CP11
Resuscitation Policy

Contents

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Appendices

1.0 Policy Statement (Purpose / Objectives of the policy)

This resuscitation policy fully supports the recommendations for quality standards for cardiopulmonary resuscitation practice and training published by the Resuscitation Council UK https://www.resus.org.uk/quality-standards/ .

The purpose of the policy is to provide direction and guidance for the planning and implementation of a high-quality and robust resuscitation service to the organisation. The strategy for resuscitation incorporates the current published guidelines for resuscitation (Resuscitation Council UK 2021)

2021 Resuscitation Guidelines | Resuscitation Council UK

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

Advance Care Plan (ACP) - A structured, documented discussion with individuals and their families or carers about their wishes and thoughts for the future. An ACP is likely to contain information about personal preferences (e.g. place of care preferences, funeral plans, understanding prognosis etc.)

Anaphylaxis - A severe systemic allergic reaction.

Basic Life Support - A fundamental emergency treatment consisting of Cardiopulmonary Resuscitation or emergency care that is provided until more advanced treatment is available**.**

Best Interests - An objective measure of overall benefit to a particular person. Under the Mental Capacity Act 2005, decisions made on behalf of people who lack mental capacity to do so themselves must be made in their 'best interests'. This includes a consideration of the wishes and values of the person, and consultation with those close to them. Please refer to the Mental Capacity Act 2005, and local policy, for further information.

Capacity - Capacity means the ability to make and express a decision in relation to a particular matter. To have capacity a person must be able to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision and to communicate that decision (whether by talking, using sign language or any other means). If their mind is impaired or disturbed in some way, making and communicating decisions may not be possible. A person may lack capacity temporarily or permanently. However, a person should be assumed to have capacity for a decision unless or until it has been shown that they do not.

Cardiac Arrest - Cessation of breathing and circulation.

Cardiac Arrest Team - A multidisciplinary team of healthcare professionals who will respond to a patient in the event of a cardiac arrest.

Cardiopulmonary Resuscitation (CPR) - A procedure to support and maintain breathing and circulation for a person in the event of a cardiac arrest.

Children and Young People - In law, a child is anyone under the age of 18 years. Parental responsibility persists until a child is 18, but a child can attain competence to make decisions for themselves (Gillick competence) according to their age and maturity and, once they are 16 years old, are assumed to have capacity to make their own decisions like an adult. In this document the term “children and young people” is used to refer to anyone under the age of 18, but the law in this area is complex, particularly with regards to those who are 16 and 17.

Consent - The process by which a person with mental capacity can accept or refuse a treatment that is offered to them. To be valid, consent must be given freely, based on adequate information.

Defibrillation - The delivery of a brief electric shock to the heart which may terminate a shockable rhythm during cardiac arrest.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) - To withhold the techniques of cardiopulmonary resuscitation following formal agreement of a Do Not Attempt Resuscitation order.

Mental Capacity Act (MCA) - The Mental Capacity Act (MCA) is legislation designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

Resuscitation Council UK - A nationally recognised registered charity which publishes guidelines and recommendations for resuscitation in clinical practice.

3.0 Accountabilities

Healthcare organisations have an obligation to provide an effective resuscitation service to their patients and appropriate training to their staff. A suitable infrastructure is required to establish and continue support for these activities. The following will be responsible for implementing this policy throughout the organization.

3.1 Chief Executive

The Chief Executive will ensure that an appropriate resuscitation policy which respects patients' rights is in place, understood and accessible by all relevant staff, and that such policies are subject to appropriate audit and monitoring arrangements.

3.2 Resuscitation Group

The Trust Resuscitation Group will be responsible for the policy content, review, distribution, implementation and monitoring of compliance. They will ensure the policy complies with national and international guidelines and reflects best evidence-based practice.

3.3 The Resuscitation Group will report to the Quality and Safety Advisory Group on a 6-monthly basis. Reporting up to board level and down to local management levels will be in accordance with OP10 Risk Management and Patient Safety Reporting Policy

3.4 Line Managers

Managers will be responsible for ensuring that mandatory resuscitation training outlined in this policy is met by their staff.

3.5 All Staff

All employees will be responsible for ensuring that they meet the mandatory resuscitation training requirements that will equip them to competently carry out the duties and responsibilities of their posts.

4.0 Policy Detail

4.1 Training Strategy

The strategy for resuscitation training embodies the statements and guidelines published by the Resuscitation Council UK and the European Resuscitation Council, incorporating the most recent updates to these guidelines. This explicitly incorporates the identification of deteriorating patients at risk of cardiac arrest and a strategic approach to implement preventative measures using an Early Warning System.

4.1.1 The organisation will provide sufficient and appropriate resuscitation training for each of the main staff groups. Profession specific resuscitation training will be directed by their respective functional role and the guidelines and directives issued by their professional bodies (e.g. The Royal College of Anaesthetists).

4.1.2 **Training Recommendations**

For mandatory resuscitation training requirements, refer to the training needs analysis OP 41 *Induction and Mandatory Training Policy* (Appendix 4).

For training recommendations, training content, booking and monitoring information, see Attachment 1).

4.2 Prevention and Management of the Deteriorating Patient

There must be a co-ordinated approach to identifying any deterioration in patients and the subsequent actions that aim to prevent further deterioration and possible subsequent cardio-respiratory arrest.

4.2.1 Prevention of cardiac arrest requires:

- Monitoring of patients
- Recognition of patient deterioration
- A system to call for help
- An effective response
- Staff Training

Details of the above can be found in the Management of the Deteriorating Patient Policy (CP61).

4.2.2 If a patient is deteriorating rapidly and a cardiac arrest may be imminent, consider activation of the cardiac arrest team.

4.3 The Resuscitation Team

4.3.1 **The patient in cardiac arrest (New Cross and Cannock Chase Hospital site)**
In the event of a cardiac arrest the appropriate emergency team must be summoned immediately by using the universal telephone number **2222** or alternatively, where available, using the cardiac arrest alarm system. When dialling **2222** the caller must state: adult, paediatric or neonatal cardiac arrest and specify the precise location of the patient. At New Cross Hospital, state zone and number, and at Cannock Chase Hospital (CCH) state ward or department name and specify CCH.

4.3.2 **The patient in cardiac arrest (Community)**
In the event of a cardiac arrest, an emergency ambulance must be summoned by telephoning 999. When dialling 999 the caller must state adult, paediatric or neonatal cardiac arrest and specify the precise location of the patient.

4.3.3 **The patient in cardiac arrest (West Park Hospital)**
In the event of a cardiac arrest, an emergency ambulance must be summoned by telephoning 9 followed by 999; the caller must state adult, paediatric or neonatal cardiac arrest and specify the precise location of the patient.

4.3.4 **Activation of the Cardiac Arrest Team (New Cross and Cannock Chase Hospital sites)**
On receipt of a 2222 call or the cardiac arrest alarm system being activated in switchboard, the switchboard operator will alert the appropriate cardiac arrest team members (Attachment 2).

4.3.5 **Composition of New Cross Hospital Cardiac Arrest Team**
The Trust will have at all times designated members of the resuscitation team that will respond to adult, paediatric, neonatal and Heart and Lung Centre cardiac arrests. The members will be identified at the beginning of each shift as per specialist area arrangement (Attachment 2).

4.3.6 **Composition of Cannock Chase Hospital Cardiac Arrest Team**
The Trust will have at all times designated members of the resuscitation team that will respond to adult and paediatric cardiac arrests. The members will be identified at the beginning of each shift (Attachment 2).

4.4 Procedure in the Event of a Cardiac Arrest

The procedure in the event of a cardiac arrest must be fully compliant with the guidelines specified by the Resuscitation Council UK 2021(Attachment 3).

4.5 Post Resuscitation Care

The organisation will make provisions for safe continuity of care and, where necessary, safe transfer following resuscitation of the patient. This is the responsibility of the cardiac arrest team leader and may involve the following steps:

- Referral to a 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 Service

- Staff experienced in patient retrieval and transfer
- Informing relatives.

4.5.1 Transfer of patients post resuscitation must be in adherence with Resuscitation Council UK 2021 Guidelines - Post-resuscitation Care (appendix 1) and with Trust Policy CP05, *Transfer of patients between wards, departments, specialist units and other hospitals.*

4.6 Resuscitation Equipment, Checking, Replenishment and Cleaning

All resuscitation equipment (cardiac arrest trolleys, defibrillators, oxygen and suction) must be maintained in a state of readiness at all times (Attachment 4).

4.7 Procurement

All defibrillators and defibrillator consumables at New Cross, Cannock Chase and West Park Hospitals will be standardised. Specification will be determined by the Medical Physics Department.

4.8 Manual Handling

In situations where the collapsed patient is on the floor, in a chair or in a restricted or confined space, the organisational guidelines for the movement of the patient must be followed to minimise the risks of manual handling and related injuries to both staff and the patient. Please also refer to https://www.resus.org.uk/library/publications/publication-guidance-safer-handling

4.9 Infection Prevention

Personal safety is the first priority during any resuscitation attempt. Gloves must be put on as soon as possible. Other protective measures such as eye protection, aprons and face masks may be needed. Sharps boxes must be available on all cardiac arrest trolleys. See Trust Policy IP12, Standard Precautions for Infection Prevention.

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

- All patients who are known to have or suspected of having an infectious disease;
- All undiagnosed patients entering the & Emergency Department, Emergency Admission Unit, Outpatients, Walk in Centres or other admission source;
- Other persons where the medical history is unknown.

All clinical areas will have immediate access to airway devices (e.g. a pocket mask) to minimise the need for mouth-to-mouth ventilation. However, in situations where airway protective devices are not immediately available, start chest compressions whilst awaiting an airway device. If there are no contraindications consider giving mouth-to-mouth ventilations.

4.10 Anaphylaxis

The management of suspected anaphylaxis reactions must be conducted in accordance with the Resuscitation Council UK Guidelines (2021) for the management of anaphylaxis (Appendix 2).

4.11 Defibrillation

Defibrillators must only be operated by persons specifically trained in their use. The operation of defibrillators by doctors, nurses, midwives and allied health care professionals is subject to their compliance with the Trust defibrillation protocol Attachment 5).

4.12 Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Process and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Guidelines

All DNACPR decisions must be based on current legislation and national guidance. Prior to following the Trust's local procedures (Attachment 6) all staff involved in the decision making process must have read and must adhere to Decisions Relating to Cardiopulmonary Resuscitation (3rd edition 1st revision). Guidance from the British Medical Association, the Resuscitation Council [UK] and the Royal College of Nursing

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	Yes – No
2	Does the implementation of this policy require additional revenue resources	Yes – No
3	Does the implementation of this policy require additional manpower	Yes – No
4	Does the implementation of this policy release any manpower costs through a change in practice	Yes – No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	Yes – No
	Other comments	

6.0 Equality Impact Assessment

Equality and diversity risk assessment has been completed by the Resuscitation Group. There is no adverse Equality and Diversity impact identified at this time.

7.0 Maintenance

The Trust Resuscitation Group will be responsible for reviewing this policy every 3 years or with national guidance change, to ensure that it reflects best evidence-based practice and also meets the needs of the Trust.

8.0 Communication and Training*

This policy will be communicated to all new staff at Trust Induction.
This policy is located under the policies listing on the Trust Intranet.
Training related to this policy is covered in section **4.1**

9.0 Audit Process

	Lead	Monitoring	Frequency	Committee/ Group
Duties	Resuscitation Group	Policy Review	3 yearly	Trust Policy Group
ReSPECT forms	Trust Standards Lead	Audit	Annually	Resuscitation Group
Process for ensuring the continual availability of resuscitation equipment	Clinical Skills & Resuscitation Service	Audit	Annually	Resuscitation Group
Patient safety incidents	Clinical Skills & Resuscitation service	Reports from DATIX	2 monthly	Resuscitation Group
Resuscitation attempts	Clinical Skills & Resuscitation service	Audit	2 monthly	Resuscitation Group

10.0 References

Mental Capacity Act (2005) Code of Practice. London: TSO, 2007.

Resuscitation Council UK Resuscitation Guidelines 2021 Available at: 2021 Resuscitation Guidelines | Resuscitation Council UK

Quality standards for cardiopulmonary resuscitation practice and training. London: Resuscitation Council UK Available at: https://www.resus.org.uk/quality-standards/

Decisions Relating to Cardiopulmonary Resuscitation (3rd edition 1st revision). Guidance from the British Medical Association, the Resuscitation Council [UK] and the Royal College of Nursing.

Children and Young Person's Advanced Care Plan. Available at: http://CYPACP.UK

ReSPECT: Recommended Summary Plan for Emergency Care and Treatment website available at ReSPECT | Resuscitation Council UK

Reference Number and Policy name: **CP11 – Resuscitation Policy**	**Version: 8.6** **August 2022**		**Status:** **Final**	**Author: Resuscitation Group** **Director Sponsor: Chief Nurse**
Version / Amendment History	Version	Date	Author	Reason
	1	February 2003	Resuscitation Group	Original
	2	November 2008	Resuscitation Group	To comply with NHSLA Standards
	3	May 2009	Resuscitation Group	Mandatory compliance targets updated
	4	November 2011	Resuscitation Group	Harmonisation of Trust and Community Policies. New Resuscitation guidelines
	4.1	September 2012	Resuscitation Group	Amendment to Attachment 2 only so no change to version number
	5	March 2013	Resuscitation Group	Attachment 2 developed into a new policy specifically for the Deteriorating Patient
	5.1	September 2014	Resuscitation Group	Amendment to attachment 6 (agreed 27/06/14 TMC). To be live Sept 2014.
	5.2	February 2015	Resuscitation Group	Updated to incorporate practices at Cannock Chase Hospital (CCH) and minor updates to attachments
	5.3	September 2015	Resuscitation Group	Updates to Att 2 Activation and Composition of the Cardiac Arrest Team, Att 4 Equipment, Checking, Replenishment and Cleaning and Att 5 Defibrillation
	6.0	March 2016	Resuscitation Group	Full routine review
	6.1	August 2016	Resuscitation Group	National Guidance revised for decisions relating to cardiopulmonary resuscitation. Minor amendment to endorsing DNACPR orders at West Park Hospital

	6.2	Sept 2017	Resuscitation Group	Update regarding VI practices and also minor amendments, additions and clarification
	6.3	April 2018	Resuscitation Group	Update to appendix 1 and Attachment 1, 2 & 6
	7	April 2019	Resuscitation Group	Full Routine Review
	7.1	Dec 2020	Resuscitation Group	Update to Attachment 2 cardiac arrest team members / roles.
	8	May 2021	Resuscitation Group	National Resuscitation Guidance Update. Change of process from DNACPR to ReSPECT Minor alterations & definition additions
	8.1	August 2021	Resuscitation Group	Minor updates to Appendix 2 and Attachment 6-Appendix 2
	8.2	August 2021	Resuscitation Group	Minor updates to Attachment 6
	8.3	September 2021	Resuscitation Group	Minor update to Attachment 6
	8.4	September 2021	Resuscitation Group	Minor updates to hyperlinks throughout policy and Attachment 6
	8.5	July 2022	Resuscitation Group	Updates to Attachments 1, 2 & 6 – significant changes reviewed via TPG
	8.6	August 2022	Resuscitation Group	Minor updates to Attachment 6

Intended Recipients: All Trust Staff
Consultation Group / Role Titles and Date: Resuscitation Group

Name and date of Trust level committee where reviewed	Trust Policy Group – July 2022 – Version 8.5 Trust Policy Group – August 2022 – Virtual Approval – Version 8.6
Name and date of final approval committee	Trust Management Committee – July 2022
Date of Policy issue	August 2022
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	(3 Yearly) July 2024

Training and Dissemination: Policy will be available on the Trust intranet.

