respiratory arrest, when indicated.
- 2.3 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.

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 and 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
 - 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 'Not For Resuscitation' orders within their directorate

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

3.6 Clinical staff

- Attend annual basic Life support 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 next nearest resuscitation equipment.

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 2004
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- 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

- 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.

Staff working only in adult patient areas

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

Staff working with paediatric patients - minimum requirements

Staff Group	Adult BLS	Paed BLS	NLS
Medical Staff (with patient contact)	✓	✓	
Nursing staff	✓	✓	
Nursing Assistants (Aux/N; S/W;HCA)	✓	✓	
Dentist (all grades)	✓	✓	
Dental Nurses	✓	✓	
Technicians in dentistry (with patient contact)	✓	✓	
Physiotherapists	✓	✓	
Physiotherapy assistants / helpers	✓	✓	
Pharmacists	✓	✓	
Occupational Therapists	✓	✓	
Occupational Therapy assistants / helpers	✓	✓	
Portering Staff	✓	✓	
Plaster Technicians	✓	✓	
Cardiac & Nuclear Technicians	✓	✓	
Operating department practitioners	✓	✓	
Operating Department Technicians and Anaesthetic Assistants (nursing)	✓	✓	
Radiographers Radiography practitioners	✓	✓	
Radiographer assistants / helpers	✓	✓	
Dieticians	✓	✓	
Any staff member who regularly cares for / deals with paediatric patients	✓	✓	
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

Staff Group	Adult BLS	Paed BLS	NLS
Midwives	✓		✓
Medical Staff	✓		✓
Neonatal Nursing staff	✓		✓
Nursery Nurses	✓		
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			

4.15 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 nor 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

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

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

I. 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.

Staff Group	Paed ILS / 1day PLS	APLS / EPLS
Consultant Anaesthetists/ Accident and Emergency	✓	
SpR's, SHO's' F2's	✓	
SpR's & Consultant anaesthetist (if appropriate to their role)		✓
Nursing staff - On arrest team	✓	
Operating Department Practitioners (on paediatric arrest team)	✓	
Potential BLS Cascade trainers	✓	

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

Staff Group	In-house Clinical Skills day
Midwives	✓
Medical Staff	✓

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, (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:

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 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 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. paediatric paddles, 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 qualified 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, 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 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 are available at the RVI, NGH 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; NGH; FH has access to a fast response multidiscipline team in the event of a cardiopulmonary arrest occurring.

Walkergate relies on a paramedic response. A senior nurse and porter are also called to the scene urgently (semiautomatic defibrillators are being introduced).

The Centre for Life relies upon a paramedic response (semiautomatic defibrillators are being introduced).

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

- 8.2 Adult and Paediatric arrests

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
- Coronary Care Unit nurse (RVI/ Dental / FH)
- F2 / SHO Medicine (RVI & FH) Musculoskeletal (NGH)
- 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)

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)

Adult & Paediatric Arrests		
Site	Number	Area covered
Freeman Hospital	2222	All areas
Walkergate Hospital	2222 (Switch board will then put out a 999 call for an ambulance)	All areas
Newcastle General Hospital	2222	All areas
Royal Victoria Infirmary	2222	All areas
Dental Hospital	2222	Dental Hospital
Obstetric and Neonatal emergencies		
Site	Number	Area covered
RVI	355	Obstetrics
	356	Neonatal

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 e.g. the ward and block

- Whether the arrest is adult, paediatric, or neonatal (Neonatal team available on RVI site only)
- Confirm which site they are calling from e.g. Freeman
- 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. In the case of Walkergate Hospital, switchboard will also call a paramedic ambulance to the scene.

9. 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 Algorithms and <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)
- 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 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.

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 Resuscitation](#)" Policy.

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 [Advance Refusal of Treatment](#) and the [Do Not Attempt Resuscitation Policy](#) should be consulted.

11. 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. Monitoring and Review

- 12.1 Mandatory training will be monitored in accordance with the Mandatory training policy
- 12.2 Directorates will monitor attendance rates for BLS training (adult, paediatric, neonatal) and put in place action plans to rectify any problems.
- 12.3 The Directorate of Women's services will monitor training attendance in their directorate and take appropriate action if targets are not being met.
- 12.4 The staff development and training department will provide the Resuscitation Officers / Resuscitation Committee with quarterly reports on the BLS (adult & paediatric) training figures.
- 12.5 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.
- 12.6 The introduction and use of the MEWS scoring system lies outwith this policy but will be audited by Outreach teams.
- 12.7 Resuscitation Officers will attend arrests when able (e.g. not training) to monitor the adherence to the resuscitation guidelines and equipment availability.

12.8 In order to monitor resuscitation throughout the Trust the following audits will be carried out:-

- Audits of resuscitation equipment (including resuscitation trolleys).
- Cardiac arrest calls attended by the resuscitation teams, including all calls made to switchboard.
- Do not attempt resuscitation orders. (annually)

12.9 The Senior Resuscitation Officer (or deputy) will present the monitoring reports outlined above on a quarterly basis to the Resuscitation Committee. The committee will review the reports, develop action plans to address any deficiencies identified and monitor these through to completion. The resuscitation committee will review audit results and advise the Trust accordingly.

12.10 This policy will be reviewed every three years. Comments on the content or implementation of the policy should be directed to the Chair of the Resuscitation Committee, or the Resuscitation Officers.