Staff will be made aware of changes at Trust induction and mandatory resuscitation training

To be read in conjunction with:

OP10 Risk Management and Patient Safety Reporting Policy

OP41 Induction and Mandatory Training Policy (Appendix 4).

CP61 Management of the Deteriorating Patient Policy.
CP05 Transfer of patients between wards, departments, specialist units and other hospitals.
IP12 Standard Precautions for Infection Prevention
CP06 Consent to Treatment and Investigation Policy
CP02 Deprivation of Liberty Safeguards (DoLS) Policy
CP04 Discharge Policy (Appendix 2)
OP62 Breaking Bad News Policy

Initial Equality Impact Assessment [all policies]: **Completed Yes**

Full Equality Impact assessment [as required]: **Completed No**

If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.

Contact for Review	Chair of Resuscitation Group
Implementation plan / arrangements [Name implementation lead]	Chair of Resuscitation Group

Monitoring arrangements and Committee	Resuscitation Group Quality and Safety Advisory Group

Document summary / key issues covered:

Resuscitation Training
The Resuscitation Team
Procedure in the Event of a Cardiac Arrest
Resuscitation Equipment, Checking, Replenishment and Cleaning
Defibrillation
Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Process, Advance Care Planning and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
Guidelines

High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**Yes / No (delete as appropriate)** If Yes include the following sentence and relevant information in the Intended Recipients section above – In the event that this is policy is made available to the public the following information should be redacted:

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

Part B **Ratification Assurance Statement**

Name of document: CP11 Resuscitation Policy

Name of author: Nicki Wise Job Title: Lead for Resuscitation

I, the above named author confirm that:

- The Policy presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines(OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: N Wise

Date: 26/5/21

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

CP11	**Resuscitation Policy**	
Reviewing Group		**Date reviewed:**
Implementation lead: Nicki Wise		

Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead/s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.		
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	ReSPECT training packages approved at IMTG 19/5/21	N Wise / H Jennens
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed	ReSPECT summary form approved at Heath Records group 25/5/21	N Wise
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	ReSPECT launch will be communicated throughout Trust / City	H Jennens 1/9/21
Financial cost implementation Consider Business case development	A/W pack costs	
Other specific Policy issues / actions as required **e.g. Risks of failure to implement, gaps or barriers to implementation**		

CP 11 Attachment 1

Resuscitation Training

1.0 Training Recommendations

1.1 The approach to teaching is one of positive encouragement and proven educational efficacy which follows the recommendations for resuscitation teaching advocated by the Resuscitation Council UK.

1.2 All resuscitation training will be provided by the Clinical Skills and Resuscitation Service or by Link Workers or independent Resuscitation Trainers who have been approved by them.

1.3 **Clinical Staff -** Clinical staff will be trained in the recognition of patients at risk and the prevention of cardio-respiratory arrest. Cardiopulmonary resuscitation training and the updating of these skills have been identified as appropriate to role and the expected clinical responsibilities that staff would be expected to undertake when in attendance at a cardiac arrest or a medical, surgical, obstetric, paediatric or neonatal emergency. The level of training may also be determined by their respective professional bodies.

1.4 For mandatory resuscitation training requirements, refer to the training needs analysis OP 41 Induction and Mandatory Training Policy (Appendix 4).

1.5 **Non-Clinical Staff and Volunteers -** Trust staff will have the opportunity to access resuscitation training appropriate to their roles and responsibilities.

1.6 **Communication -** All new Trust employees will be made aware of their training requirements at via their My Academy account.

1.7 Staff that have received resuscitation training elsewhere that is in date and meets the specified criteria for this Trust will be accredited on production of their resuscitation training certificate.

2.0 Booking Information / Access to courses

2.1 Staff who are mandated to require BLS / PBLS / NBLS training will see their required level / topic via their My Academy profile and be able to book a place through this system.

2.2

2.3 Access to training courses that are not mandated to role cannot be booked as per 2.1. These courses may be available via the My Academy Course catalogue or will be communicated locally.

2.3 For Primary Care Vertical Integration sites - BLS training may be delivered by independent resuscitation trainers that have been approved by the Clinical Skills and Resuscitation Service, This training must be booked directly with the trainer. The VI practice / trainer must email the registration / attendance sheet to the

Education and Training Department at New Cross Hospital (rwh-tr.TrainingDatabase@nhs.net.) for training to be accredited

3.0 Training Content

3.1 Resuscitation Theory (Adult) (online e-learning)

- Prevention and recognition of the sick patient
- Recognition and management of Anaphylaxis
- Choking
- Adult Basic Life Support including modifications for the patient in respiratory arrest, children, neck breathers and in pregnancy
- ReSPECT

3.2 Adult Basic Life Support (BLS) Level 2/3 - Practical

- Adult BLS
- Basic airway management including opening manoeuvres, pocket mask and 2-person bag mask valve
- Automated External Defibrillation

3.3 Adult Basic Life Support (BLS) level 1

- Management of the collapsed patient
- Adult BLS

4.0 Paediatric Basic Life Support

4.1 Clinical staff that access Adult Resuscitation Theory will receive information in appropriate modifications for resuscitating children. This does not accredit mandatory paediatric BLS

4.2 Registered health care professionals with a duty to respond to paediatric emergencies must be paediatric basic life support trained

Training Content

- Advanced Care Planning and DNACPR / ReSPECT
- Recognition of the Sick Child (including Paediatric Early Warning Systems)
- Recognition of Anaphylaxis
- Paediatric Basic Life Support (Health Care Professionals with a duty to respond)
- Choking.

5.0 Newborn Life Support

Medical Staff, Nurses and Midwives, who work in Obstetrics or on the Neonatal Unit must do Newborn Life Support training.

Training Content

- Newborn Life Support.

6.0 Immediate / Advanced Life Support

6.1 It is desirable that some groups of staff are trained in Immediate or Advanced Life Support Skills appropriate to their clinical area. This will be determined by the professional's governing body and locally with consideration to risk, resources and availability of training.

6.2 Medical staff within the adult cardiac arrest team must hold an Immediate or Advanced Life Support certificate (or RWT agreed 'in house' equivalent) as detailed in Attachment 2. An Immediate or Advanced Life Support Certificate will cover an individual for the relevant mandatory BLS training for the duration of the certification period.

6.3 Medical staff within the paediatric cardiac arrest team must hold a paediatric Advanced Life Support certificate (or RWT agreed 'in house' equivalent). An Advanced Life Support Certificate will cover an individual for the relevant mandatory BLS training for the duration of the certification.

6.4 Medical staff within the paediatric cardiac arrest team must hold a paediatric Advanced Life Support certificate (or RWT agreed 'in house' equivalent). An Advanced Life Support Certificate will cover an individual for the relevant mandatory BLS training for the duration of the certification.

7.0 Monitoring

7.1 Competency will be assessed at the appropriate training session. If competency is not achieved, Managers will be informed and further training and assessment will be necessary.

7.2 A monthly report will be generated by the Training Database Team for Managers to review their staffs' compliance with mandatory training. It is the Managers' responsibility to take any appropriate action required in the event of non-compliance.

7.3 A monthly report will be generated by the training database team for the Corporate Education Steering Group and the Resuscitation Group to monitor compliance and agree any necessary action plans.

CP 11 Attachment 2

Activation and Composition of the Cardiac Arrest Team

1.0 On receipt of the cardiac arrest message, the resuscitation team will report immediately to the specified location. Resuscitation team members do not need to contact switchboard to acknowledge the call.

1.1 If the cardiac arrest has occurred in an area where there is restricted access, e.g., the Maternity Unit or Paediatric Ward, a member of staff must be made responsible for facilitating access to the area after checking identification of the team member.

1.2 The switchboard operator will contact the staff in the location where the cardiac arrest has occurred to confirm the arrival of the resuscitation team.

1.3 If the cardiac arrest alarm system has been activated and the team has responded, the alarm will be reset.

1.4 The cardiac arrest bleeps will be tested between 11.00 - 12.00 hours each day to ensure that the system and individual bleeps are in working order; all members must respond to this test call at the earliest opportunity. Responses to test calls must be monitored. If there is a failure to respond, the switchboard operator will contact the Consultant on call for that speciality who must investigate and take appropriate action.

1.5 If a member of the cardiac arrest team does not receive a test call or identifies that their bleep is not in working order, they must contact switchboard who will then check the bleep and repeat the test call if necessary.

2.0 Composition of the Resuscitation Teams

2.1 **New Cross Hospital**
The Trust will have at all times designated members of the resuscitation team that will respond to adult, paediatric, neonatal and Heart and Lung Centre cardiac arrests. The members will be identified at the beginning of each shift as per specialist area arrangement.

2.2 **Cannock Chase Hospital**
The Trust will have at all times designated members of the resuscitation team that will respond to adult and paediatric cardiac arrests. The members will be identified at the beginning of each shift.

3.0 The Core Adult Resuscitation Team at New Cross Hospital

Refer to the ‘Medical Cardiac Arrest Team Bleep Allocation’ / ‘crash team rota’ and the ‘General Surgery on Call’ rotas on the Intranet for breakdown of bleep allocations and times. The team will include staff listed below or any other discipline (e.g., Physician Associate) as authorised by Physician A.

Weekday cover

- 'Medical Registrar B' - in the event of this being a locum doctor this role will be covered by 'Registrar A',
- 'AMU cover' - Junior Doctor and
- 'C ward cover' - Junior Doctor.
- If two cardiac arrest calls occur within 30 minutes of each other, a 'Surgical FY1'(or other agreed position / role identified via on-call rota) will attend the second event.

Weekend cover

- 'Medical Registrar B' - in the event of this being a locum doctor this role will be covered by 'Registrar A',
- 'C ward cover' - Junior Doctor and
- 'C ward cover' - Junior Doctor.
  Only 1 of the C ward cover doctors stated above can be FY1 grade
- If two cardiac arrest calls occur within 30 minutes of each other a 'Surgical FY1' (or other agreed position / role identified via on-call rota) will attend the second event.

Night cover

- 'Medical Registrar A' (Mon-Sun),
- 'Medical Registrar B' (Mon-Sun),
- 'C ward cover' - Junior Doctor (Mon-Sun), and
- 'AMU cover' - Junior Doctor (Mon – Thurs) / Additional 'C ward cover' - Junior Doctor (Fri-Sun).
- The '1st on-call Trainee Anaesthetist' is expected to attend when available; however, in the event of difficult advanced airway management problems, the '2nd on-call (ICU) middle-grade doctor or Consultant can be requested using a second 2222 call specifying that anaesthetic support is required.
- Clinical Skills and Resuscitation Service Trainer (when available).
- Out of hours Nurse Practitioners (when available).
- Critical Care Outreach Nurse (when available).

4.0 The Paediatric Resuscitation Team will include:

- The 'on-call Paediatric Tier 2 doctor (SpR) ST 3+ or equivalent clinical fellow/speciality doctor (Team Leader),
- The 'on-call Paediatric Tier 1 doctor (SHO) - Paediatrics ST 1-2 or equivalent GPVTS ST1-2, FY2 and Clinical fellow,
- The '2nd on call (ICU) SpR trainee and
- Clinical Skills and Resuscitation Service Trainer (when available).

4.1 The Consultant 'on call' for Paediatrics must also be contacted to inform of the cardiac arrest call.

5.0 The Neonatal Resuscitation Team will include:

- Neonatal Tier 2 Doctor or Tier 2 Advanced Neonatal Nurse Practitioner,
- Neonatal Tier 1 Doctor or Tier 1 Advanced Neonatal Nurse Practitioner,
- Neonatal nurse and
- The Consultant 'on call' for Neonates can be contacted via switchboard if required.

6.0 The Heart and Lung Resuscitation Team will include:

- The Core Adult Resuscitation Team, plus, if the cardiac arrest is in Cardiothoracic Theatres, Cardiothoracic Ward, Cardiology Ward, Catheter Labs, Pacing Rooms or ICCU, the following additional team members (if available):
- 1st on-call Cardiothoracic Anaesthetist and
- 1st on-call Cardiothoracic Surgeon.

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7.0 Response to Cardiac arrests in non-clinical areas on New Cross Hospital site (e.g., corridors and car parks) will include the following.

- The Core Adult Team

  A designated member of the team identified at the cardiac arrest team meetings (see 15.0) will respond with a grab bag containing basic emergency equipment and an Automated External Defibrillator (accessed from emergency cupboards located in Zones A and C).

- The Paediatric Team

  The ST 1-2 will respond with a paediatric grab bag containing emergency equipment to any paediatric cardiac arrest call with the exception of A21 and the Emergency Department. The grab bag is located in the equipment room on A21 – ward side.

7.1 The team leader will arrange transfer of the patient in any outcome to ED by dialling 2222 and requesting the switchboard operator to connect to 999 to request an ambulance for transport.

8.0 In the event of two cardiac arrests occurring simultaneously

8.1 The cardiac arrest team leader will delegate members from the first team to attend the second call.

8.2 If a member of the cardiac arrest team requires additional support, Medical Registrar A or the 1st on call for anaesthetics may be contacted to attend.

9.0 High Dependency Area – specialist arrangements

9.1 The Critical Care Unit, ED and Operating Theatres will manage their own cardiac arrests but may also call any of the above Teams if required.

9.2 In the event of a child being in cardiac arrest in ED and it is decided to commence CPR, the Paediatric Resuscitation Team must be called to attend.

10.0 Team Qualifications at New Cross Hospital Site

10.1 The minimum requirements according to specialty are as follows.

Adult Team
ALS - Advanced Life Support (Resuscitation Council UK), except the FY1's who must be trained in Immediate Life Support (ILS) as a minimum and in Advanced Life Support within 6 months of commencement of employment at the Trust.
Or appropriate Trust equivalent course as agreed by the Clinical Director.

Paediatric Team
APLS - Advanced Paediatric Life Support (Advanced Life Support Group) or
EPALS - European Paediatric Advanced Life Support (Resuscitation Council UK) or
PLS - Paediatric Life Support (Advanced Life Support Group) or
appropriate Trust equivalent course as agreed by the Clinical Director.

Neonatal Team
NLS - Neonatal Life Support (Resuscitation Council UK) or
appropriate Trust equivalent course as agreed by the Clinical Director.

11.0 The Core Resuscitation Team at Cannock Chase Hospital will include:

- On call FY2 (or equivalent) team leader,
- Nurse co-ordinator,
- Qualified Link Nurse,
- On-call Anaesthetist and
- Porter.

In the event that any of the above members is unable to respond they must ensure this responsibility is delegated to a member of staff who can attend in their absence.

12.0 Response to paediatric cardiac arrests in clinical areas and adult or paediatric cardiac arrests in non-clinical areas on Cannock Chase hospital site (e.g. corridors and car parks) will include:

- The Core Adult Resuscitation Team.

12.1 The porter will collect the adult emergency equipment grab bag or paediatric grab bag from the Porters Room and take it to the scene of the cardiac arrest.

12.2 The team leader will arrange transfer of the patient in any outcome to ED by dialling 2222 and requesting the switchboard operator to connect to 999 to request an ambulance for transport.

13.0 In the event of two cardiac arrests occurring simultaneously

13.1 The cardiac arrest team leader will delegate members from the first team to attend the second call.

14.0 Team Qualifications at Cannock Chase Hospital

All medical members of the Resuscitation Team must hold a current Advanced Life Support Certificate (or appropriate Trust equivalent course as agreed by the Clinical Director).

- Qualifications will be checked by Medical Staffing prior to staff holding the cardiac arrest bleeps.
- 'Nurse co-ordinator' and 'Qualified Link Nurse' must hold as a minimum a current BLS 3 certificate, but holding a current ILS or ALS certificate is desirable.

All members of the Cardiac arrest Team must be trained in Paediatric Basic or Advanced Life Support (or appropriate Trust equivalent course as agreed by the Clinical Director).

15.0 Cardiac Arrest Team (core adult) briefings at New Cross and Cannock Chase Hospital sites

15.1 Team members will meet morning and evening at New Cross Hospital and morning and evening at Cannock Chase Hospital.

15.2 The purpose of the briefing is to:

- Identify and introduce team member (names, levels, skills and experience),
- Check cardiac arrest bleeps are working, and
- Allocate roles and responsibilities:
- Team Leader / Debrief Lead / Resuscitation Record Form Completion,
- Airway / Breathing,
- Circulation, IV / Intraosseous Access / Drugs,
- EZIO and Capnograph Equipment (grab bag collection),
- BLS,
- Defibrillation,
- Out of Clinical Area Equipment (grab bag collection), and
- Plans for Simultaneous Cardiac Arrest Calls

Procedure in the Event of a Cardiac Arrest

1.0 Basic Life Support

Basic Life Support will be initiated by local staff (Resuscitation Council UK) guidelines must be followed (see 2.0).

1.1 Local staff must ensure that the appropriate cardiac arrest team is activated and that the resuscitation trolley, defibrillator, portable oxygen & suction (if applicable) are taken to the patient.

1.2 Modifications for Neck Breathers

All patients with a tracheostomy or laryngectomy who are admitted to hospital (with the exception of the Ear, Nose and Throat ward, unless required) must be referred to the Critical Care Outreach Team who will assess the patient's care needs and equipment requirements in the event of a cardiac arrest.
The modifications to Basic Life Support that will be required for neck breathers relate to the management of respirations the indications for and delivery of cardiac compressions remain unchanged:

- Remove any clothing from the neck including the stoma cover, remove any speaking valve or cap if present
- Ensure the stoma or any tube in place is clear
- Listen and feel for any air escaping from the stoma and look for chest movement for 10 seconds - if there is evidence of blockage in the tube, the tube must be removed
- If rescue breathing is required, ensure the patient is on their back with their head tilted backwards, occlude both the nose and the mouth to prevent any escape of air, and make a seal around the stoma with your mouth
- Blow into the stoma until the patient's chest rises (alternatively, a pocket mask or bag / mask / valve can be used if competent to do so)
- Open both the nose and the mouth between each blow or ventilation to allow the chest to fall.

1.3 Modifications for Children

All clinical staff that have been trained in adult Basic Life Support will also be trained in modifications to the adult sequence required for resuscitating children:

- Give 5 initial rescue breaths before starting chest compressions
- If you are on your own perform CPR for 1 minute before going for help
- Compress the chest by approximately one-third of its depth using 2 fingers for an infant, and 2 hands for a child over 1 year, as needed to achieve an adequate depth of compression.

1.4 **Automated External Defibrillator**

If trained to do so apply the Automated External Defibrillator, follow the voice prompts, and await the arrival of the cardiac arrest team.

1.5 **Advanced Life Support**

Advanced Life Support will be co-ordinated by the cardiac arrest team leader.

1.6 If a manual defibrillator is required, the Ward / Department staff will be responsible for collecting the nearest manual defibrillator to their area.

1.7 The cardiac arrest team leader will be responsible for the immediate post resuscitation care.

2.0 Resuscitation Council UK Guidelines

The Resuscitation Council UK Guidelines 2021 below must be followed.

2.1 Adult Choking Treatment (appendix 3)

2.2 Adult Basic Life Support (community) (appendix 4).

2.3 Adult In-hospital Resuscitation (appendix 5)

2.4 Adult Advanced Life Support (appendix 6)

2.5 Paediatric Choking Treatment (appendix7)

2.6 Paediatric Basic Life Support (appendix 8)

2.7 Paediatric Advanced Life Support (appendix 9)

2.8 Newborn Life Support (appendix 10).

3.0 Resuscitation Attempt Record

Following an adult or paediatric cardiac arrest a **'Resuscitation Attempt Record'** form must be completed. This is the responsibility of the Cardiac Arrest Team Leader; however, the audit form can be completed by any member of qualified staff involved in the resuscitation attempt. The top copy of this form will be inserted into the patient's hospital notes and the carbon copy will be returned to the Clinical Skills and Resuscitation Service for monitoring and audit purposes.
If a cardiac arrest occurs in a community setting, e.g. a patient's home or at a GP practice, the incident must be reported on Datix.

3.1 **For New Cross Hospital Site**

If any areas of concern are raised in relation to neonatal resuscitation, an incident form must be completed and a copy of any investigation must be sent to the Clinical Skills and Resuscitation Service and taken to the Resuscitation Group for review.

Equipment, Checking, Replenishment and Cleaning

1.0 Equipment Checking (All Areas with a Cardiac Arrest Trolley)

1.1 Equipment must be checked for completeness and operational readiness by a qualified, registered member of staff, e.g. Nurse, Midwife or Allied Health Care Professional, and one other member of staff of any grade or discipline. All checks must be completed using the appropriate checklists and then recorded on the checklist record form (available on the Kite site).

1.2 The top surface of all cardiac arrest trolleys must have a cardiac arrest folder that contains a Clinical Skills & Resuscitation Service agreed Equipment List (to comply with Resuscitation Council UK guidance), Cardiac Arrest Equipment Checklist Record and Resuscitation Attempt Record Forms.

1.3 Cardiac Arrest Trolleys must be clean, dust free and uncluttered.
Wards and Departments must display a poster signposting where the nearest manual defibrillator is located if this is not on the trolley

1.4 All equipment must display an expiry date. Equipment should be replenished from locally held stock at the earliest opportunity if used or expired. There should be an adequate supply of these items to ensure their immediate and constant availability for the trolley.

1.5 Single patient use items should be used wherever possible. Where disposable items cannot be used, non-disposable items should be decontaminated and cleaned in accordance with both the manufacturer's guidance and the Trust Infection Prevention Policies.

1.6 **New Cross / West Park and Cannock Chase Hospital Sites**

The resuscitation trolleys must be stocked in accordance with the Trust's standardised Adult and Paediatric Emergency Cardiac Arrest Booklets issued by the Clinical Skills and Resuscitation Service. The exceptions are higher dependency areas where additional equipment may be required. In this event all equipment lists must be agreed and a copy held by the Clinical Skills & Resuscitation Service.

1.7 All resuscitation trolleys must remain sealed unless in use. Security seals that reveal 'opened' if tampered with must be replaced; supplies are available from the Medical Equipment Library.

1.8 The top surface of the resuscitation trolley, including any defibrillators and portable oxygen and suction, must be checked daily and post use. Ensure that any size E oxygen cylinder that is attached to the cardiac arrest trolley is a minimum of half full and is within expiry date. In the event of portable oxygen being used in a resuscitation attempt, ensure at the earliest appropriate opportunity the patient is moved to an area / bed space where a continuous supply of oxygen can be accessed, or if not appropriate to move the patient, that an additional cylinder is

sourced early to avoid the oxygen running out. Ensure that any portable suction is in working order and has the appropriate suction tubing attached.

1.9 The remaining contents of the resuscitation trolley must be checked weekly, post use or if the security seal reveals 'opened'. Any equipment that is due to expire must be replaced prior to the expiry date.

1.10 Evidence of checking must be documented and retained for record and auditing purposes for a minimum of 12 months. Checking must be recorded on the Cardiac Arrest Equipment Checklist Record, available on the Kite site.

1.11 Emergency Cardiac Arrest Drug Boxes must be in date and replaced if used. A replacement box must be collected from the Pharmacy Department or if required out of hours, from the Mediwell.

The emergency drug boxes on trolleys will stock 1st line drugs only; 2nd line drugs will be available in designated wards/departments, which are listed inside the emergency drug boxes.

1.12 **Neonatal Unit / Delivery Suite (Neonatal Equipment) at New Cross Hospital**

Equipment lists agreed by the Clinical Skills & Resuscitation Service for the resuscitation of neonates on resuscitaires must be checked daily and post use. Any equipment that is due to expire must be replaced prior to the expiry date.

1.13 Equipment used by Community Midwives must be checked at least weekly and post use.

1.14 Evidence of checking must be documented and retained for record and auditing purposes for a minimum of 12 months.

1.15 Emergency Cardiac Arrest Drug Boxes must be in date and replaced if used. A replacement box must be collected from the Pharmacy Department.

1.16 **Community**

All resuscitation equipment lists must be agreed and a copy held by the Clinical Skills & Resuscitation Service.

1.17 If security seals are utilised on cardiac arrest trolleys or cardiac arrest grab bags the procedure detailed above for New Cross, West Park and Cannock Chase Hospital sites must be followed.

1.18 If security seals are not utilised the cardiac arrest trolley must be checked daily and post use. Any equipment that is due to expire must be replaced prior to the expiry date.

1.19 Evidence of checking must be documented and retained for record and auditing purposes for a minimum of 12 months. Checking must be recorded on the Cardiac Arrest Equipment Checklist Record available from the Kite site

1.20 Emergency Cardiac Arrest Drug Boxes must be in date and replaced if used.

2.0 Monitoring

2.1 Managers are responsible for monitoring compliance with checking of equipment in accordance with this policy.

2.2 The Clinical Skills & Resuscitation Service will co-ordinate the audit of cardiac arrest trolleys/equipment within the Trust annually. Results will be communicated to the Resuscitation Group, Divisional Managers, Divisional Heads of Nursing and Healthcare Governance Managers.

CP 11 Attachment 5

Defibrillation

1.0 Defibrillation is well established as the only effective therapy for cardiac arrest due to Ventricular Fibrillation (VF) or pulseless Ventricular Tachycardia (pVT). The scientific evidence to support early defibrillation is overwhelming (Resuscitation Council UK 2021).

2.0 Automated External Defibrillation (AED)

2.1 AED's are sophisticated, reliable, computerised devices that deliver defibrillation shocks to victims of cardiac arrest. They use voice and visual prompts to guide rescuers.

2.2 All clinical Wards and Departments will have an AED or access to one in close proximity ensuring that in the event of a cardiac arrest an AED can be used within the optimal time of 3 minutes. There will be access to AED's in some community areas.

2.3 In the event of a cardiac arrest occurring in a non-clinical area the Cardiac Arrest Team will attend with an AED.

2.4 The Resuscitation Council UK In-hospital Resuscitation algorithm must be followed.

2.5 Registered clinical staff at New Cross Hospital, Cannock Chase Hospital, West Park Hospital, Walk In Centres and Community Services where there is an AED will be trained in the use of an AED. This will also apply to all GP practice staff.

2.6 Once competency has been achieved in the use of an AED, it is the individual's responsibility to maintain competency and access training annually. AED Training is incorporated in various training courses including:

- Basic Life Support (BLS) Level 2 / 3
- Immediate Life Support (ILS)
- Advanced Life Support (ALS)
- Paediatric Life support (PLS)
- European Paediatric Advanced Life Support (EPALS)

3.0 AED use in Children

3.1 Standard AED's are suitable for use in children older than 8 years. In children between 1 and 8 years, attenuated Paediatric Pads must be used if available; if not, the AED can be used with adult pads with consideration paid to patient size when choosing pad position e.g. anterior/posterior pad placement in the smaller child. If the AED has a 'CHILD' button, this option must be selected. There is insufficient evidence to support a recommendation for the use of AED's in children less than 1 year, however, if an AED is the only defibrillator available its use can be considered, preferably with attenuated paediatric pads (Resuscitation Council UK 2021).