References

- Clinical Negligence Scheme for Trusts (CNST) (2003)
- NHSLA Risk Management Standards for Acute Trusts
- Risk Management standards and Procedures: Manual of Guidance.
- Willis Corroon.
- European Resuscitation Council (1992)
- CPR Instructor's guide cited in Association of Resuscitation Officers (1993) Standards in Resuscitation Training for Hospital Staff.
- European Resuscitation Council
- Resuscitation Council (UK) (2004)
- Cardiopulmonary Resuscitation: Guidance for clinical practice and training in hospitals.
- 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.

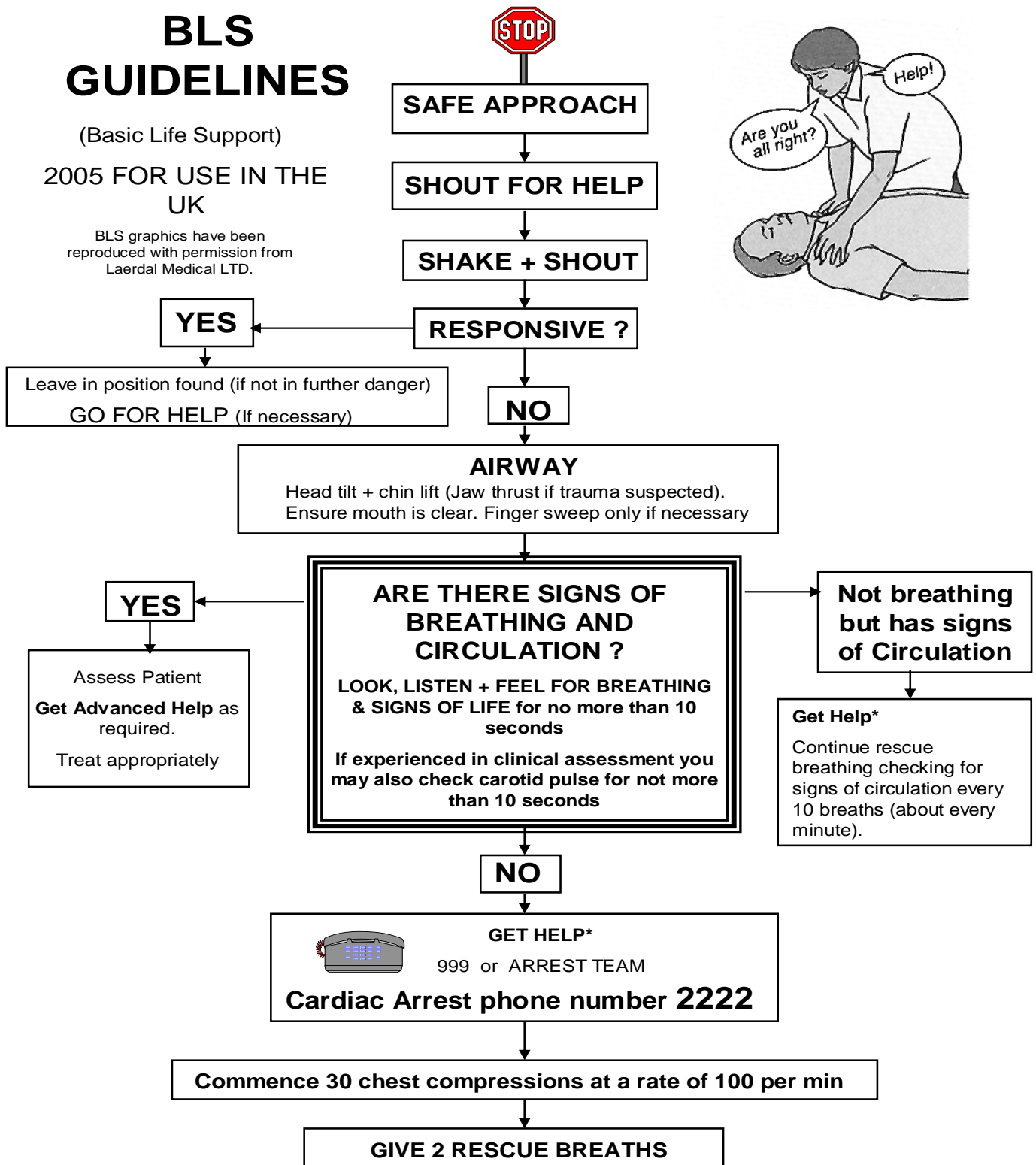
For battery type please refer to the dect telephone system on the trust intranet

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

BLS GUIDELINES

(Basic Life Support)
2005 FOR USE IN THE UK

BLS graphics have been reproduced with permission from Laerdal Medical LTD.



Continue at ratio 30:2 until either:

1. help arrives to take over
2. You become exhausted
3. The patient makes a sign of life

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Cardiopulmonary Resuscitation (CPR) and Training Policy	Policy Author:	Karen Rowell, Senior Resuscitation Officer
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:	No	This policy does not discriminate against any race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age or disability
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?		In relation to training all staff who require the training for their job are welcome. There may be some staff who may be unable to undertake some resuscitation skills due to disability / disease.
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?		Clinical staff have a duty of care for their patients, risk assessments will be made on an individual basis if a member of staff cannot perform basic life support. There may be individual exception / adaption to meet the individual's needs.
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If "yes", please answer sections 4(b) to 4(d)).</i>	No	
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):
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Name and Designation of Person responsible for completion of this form: Karen Rowell, Senior Resuscitation officer

Date: 23 / 02/2010

Names & Designations of those involved in the impact assessment screening process:

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 (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.)