4.0 Manual Defibrillation (Adult)

4.1 Medical Staff performing manual defibrillation in adults must hold a valid Immediate or Advanced Life Support Certificate.

4.2 It is recommended that Health Care Professionals (excluding medics) use an AED. Staff that may be required to use a manual defibrillator as part of their clinical role must be an Advanced Life Support (ALS) Provider, or alternatively, trained as a minimum in Immediate Life support (ILS) with a period of practice supervised by a competent practitioner experienced in manual defibrillation and who holds a valid Advanced Life Support Certificate. When deemed appropriate by the supervisor, the supervisor must assess competency using the standard framework: Manual Defibrillation using Hands Free Pads (Table 1).

5.0 Manual Defibrillation (Children)

5.1 Medical Staff performing manual defibrillation in children must hold a valid Advanced Life Support certificate.

5.2 It is recommended that Health Care Professionals (excluding medics) use an AED. Staff that may be required to use a manual defibrillator as part of their clinical role must be an Advanced Paediatric Life Support (APLS) Provider, or alternatively, trained as a minimum in Paediatric Life support (PLS) or European Paediatric Advanced Life Support (EPALS) with a period of practice supervised by a competent practitioner experienced in manual defibrillation and who holds a valid Advanced Life Support Certificate. When deemed appropriate by the supervisor, the supervisor must assess competency using the standard framework: Manual Defibrillation using Hand Free Pads (Table 1).

6.0 Manual Internal Defibrillation and Cardioversion

6.1 Health Care Professionals performing manual internal defibrillation in adults must be the first surgeon at the cardiac operation, this must be either a consultant or a middle-grade doctor acting under supervision (direct or indirect) or must hold a valid Immediate or Advanced Life Support Certificate.

6.2 The procedure for manual internal defibrillation/cardioversion (table 2) must be adhered to. It requires two Health Care Professionals, one to have overall responsibility for the defibrillation/cardioversion procedure, including delivery of a safe internal shock (OPERATOR), and one to assist the operator by managing the settings on the manual defibrillator under direct supervision (ASSISTANT).

6.3 The Operator for this procedure must be a member of the surgical team (as detailed in 6.1).

6.4 The Assistant for this procedure must be a Health Care Professional that has received training to do this role. Training will be provided locally in Cardiothoracic Theatres and will include familiarisation with the manual defibrillator settings and familiarisation with the assistant role as detailed in table 2.

Table 1

Assessment of Competence in Manual Defibrillation (Hands free adhesive pads)

Structure **Skill Description**	Process **The action candidate demonstrates competently during skills practice**	Outcome **Desired skill outcome**	Assessment	
			Achieved	**Not achieved**
Check the environment	Ensures a safe environment	Scene safety		
Check for a response	Assesses the patient's conscious level, airway, breathing & circulation	Confirm cardiac arrest [clinical diagnosis]		
Establish cardiac monitoring	Places adhesive pads (or Internal Paddles where appropriate) in correct position & establish monitoring	Cardiac monitoring is established		
Assessment of patient's cardiac rhythm	Correctly identifies the rhythm.	To determine need for defibrillation		
Preparation for delivery of shock	Demonstrates the importance of patient & team safety and gives clear instructions	Safety measures achieved		
Delivery of shock	Charges the defibrillator to appropriate energy level and delivers shock.	Effective delivery of shock		
Repeated delivery of shocks	Safely delivers shocks.	Effective delivery of shock		

Name:
Achieved assessment outcome: **Yes / No**
Assessor Name: **Date:**

Procedure for Manual Internal Defibrillation/Cardioversion **Table 2.**

Role	Skill/Procedure Description	Skill/Procedure Expected Outcome
Anaesthetist	Ensure Cardiac Monitoring is attached to the patient	Enable patients heart rhythm to be effectively monitored
Operator	Assess the patients' Heart Rhythm	Determine the need for Internal Defibrillation or Cardioversion
Assistant	Check that the internal defibrillator paddles are connected to the manual defibrillator	To ensure readiness of equipment for determined procedure
Assistant	Turn defibrillator dial to the ON position. Using the soft keys, press the key under 'Manual Mode' and then the key under 'Confirm'	To ensure appropriate mode for the procedure
Assistant	Ensure the 'LEAD SELECT' button is selected to 'Pads'	To ensure appropriate mode for the procedure
Operator	Determine and give clear verbal instruction of the energy level to be selected by the assistant	A decision is made and communicated regarding the energy level to be selected in accordance with local/national guidance
Assistant	Select the requested energy level and confirm verbally to the operator the energy level that has been selected	The appropriate energy level is selected and confirmed with the operator
Operator	Prepare for safe delivery of shock by carrying out standard defibrillator safety checks and confirm safe to proceed	To ensure a safe environment
Operator	Instruct the assistant to press the 'charge' button	To prepare defibrillator for determined procedure
Assistant	Press the 'charge button' and verbally confirm 'charging'	To ensure readiness of equipment for determined procedure
Operator	Deliver the shock safely using internal defibrillator paddles	Safe and effective delivery of shock for determined procedure

CP 11 Attachment 6

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Process, Advance Care Planning and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

All decisions must be based on current legislation and national guidance. Prior to following the Trust's local procedures, all staff involved in the decision making process must have read and must adhere to the guidance Decisions Relating to Cardiopulmonary Resuscitation (3rd edition 1st revision). Guidance from the British Medical Association, the Resuscitation Council [UK] and the Royal College of Nursing

ReSPECT stands for **R**ecommended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment. It is a widely used process and is recognised nationally. Further information can be viewed via the link ReSPECT | Resuscitation Council UK.

ReSPECT is a process which establishes a shared understanding of an individual's health, current condition and future wishes. This understanding is between the individual and the healthcare professionals caring for them.

The process will explore the individual's health beliefs and choices in conjunction with clinical understanding and judgement. The result of this will be an agreed clinical recommendations for the individual's care in an emergency event, including cardiac arrest and cardiopulmonary resuscitation (CPR), when their capacity to make or express choices is reduced or lost.

ReSPECT is not legally binding; it does not replace more detailed treatment plans,/ Advanced Decision to Refuse Treatment (ADRT) and, or Advance Care Plans (ACP), but it provides a summary of agreed clinical recommendations and treatments to guide an emergency situation.

This shared understanding and subsequent recommendations is supported by a summary form – the ReSPECT form, version 3 (Attachment 6 Appendix 1).

The ReSPECT form is a patient-held document, and people in Wolverhampton and surrounding areas will be able to transition from one care setting to another with their wishes and plans clearly summarised.

ReSPECT is a nationally recognised process, established in many neighbouring localities.

The ReSPECT summary form is valid across the Wolverhampton Health Care Economy with all professionals endorsing the process.

Through engaging with the ReSPECT process, better care for individuals at risk of deterioration will lead to increased planning, better communication, better decision making and better overall care.

Clinicians should not complete a ReSPECT form without engaging fully in the process.

The ReSPECT document replaces all other previously used forms, and this process replaces any previously used DNACPR processes within the local healthcare economy.

The procedure flow chart detailed in **2.0** describes the process for completion of ReSPECT forms that are completed within RWT hospital sites and community settings. The flow chart is designed to provide a brief summary of responsibilities with a full explanation of each step below.

An understanding of the flow chart and detail is essential to ensure that the ReSPECT decisions work across all health care settings.

1.0 ReSPECT – Adults and Young People aged 16 years and over (unless an 'Advance Care Plan for a Child or Young Person' (CYPACP) already exists – see **6.0**)

1.1 The ReSPECT process is an integral part of the Resuscitation Policy. Any completed ReSPECT form will be valid in any care setting within the Wolverhampton Healthcare Economy, including patients' homes, care homes and hospices. It will also be valid at New Cross, Cannock Chase and West Park hospitals and for any transfer of care via West Midlands Ambulance Service (WMAS).

The ReSPECT process and procedures detailed in this attachment aim to ensure:

- Effective recording of patient preferences in a summary form that is recognised by all those involved in the care of the patient;
- Effective discussion, understanding and decision on treatments to be offered or withheld in the event of emergency treatments, including resuscitation, with the patient;
- Effective communication and explanation of these decisions where appropriate, and with due respect for confidentiality, with the patient's relatives, significant others or chosen representatives;
- Effective communication and explanation of these decisions between all healthcare professionals and organisations involved with the patient.

1.2 The procedures have been agreed by the RWT ReSPECT Implementation Group, Resuscitation Group, End of Life Steering Group and the Wolverhampton ReSPECT Steering Group.

1.3 Survival following CPR in adults is between 5 - 25% depending on the circumstances. Although CPR can be attempted on any person prior to death it may not be in the person's best interest to do so. It may be appropriate to consider a 'CPR attempt not recommended' decision to enable the person to die with dignity.

1.4 'CPR attempt not recommended' decisions refer only to CPR and not to any other aspect of the individual's care or treatment options. This leaves large gaps in advance care planning. These decisions were often poorly communicated or misunderstood by patients, resulting in distress and poor care. The ReSPECT process addresses these needs.

1.5 The ReSPECT process focuses on care and treatments that could be of benefit and that the person would want, not just on withholding of one treatment – CPR.

1.6 The ReSPECT process must be considered for all acute admissions during the initial admission process or the initial consultant review. It may also be appropriate to consider for service users of the outpatient or day treatment settings.

1.7 The ReSPECT process is supported by the ReSPECT summary form. This documents the patient's care and treatment preferences. This includes explicit decision to be made and clearly documented: either for CPR recommended or not recommended.

1.8 An individual is only "*Not for cardiopulmonary resuscitation*" when a valid completed ReSPECT form includes completion of the red "CPR attempts NOT recommended" box (bottom right of the summary form).

1.9 A person is presumed to be for CPR unless documented as 'CPR attempt not recommended' within a ReSPECT form, or an Advance Decision to Refuse Treatment (ADRT) prohibits CPR.

1.10 If there is no form or it is incomplete, a person is presumed to be for CPR.

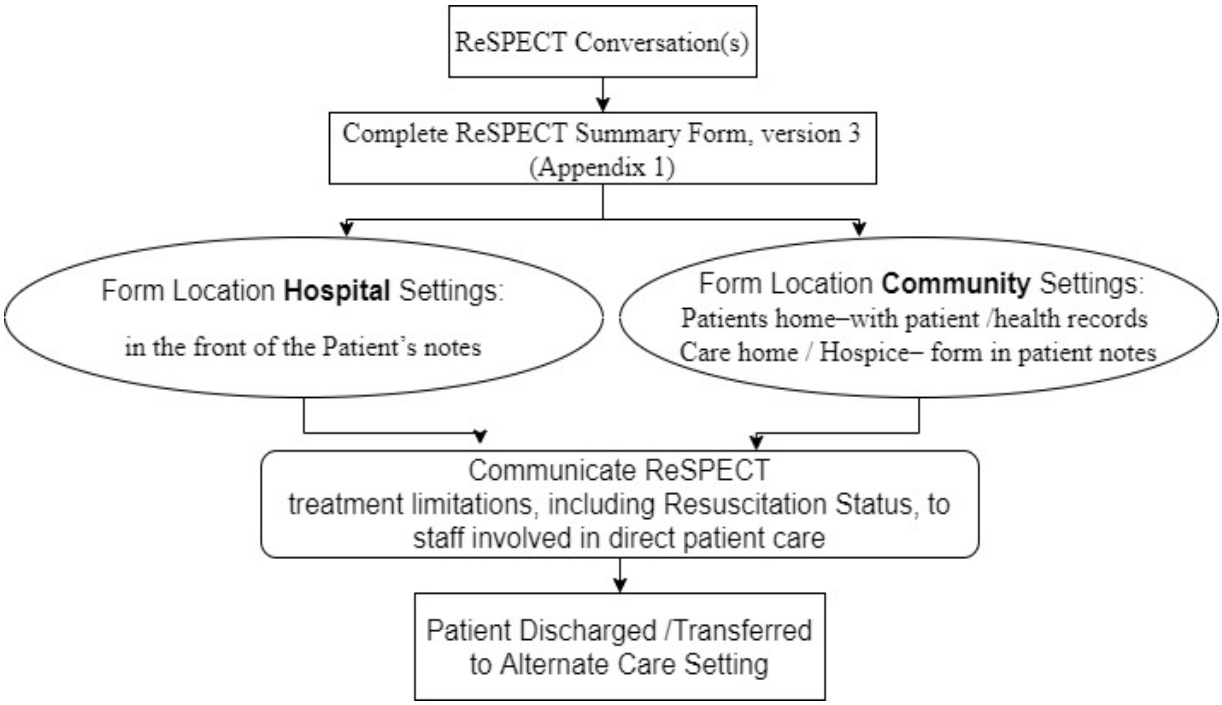
1.11 Consultants, General Practitioners, SAS doctors and those with appropriate training as identified in OP41 Induction and Mandatory Training policy are responsible for completing the ReSPECT process.

1.12 Hospital settings: CPR decisions recorded on DNACPR forms dated on or before 31st August 2021 will remain valid. However, if noted on admission a ReSPECT conversation must occur and a ReSPECT form completed within 5 days. The old DNACPR form must be cancelled as per 2.1.6.

1.13 Community settings: CPR decisions recorded on DNACPR forms dated on or before 31st August 2021 will remain valid. However, at the earliest opportunity a ReSPECT conversation must occur and a ReSPECT form completed. The old DNACPR form must be cancelled as per 2.1.6.

2.0 ReSPECT Decisions made in the RWT Hospital Setting and Community Settings

2.1 Procedure Flow Chart – see relevant points for information:



2.1.1 ReSPECT Conversation(s) / Process

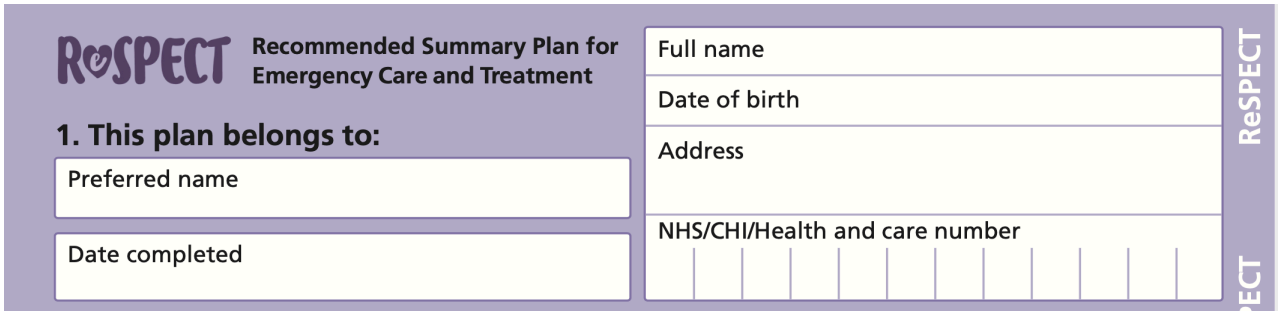
- The ReSPECT process is completed through discussions with the patient or their representative to establish an understanding of their health, their current condition and preferences surrounding their future care.
- This is in conjunction with the clinician's appraisal of potentially beneficial treatment options in possible clinical scenarios.
- See appendix 2 for a discussion guide.

2.1.2 Completing a ReSPECT Summary Form

The National ReSPECT form version 3 must be completed. Any older forms that are noted must be cancelled and the information transferred to the current version.

A ReSPECT pack will be available in ward and department areas. This will be a purple plastic folder containing a ReSPECT form, MCA form and patient information leaflets. If completed the MCA form must be filed in the patient's notes .

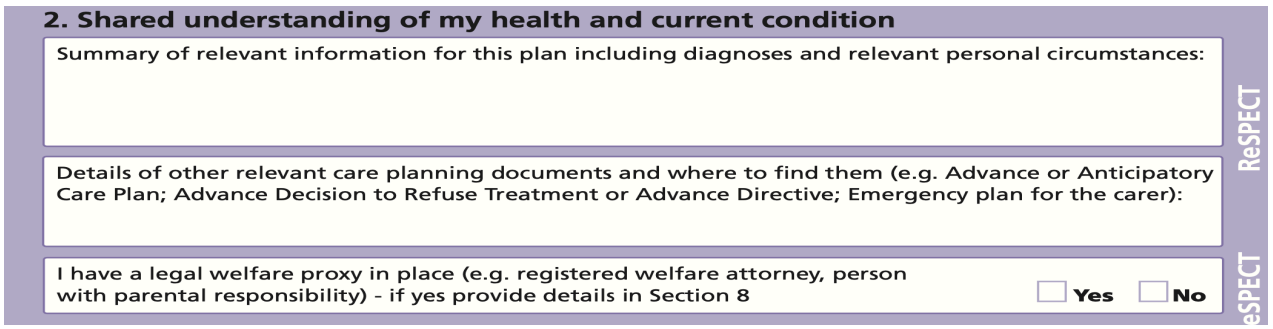
Section 1: This Plan Belongs to:



1. Confirm the patient's identity, personal details and how they prefer to be addressed.

2. The date of form completion MUST be entered.

Section 2: Shared Understanding of my Health and Current Condition



1. The first box records the agreed understanding of their condition, a summary that the patient is happy with.

2. The second box records specific detail and relevant location of any other relevant documents such as an ADRT / ACP.

3. To be valid, the patient must have had capacity **when** the ADRT decision was made.

4. A patient that is not deemed to have capacity must have the Trust approved Mental Capacity Assessment (MCA) completed documenting this conclusion – see section 5.

5. If the person does not have capacity to reach a decision in these matters, the discussion should take place with their legal welfare proxy / Lasting Power of Attorney (LPA) for Health and Welfare, their family or other representatives, as well as the patient and healthcare professionals.

6. A decision must be made to determine if the ADRT is currently applicable or has not been reviewed for a long time and the patient's circumstances have changed.

If there is any doubt about validity, in an emergency the presumption should be in favour of CPR. For further guidance refer to Decisions Relating to Cardiopulmonary Resuscitation (3rd edition 1st revision). Guidance from the British Medical Association, the Resuscitation Council [UK] and the Royal College of Nursing.

7. It is crucial to identify any problems that the person may need help with in an emergency – such as visual or hearing difficulties, or important allergies.

8. If they have legal welfare proxy / LPA and, – if so – who they are and how they can be contacted (information to be recorded in 'section 8 of the form')

Section 3: What Matters Most to me about My Treatment and Care in an Emergency

1. A record of what treatment preferences a patient would wish for in the future and those which they wish to avoid.

2. All eventualities are not able to be considered but general preferences (using the scale) and specific examples such as ventilation and, or artificial nutrition may help discussion along with quality of life and symptom control.

3. Using the patient's own words may be helpful.

4. In the event that the patient lacks capacity, discussion should be held with the patient's family or other representative to ascertain this information and arrive at a best interests' decision.

Section 4: Clinical Recommendations for Emergency Care and Treatment

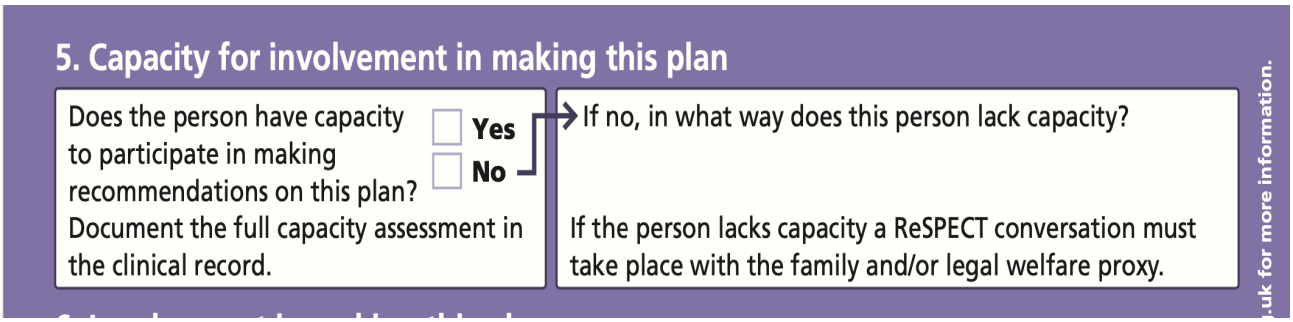
1. A signature is required to record the priority that you have agreed between trying to extend life and a focus on maintaining comfort.

2. This agreement is made with a patient who has capacity, or with their representatives in a best interests process if they lack capacity.

3. The second box should include the specifics of emergency care and treatment. For example, wishes not to be transferred to hospital, admitted to ICCU or mechanical ventilation.

4. The third box indicates the patient's wishes to receive or not receive cardiopulmonary resuscitation (CPR). This discussion should be made after discussion including sudden cardiac arrest and reversible causes with realistic and potential outcomes.

Section 5: Capacity for Involvement in making this plan



1. This is an acknowledgement of the patient's capacity to participate in a ReSPECT conversation with an assumption that capacity is present unless reasoning suggests otherwise. This includes people with Learning Disabilities and / or Autism.

2. If a patient has capacity and requests that that they do not wish family members to be informed of the ReSPECT decisions, this must be recorded in the patient notes and communicated to relevant staff members.

3. If the patient has been shown to lack capacity, the reason MUST be recorded on the ReSPECT form. A formal mental capacity assessment must be completed on a Trust approved MCA form. The MCA form must then be recorded in their health records. MCA forms are available in the clinical area and within ReSPECT packs.

4. If an individual has been shown to lack capacity to participate in the conversation, the discussions must include their legal welfare proxy / LPA or those close to the patient who must be contacted by law unless deemed impracticable or inappropriate to do so.

5. Legal advice should be sought in the event of disagreements on this issue between the decision maker and those close to the patient. In this situation advice from the Safeguarding Team can also be sought.

6. Whilst the patient may lack capacity to reach a decision, they should remain involved in the discussion as much as possible, in line with best practice advice.

7. If the patient has been proven to lack capacity and has made a Lasting Power of Attorney (LPA) appointing a Health and Welfare Attorney to make decisions on their behalf, the attorney must be contacted. The contents of the LPA document must be read to confirm what the Health and Welfare Attorney can make decisions on.

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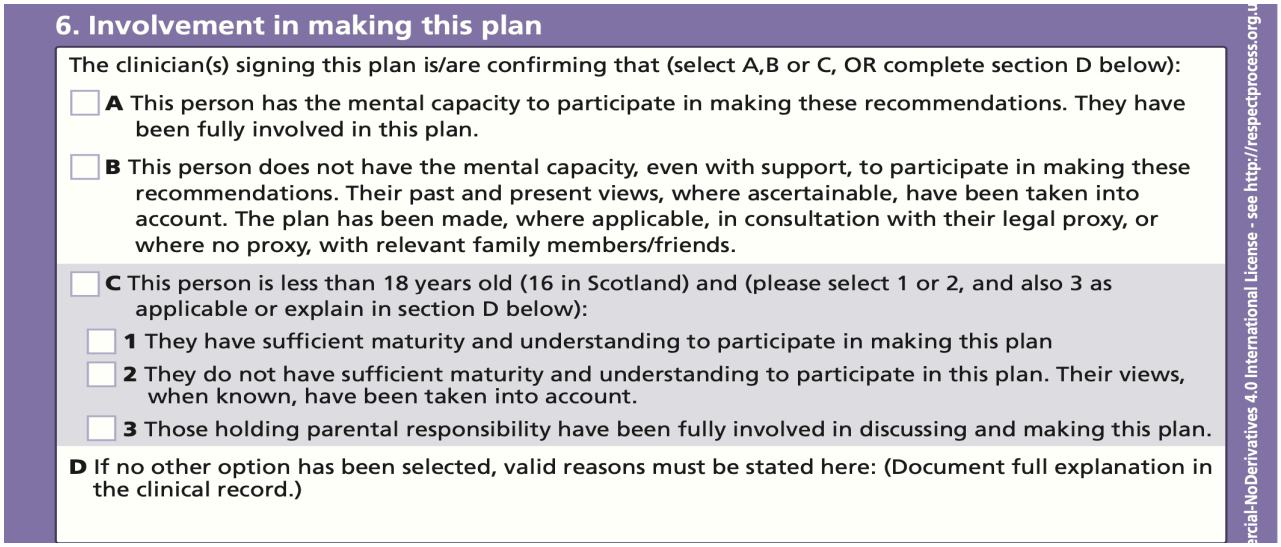
8. By law an Independent Mental Capacity Advocate (IMCA) must be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), when decisions about providing, withholding or stopping serious medical treatment are made. In this situation, advice from the Safeguarding Team can be sought.

9. For 16 / 17-year-olds - whilst those with capacity are treated as adults for the purpose of consent, where an assessment of capacity has concluded no capacity to consent, a best interests assessment must be completed. This would subsequently include a consultation with those who have parental responsibility for the young person. Legal advice should be sort in the events of disagreements on this issue between a young person and those holding parental responsibility. In this situation advice from the Safeguarding Team can be sort.

10. For additional information regarding patient capacity refer to:
    - **CP06 Attachment 3 - Guidance for Healthcare Professionals on the Mental Capacity Act 2005**
    - **http://trustnet.xrwh.nhs.uk/strategies-policies/clinical-policies-procedures-guidelines/clinical-practice-policies/cp02-deprivation-of-liberty-safeguards-dols-policy/**

Section 6: Involvement in Making this Plan



6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.

☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

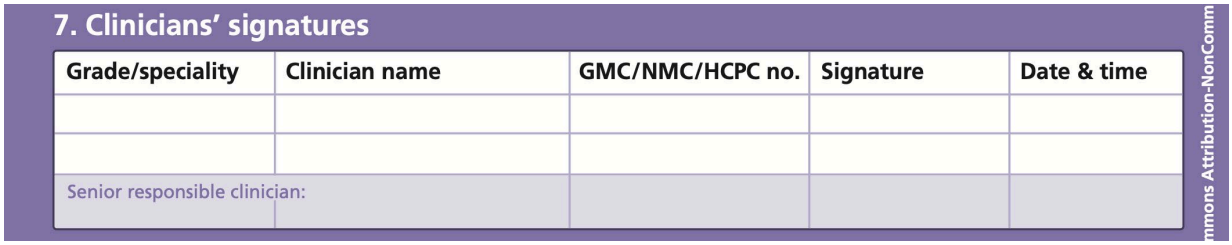
1. Record who is involved in the agreements.

2. If the legal welfare proxy / LPA and / or those close to the patient cannot be contacted, the reason must be recorded, with a plan made to facilitate contact when it is deemed appropriate – this must be recorded in the health records and communicated.

3. Section C relates to paediatrics. For those aged 16 / 17 years old who do not already have an Advance Care Plan for a Child or Young Person' (see **6.0**) and are not under the care of a paediatrician a ReSPECT form may be completed.

4. If the person lacks capacity and neither legal proxy and / or family members are contactable option D must be selected with a clear explanation documented in the healthcare records.

Section 7: Clinicians' Signatures / Form Endorsement



7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

Hospital Settings (New Cross / Cannock Chase / West Park):

1. The consultant or SAS doctor in charge of the patient has overall responsibility for the completion of the form.

2. In the consultant or SAS doctor's absence the most senior doctor caring for the person at the time (specialist registrar level/ equivalent or higher), or appropriate staff within specialist teams who have received Authorship Training as per OP41 Induction and Mandatory Training Policy can complete the form. However, the form MUST then be reviewed / signed by the consultant within 72 hours.

3. At WPH if a consultant is not available within 72 hours the consultant's verbal consent must be documented on the ReSPECT form (and within the patient's notes). This then must be endorsed at the earliest opportunity.

RWT Community and Vertically Integrated General Practices Services:

1. In the event that an RWT community team has assessed a patient and deems the Respect process and summary form are necessary, then agreement / endorsement should be sought from the teams GP / responsible Consultant Physician / SAS Doctor either verbally or written (e-mail) and should occur prospectively.

2. The ReSPECT form is only to be completed by a community team member who has received Authorship Training as per OP41 Induction and Mandatory Training Policy in line with their role.

3. Teams completing a ReSPECT form by hand must have the endorsement agreement documented in Section 8 and in the contemporary clinical record.

3.1 For endorsement, a 'wet' signature is not required by the consultant, providing discussion has occurred and is documented.

3.2 Immediately following form completion, a photograph or digital copy made using an RWT agreed process (e.g.the Bantham app) must be recorded. This will automatically upload to RWT Clinical Web Portal (documents and advance decisions).

3.3 The GP must also be informed via the community team's digital documentation.

3.4 The original form MUST remain with the patient and should not be removed for scanning / copying purposes.

4. Staff with authorship status completing a ReSPECT form electronically (EMIS version 3.5) must ensure their details are added to section 7.

4.1 Endorsement may be obtained either by contacting the Community Consultant either orally or in writing (e-mail) or the GP via online communication, and Section 8 must be completed.

4.2 The electronic ReSPECT summary form must then be printed, signed in black ink by the author in Section 7and a paper version given to the patient and/ added to patient notes.

4.3 The ReSPECT form must then remain with the patient and must not be removed.

5. When the patient has their next clinical interaction with a GP, consultant or SAS doctor, the ReSPECT form should be reviewed.

6. If the GP chooses to complete the form electronically (EMIS version 3.5), it must then be printed, signed in black pen and a paper version given to the patient, ensuring it is then taken with them in the event of a transfer of care setting.

Section 8: Emergency Contacts and Those Involved in Discussing this Plan

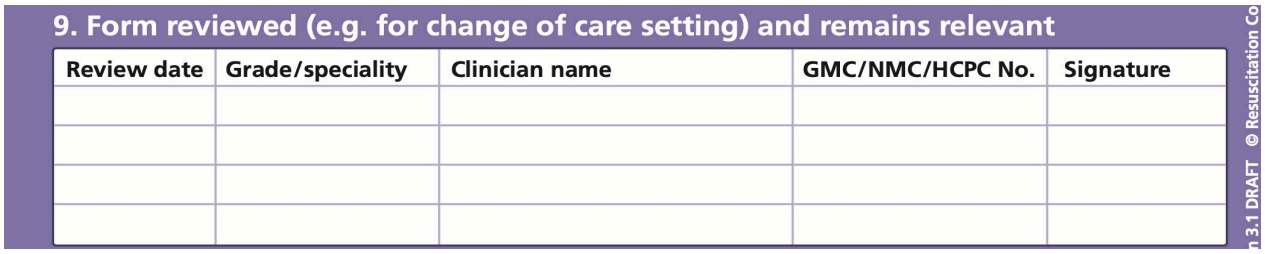
8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	**Role and relationship**	**Emergency contact no.**	**Signature**
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

1. The shaded area requires accurate details of the primary contact.

2. Option to include details of others involved in the conversation.

Section 9: Form Reviewed (e.g. for change of care setting) and Remains Relevant



9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

1. Recommendations for form review include:
- If it is requested by the individual or others,
- If the person's condition changes, or
- If there is a change in healthcare settings

2. If a patient presents with an existing ReSPECT summary form, it MUST be reviewed to ensure the contents are accurate and relevant.
   If there are no changes to be made, and the reviewer has authorship status, but is not a consultant, SAS doctor, Community Consultant or GP, then endorsement must be facilitated and recorded as per section 7.
3. If there are significant changes it may be appropriate to cancel the form and complete a new version. For cancellation of a form see **2.1.6.**

2.1.3 Location of the ReSPECT form

- ReSPECT forms (original paper copy) should be available in clinical areas.
- If the patient is in hospital, the completed form must be located at the front of the patients' notes.
- GP's may choose to colour print the form (EMIS version 3.5) but it must then be signed in black ink. Any completed forms held electronically are for reference only and must not guide clinical decision making in case they are an outdated version. ReSPECT packs will be available within Care Homes and GP practices.
- If the patient is at home, the form should be kept with the patient, either somewhere that can be easily found or viewed as necessary or within their healthcare records (if they have any).
- For patients in a Care Home or Hospice, the form must be kept in the patient's records where it can be easily viewed.

2.1.4 Communicate ReSPECT treatment limitations, including Resuscitation Status, to those involved in patient care

- Ensure that the patient's preferences have been communicated to all relevant members of the health and social care teams.

- Ensure that the CPR recommendations have been communicated to all relevant members of the healthcare team.

2.1.5 Patient Discharged /Transferred to Alternate Care Setting

- If the patient is transferred to another ward in the hospital setting, the ReSPECT form must remain in the hospital notes and must be transferred with the patient.

- On discharge or transfer to an alternate care setting, e.g. home, residential or nursing home, hospice etc, the Trust Discharge Policy CP04 must be adhered to and the Discharge Checklist completed including transfer of the ReSPECT form with the patient.

- On discharge ensure the presence of a ReSPECT form is communicated to the GP via the e-discharge platform.

- 'Adv. Decisions' button on Clinical Web Portal to be highlighted when ReSPECT form noted by Scanning Team / Secretaries and other appropriate administration staff.

- On discharge from hospital the ReSPECT from must be photocopied and added to the patient's file. The photocopy will be for auditing and record purposes only and must not be used a guide for management or treatment.

- The ReSPECT form must be shown to West Midlands Ambulance Service staff prior to any transfer of the patient. If noted not for CPR, this will be valid during any transfer journey to any alternate care setting.

- If the patient is discharged to a residential or nursing home or to a hospice or to another hospital, the ReSPECT form must accompany the patient.

- Patients who are being discharged home will normally be fully aware of the ReSPECT form and preferences. If for any reason this is not appropriate, the patient's relatives or significant others must be made fully aware.

- The patient, relatives or significant others (as appropriate) should be advised that the ReSPECT form must accompany the patient during any future transfer by West Midlands Ambulance Service or any transfer or admission to any alternate care setting.

2.1.6 How to Cancel a ReSPECT Form

- A ReSPECT document must be cancelled when its contents are no longer valid or applicable to the individual. This may be due to clinical changes, options relating to the patient's best interest have changed or because the patient or representative have requested.

- To cancel the document, pages 1 and 2 of the form must be crossed through with 2 diagonal lines in black ball point ink and 'CANCELLED' written clearly between, this must be signed and dated clearly by the clinician cancelling the order alongside their name.

- Hospital Settings - the form must be removed from the front of the patient's notes and filed at the end of the current hospital speciality admission notes (not necessary if the patient is deceased).

- Community Settings - the cancelled form must be filed within the patient's records at the community locality base (if receiving intervention from community healthcare teams) or returned to the patient's GP for filing in the patient's records.

3.0 Patient Held ReSPECT Forms

3.1 If the patient or representative has lost or defaced an existing ReSPECT from, they must inform the relevant Healthcare Professional whose care they are under so that a new form can be completed. If the original form is then found, it must be cancelled (see 2.1.6).

3.2 In circumstances where two or more ReSPECT forms are found to be in existence, the form with the latest date on will be considered valid and the older forms must be cancelled.

3.3 Any cancelled forms must be filed in the patient's records as appropriate to their care setting.

3.4 If the patient is transferred to an alternative care setting and the form does not accompany them, all efforts must be made to locate and collect the form. If that is not possible, a new form must be completed.

3.5 The patient should take the ReSPECT form to all outpatient appointments for awareness and potential review if a change in circumstances.

4.0 Patient Information

4.1 Patient information leaflets will be available in wards /depts as part of the ReSPECT pack, and on the Trust intranet's ReSPECT page.

4.2 Easy read information and other patient information is available via the following link ReSPECT | Resuscitation Council UK.

4.3 In addition to the leaflets, patients, relatives or significant others can request to discuss the ReSPECT process and CPR recommendations in more detail with the team caring for the patient.

4.4 Information for patients can be found via the NHS website https://www.nhs.uk/conditions/do-not-attempt-cardiopulmonary-resuscitation-dnacpr-decisions.

5.0 Training

5.1 All staff will be informed of the Resuscitation Policy CP11 at Induction. This policy contains information on the ReSPECT Process.

5.2 ReSPECT will be discussed in mandatory basic and advanced life support training for awareness.

5.3 Two e-learning packages are mandated as 'once only' topics and are accessible via the Trusts My Academy - 'Awareness' and 'Authorship'.

5.4 ReSPECT Awareness training is mandated for specific administration and clerical staff, FY1 level medical staff, and all clinical staff who do not require Authorship training.

5.5 ReSPECT Authorship training is mandated for all medics above FY1 level and specific band 7 level and above staff as agreed by the Resuscitation Group.

5.6 For ReSPECT mandatory training requirements refer to the training needs analysis (TNA) OP41 Induction and Mandatory Training Policy appendix4.

5.7 Staff involved in the ReSPECT process may access the following link to provide guidance on DNACPR decisions Decisions Relating to Cardiopulmonary Resuscitation (3rd edition 1st revision). Guidance from the British Medical Association, the Resuscitation Council [UK] and the Royal College of Nursing.

5.8 Staff involved in the ReSPECT process may access the following link to provide guidance on difficult discussions OP62, Breaking Bad News Policy.

5.9 Requests for authorship as a mandatory training requirement for staff groups must be directed through the Resuscitation Group, who will review this yearly.

6.0 ReSPECT / DNACPR – Young People

6.1 For all children up to the age of 18 years of age, DNACPR decisions will be recorded in the Child and Young Person's Advanced Care Plan (organisational specific -West Midlands Paediatric Palliative Care Network). The CYPACP is available to download from the following link http://CYPACP.UK.

6.2 The Child and Young Person's Advance Care Plan (CYPACP) is designed to communicate the healthcare wishes of children or young people who have chronic and life-limiting conditions. It sets out an agreed plan of care to be followed when a child or young person's condition deteriorates. It provides a framework for both discussing and documenting the agreed wishes of a child or young person and his or her parents, when the child or young person develops potentially life-threatening complications of his or her condition. It is designed for use in all environments that the child encounters: home, hospital, school, hospice and respite care and for use by the ambulance service. This ACP can be used as a resuscitation plan or as an end-of-life care plan. It remains valid when those with parental responsibility cannot be contacted.

6.3 The CYPACP must only be completed by a Consultant Paediatrician.

6.4 The Trust will have a nominated CYPACP Co-ordinator (details of this person will be available from the Clinical Director for Paediatrics). The CYPACP coordinator will be responsible for ensuring that all ACP's in their area are appropriately completed, regularly reviewed and that all parties access the most recent copy of the CYPACP.

6.5 Information for Trust staff is provided in the Child and Young Person's Advance Care Plan Policy. This is supported by document guidelines for professionals who may be involved in developing a CYPACP for a child or young person in their care. The policy and guidance are available from http://CYPACP.UK.

7.0 Monitoring

7.1 Audit of ReSPECT will be undertaken annually by the Governance Department on behalf of the Resuscitation Group. The Resuscitation Group Chair will ensure that the results have an appropriate and timely action plan and other specialist groups informed of the results e.g., Trust Safeguarding Group, End of Life Steering Group and Deteriorating Patient Group.

7.2 The audit will be recorded in the Trust annual audit report.

References

- Resuscitation Council UK (2016) Decisions Relating to Cardiopulmonary Resuscitation (3rd edition 1st revision). Guidance from the British Medical Association, the Resuscitation Council [UK] and the Royal College of Nursing
- ReSPECT: Recommended Summary Plan for Emergency Care and Treatment website available at ReSPECT | Resuscitation Council UK

- CP06 Consent to Treatment and Investigation Policy. Royal Wolverhampton NHS Trust 2021
- CP02 Deprivation of Liberty Safeguards (DoLS) Policy. Royal Wolverhampton NHS Trust 2021
- OP41 Induction and Mandatory Training Policy. Royal Wolverhampton NHS Trust 2021
- CP04 Discharge Policy. Royal Wolverhampton NHS Trust 2021
- OP62 Breaking Bad News Policy Royal Wolverhampton NHS Trust 2020.
- Child and Young Person's Advance Care Plan Collaborative (2019). http://CYPACP.UK

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name
Date of birth
Address
NHS/CHI/Health and care number

1. This plan belongs to:

Preferred name
Date completed

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ **Yes** ☐ **No**

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me	**Quality of life and comfort matters most to me**
What I most value:	What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	or	Balance extending life with comfort and valued outcomes	or	Prioritise comfort
clinician signature		clinician signature		clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

CPR attempts recommended Adult or child	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

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5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? ☐ **Yes** ☐ **No**

Document the full capacity assessment in the clinical record.

If no, in what way does this person lack capacity?

If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.

☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

If this page is on a separate sheet from the first page: **Name:** **DoB:** **ID number:**

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Discussion guide

People have different views about what care or treatments they would want if they were suddenly ill and could not make choices. ReSPECT conversations allow a person and their health professionals to plan together for such a future emergency. If a person does not have capacity to participate, ReSPECT conversations should include their legal proxy (if they have one), family members or other carers.

1 Ensure that all involved in the conversation understand the purpose of ReSPECT.

2 Start the ReSPECT process with one or more conversations between each person and their health professionals to establish and record in **section 2** a shared understanding of the person's present condition or situation and how these might change....

3 Next, discuss, agree and record in **section 3** those things that the person thinks would matter most to them (values and fears) if they suddenly became less well, both in their daily lives and as a possible outcome of future emergency care and treatment.

Living as long as possible matters most to me — **Quality of life and comfort matters most to me**

Using the scale may help you to discuss and agree priorities. Use the discussed / agreed goals of care to guide further planning discussions

4 Then discuss, agree and record in **section 4** recommendations about those types of care or realistic treatment that:

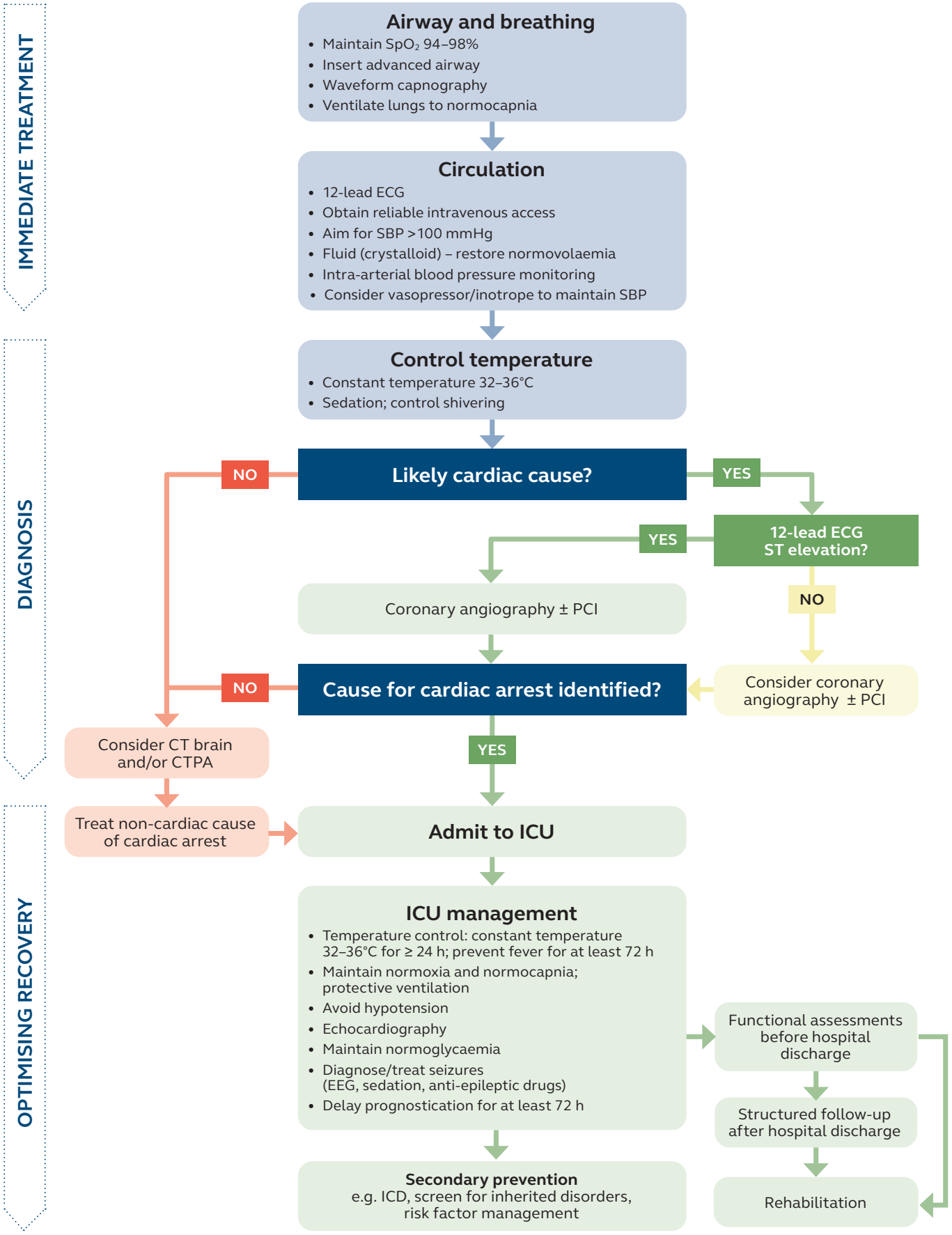
- would be wanted (to try to achieve the goals of care),
- would not be wanted,
- that would not work in this person's situation.

As part of this, discuss, agree and record a recommendation about CPR.

Resuscitation Council UK

GUIDELINES 2021

Adult post resuscitation care



Anaphylaxis

Anaphylaxis?

A = Airway **B** = Breathing **C** = Circulation **D** = Disability **E** = Exposure

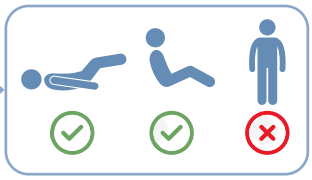
Diagnosis – look for:

- Sudden onset of Airway and/or Breathing and/or Circulation problems[1]
- And usually skin changes (e.g. itchy rash)

Call for HELP

Call resuscitation team or ambulance

- Remove trigger if possible (e.g. stop any infusion)
- Lie patient flat (with or without legs elevated)
  - A sitting position may make breathing easier
  - If pregnant, lie on left side



Give intramuscular (IM) adrenaline[2]

Inject at **anterolateral aspect** – middle third of the thigh

- Establish airway
- Give high flow oxygen
- Apply monitoring: pulse oximetry, ECG, blood pressure

If no response:

- Repeat IM adrenaline after 5 minutes
- IV fluid bolus[3]

If no improvement in Breathing or Circulation problems[1] despite TWO doses of IM adrenaline:

- Confirm resuscitation team or ambulance has been called
- Follow REFRACTORY ANAPHYLAXIS ALGORITHM

1. Life-threatening problems

Airway
Hoarse voice, stridor

Breathing
↑work of breathing, wheeze, fatigue, cyanosis, SpO_2 <94%

Circulation
Low blood pressure, signs of shock, confusion, reduced consciousness

2. Intramuscular (IM) adrenaline
Use adrenaline at 1 mg/mL (1:1000) concentration

Adult and child >12 years:	500 micrograms IM (0.5 mL)
Child 6–12 years:	300 micrograms IM (0.3 mL)
Child 6 months to 6 years:	150 micrograms IM (0.15 mL)
Child <6 months:	100–150 micrograms IM (0.1–0.15 mL)

The above doses are for IM injection **only**.
Intravenous adrenaline for anaphylaxis to be given **only by experienced specialists** in an appropriate setting.

3. IV fluid challenge
Use crystalloid

Adults:	500–1000 mL
Children:	10 mL/kg

Resuscitation Council UK

GUIDELINES 2021

Refractory anaphylaxis

No improvement in respiratory or cardiovascular symptoms despite 2 appropriate doses of intramuscular adrenaline

Establish dedicated peripheral IV or IO access

Seek expert[1] help early
Critical care support is essential

Give rapid IV fluid bolus
e.g. 0.9% sodium chloride

&

Start adrenaline infusion
Adrenaline is essential for treating all aspects of anaphylaxis

Give IM* adrenaline every 5 minutes until adrenaline infusion has been started
*IV boluses of adrenaline are not recommended, but may be appropriate in some specialist settings (e.g. peri-operative) while an infusion is set up

Give high flow oxygen
Titrate to SpO_2 94–98%

Monitor HR, BP, pulse oximetry and ECG for cardiac arrhythmia
Take blood sample for mast cell tryptase

Follow local protocol

OR

Peripheral low-dose IV adrenaline infusion:

- 1 mg (1 mL of 1 mg/mL [1:1000]) adrenaline in 100 mL of 0.9% sodium chloride
- Prime and connect with an infusion pump via a dedicated line

DO NOT 'piggy back' on to another infusion line

DO NOT infuse on the same side as a BP cuff as this will interfere with the infusion and risk extravasation

- In both adults and children, start at 0.5–1.0 mL/kg/hour, and **titrate according to clinical response**
- Continuous monitoring and observation is mandatory
- ↑↑ BP is likely to indicate adrenaline overdose

Continue adrenaline infusion and treat ABC symptoms

Titrate according to clinical response

[1]Intravenous adrenaline for anaphylaxis to be given only by experienced specialists in an appropriate setting.

A = Airway

Partial upper airway obstruction/stridor:
Nebulised adrenaline (5mL of 1mg/mL)

Total upper airway obstruction:
Expert help needed, follow difficult airway algorithm

B = Breathing

Oxygenation is more important than intubation

If apnoeic:

- Bag mask ventilation
- Consider tracheal intubation

Severe/persistent bronchospasm:

- Nebulised salbutamol and ipratropium with oxygen
- Consider IV bolus and/or infusion of salbutamol or aminophylline
- Inhalational anaesthesia

C = Circulation

Give further fluid boluses and titrate to response:
Child 10 mL/kg per bolus
Adult 500–1000 mL per bolus

- Use glucose-free crystalloid (e.g. Hartmann's Solution, Plasma-Lyte®)

Large volumes may be required (e.g. 3–5 L in adults)

Place arterial cannula for continuous BP monitoring

Establish central venous access

IF REFRACTORY TO ADRENALINE INFUSION
Consider adding a second vasopressor **in addition** to adrenaline infusion:

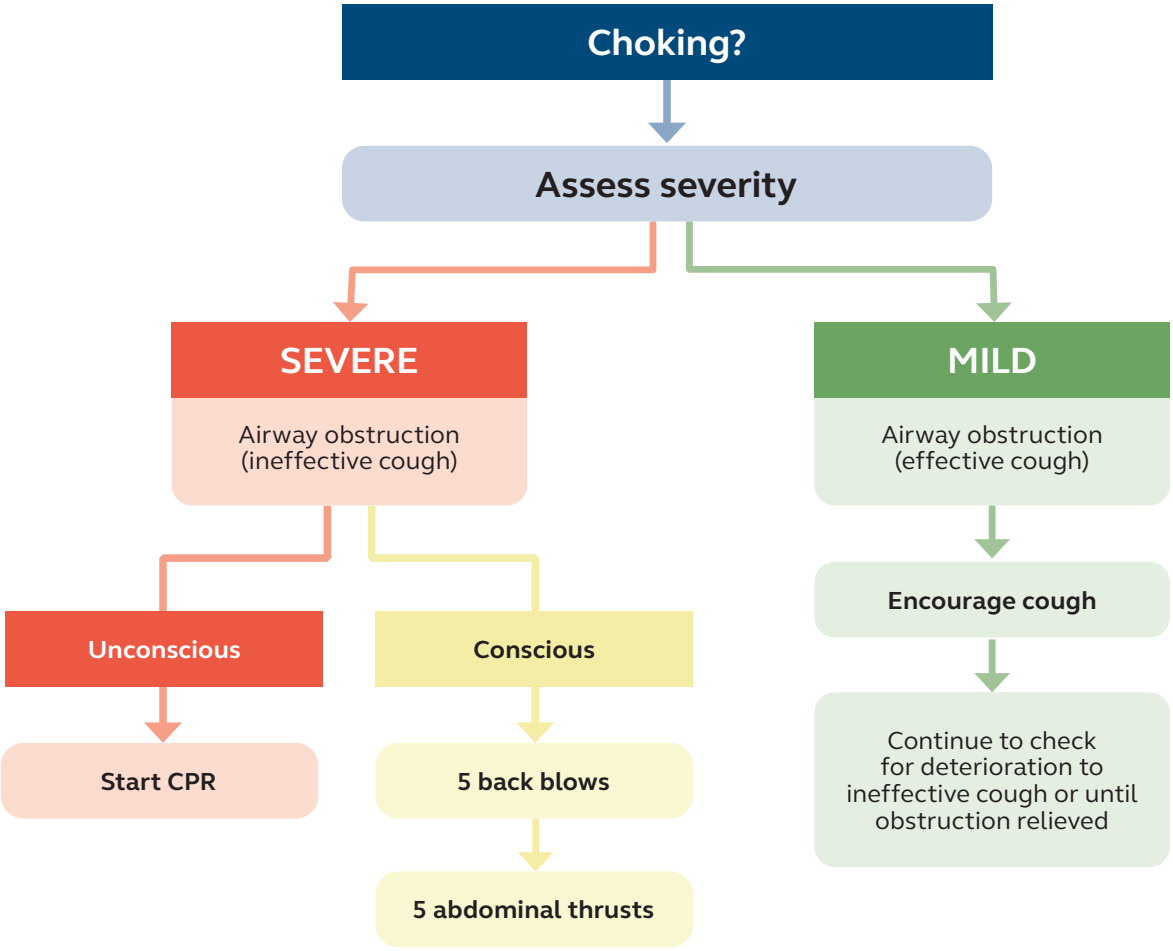
- Noradrenaline, vasopressin or metaraminol
- In patients on beta-blockers, consider glucagon

Consider extracorporeal life support

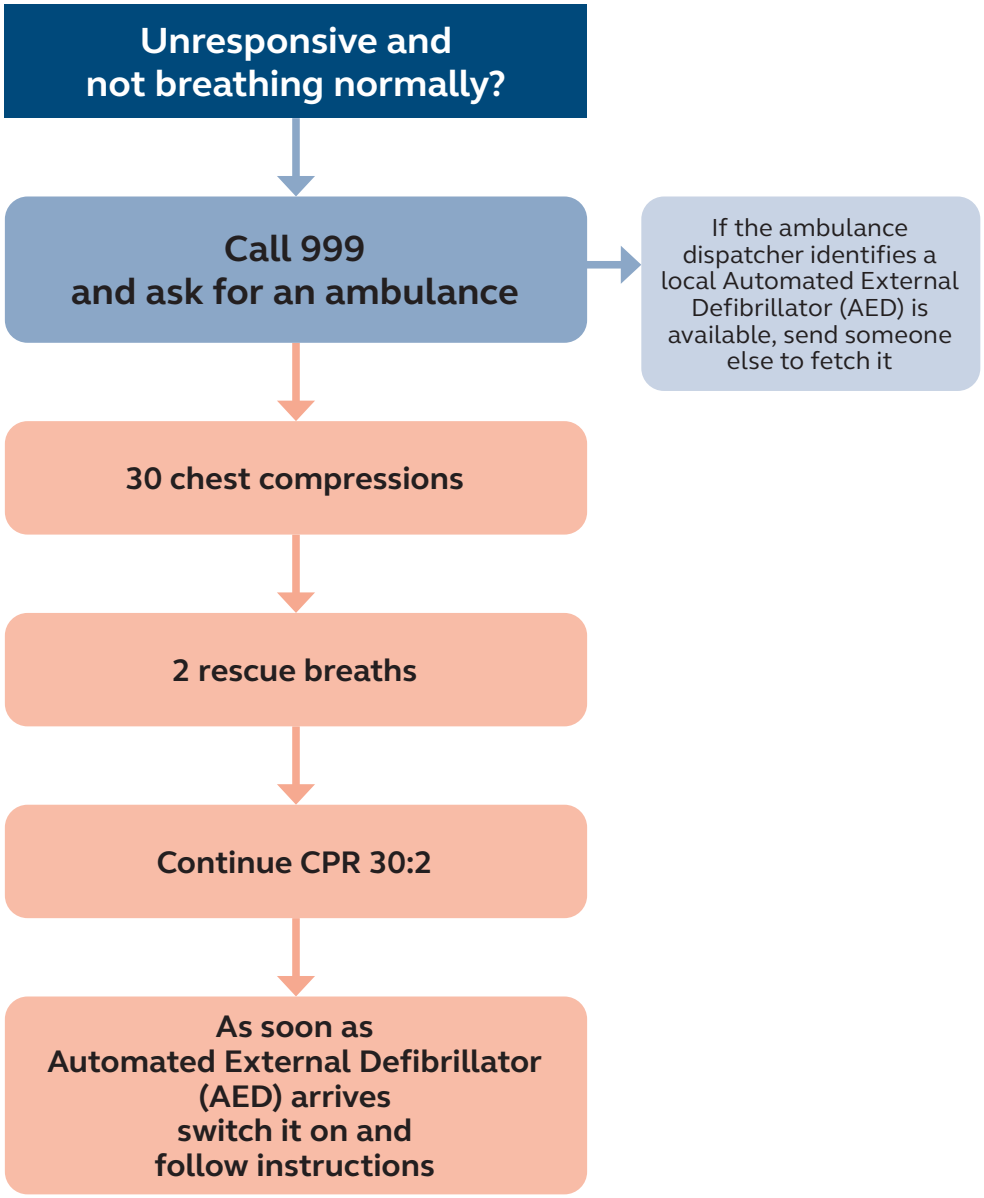
Cardiac arrest – follow ALS ALGORITHM

- Start chest compressions early
- Use IV or IO adrenaline bolus (cardiac arrest protocol)
- Aggressive fluid resuscitation
- Consider prolonged resuscitation/extracorporeal CPR

Adult choking



Adult basic life support in community settings



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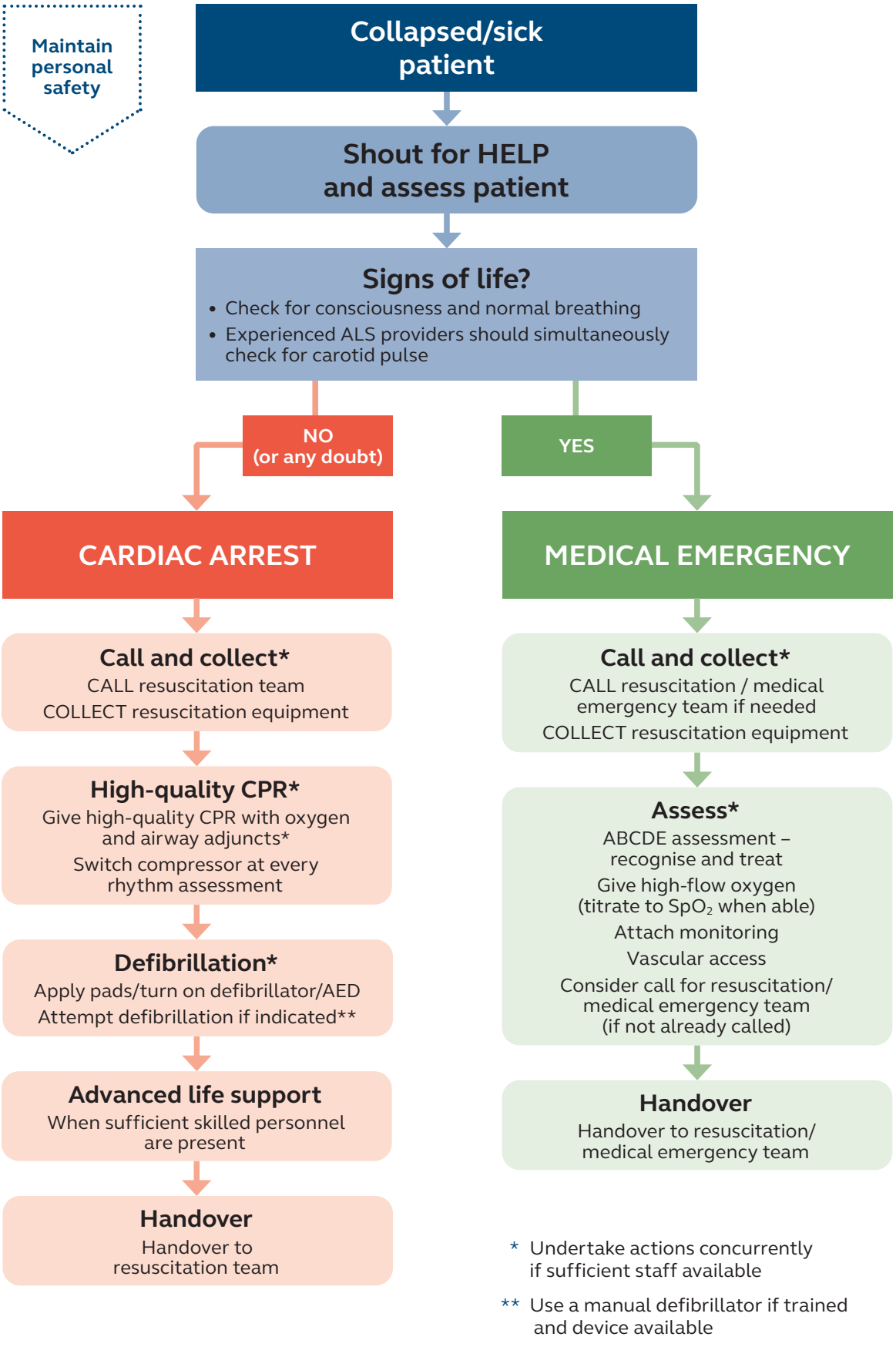
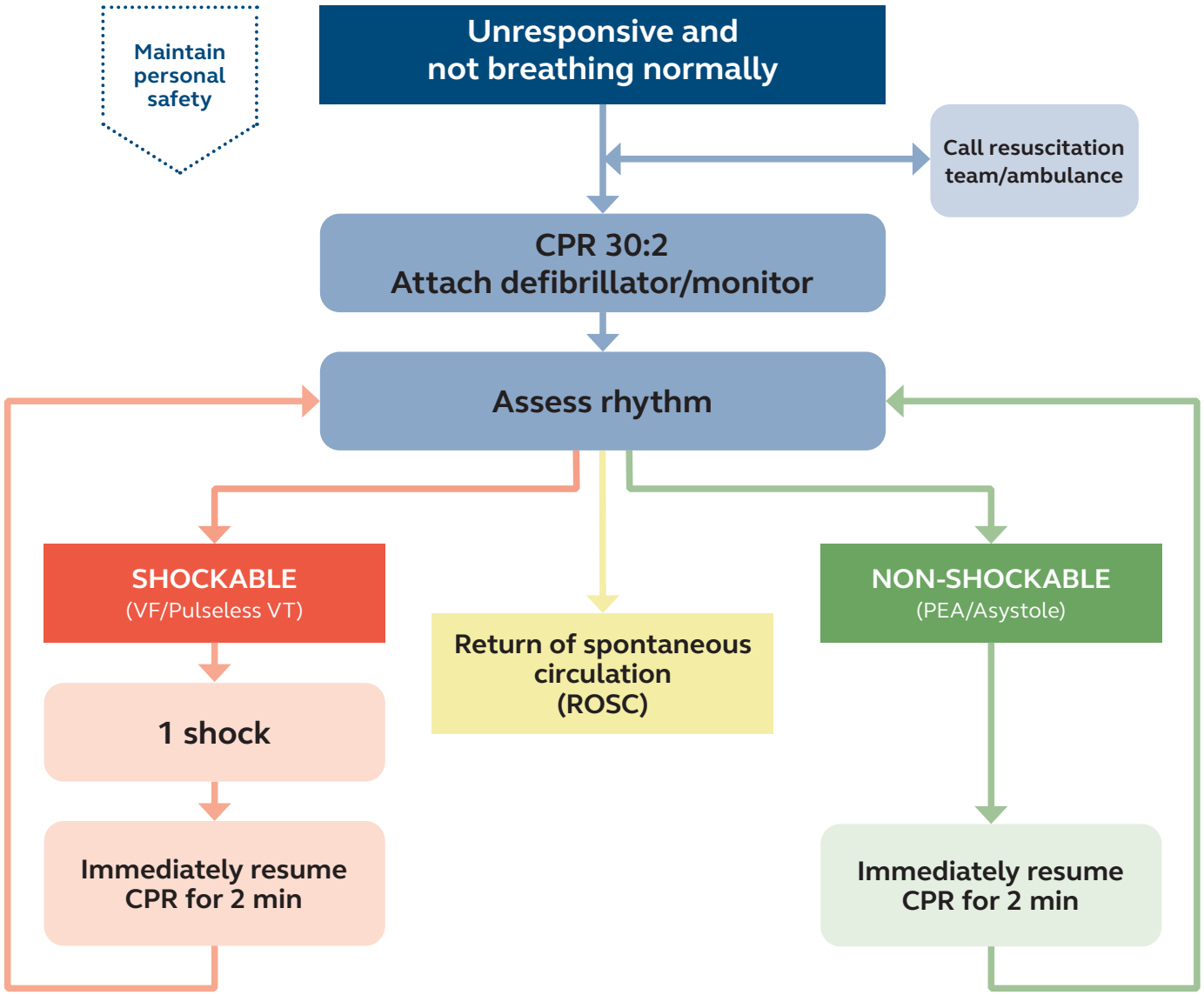
Adult in-hospital resuscitation



* Undertake actions concurrently if sufficient staff available

** Use a manual defibrillator if trained and device available

Adult advanced life support



Give high-quality chest compressions, and:

- Give oxygen
- Use waveform capnography
- Continuous compressions if advanced airway
- Minimise interruptions to compressions
- Intravenous or intraosseous access
- Give adrenaline every 3–5 min
- Give amiodarone after 3 shocks
- Identify and treat reversible causes

Identify and treat reversible causes

- Hypoxia
- Hypovolaemia
- Hypo-/hyperkalaemia/ metabolic
- Hypo/hyperthermia
- Thrombosis – coronary or pulmonary
- Tension pneumothorax
- Tamponade – cardiac
- Toxins

Consider ultrasound imaging to identify reversible causes

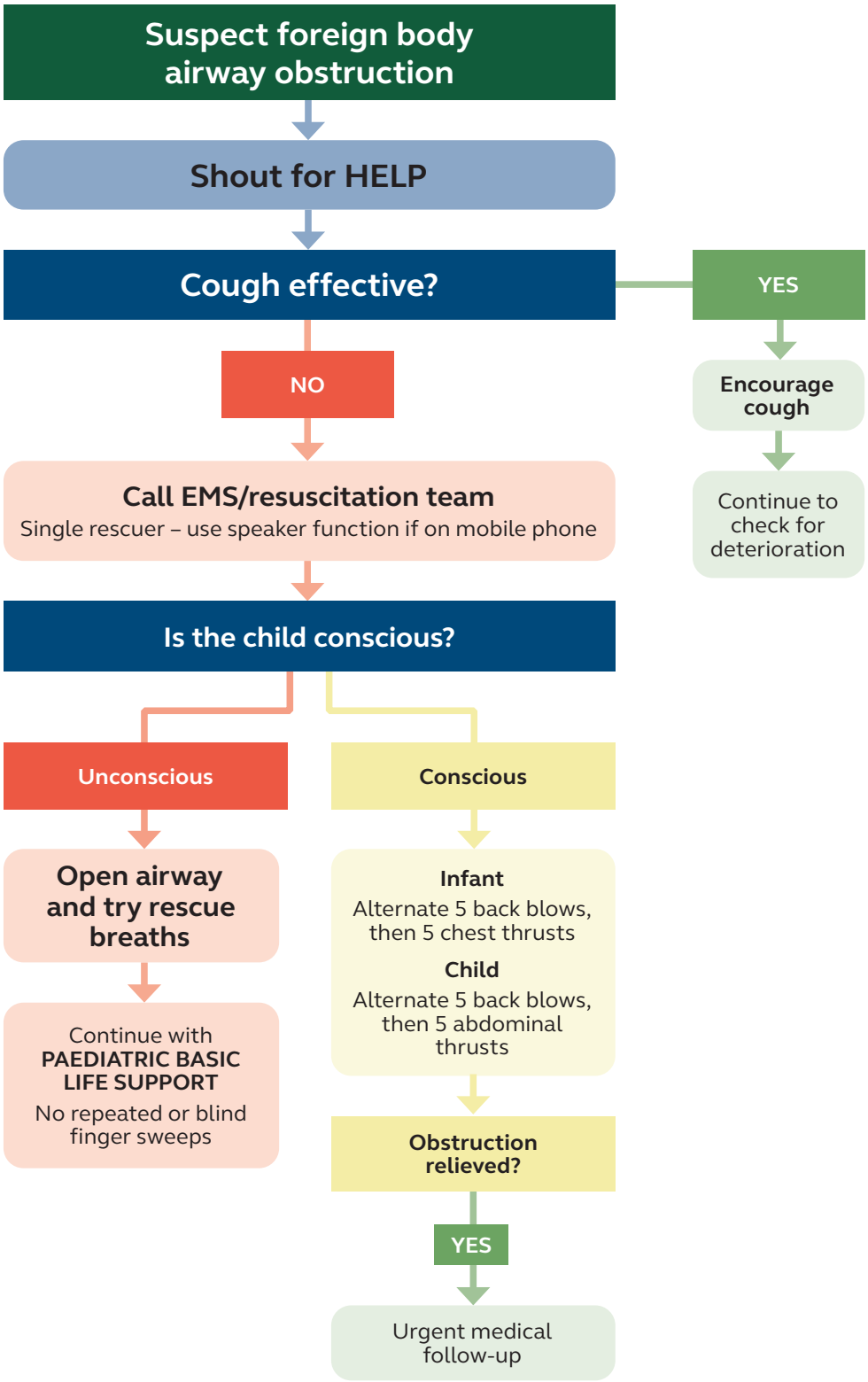
Consider

- Coronary angiography/ percutaneous coronary intervention
- Mechanical chest compressions to facilitate transfer/treatment
- Extracorporeal CPR

After ROSC

- Use an ABCDE approach
- Aim for SpO_2 of 94–98% and normal $PaCO_2$
- 12-lead ECG
- Identify and treat cause
- Targeted temperature management

Paediatric foreign body airway obstruction



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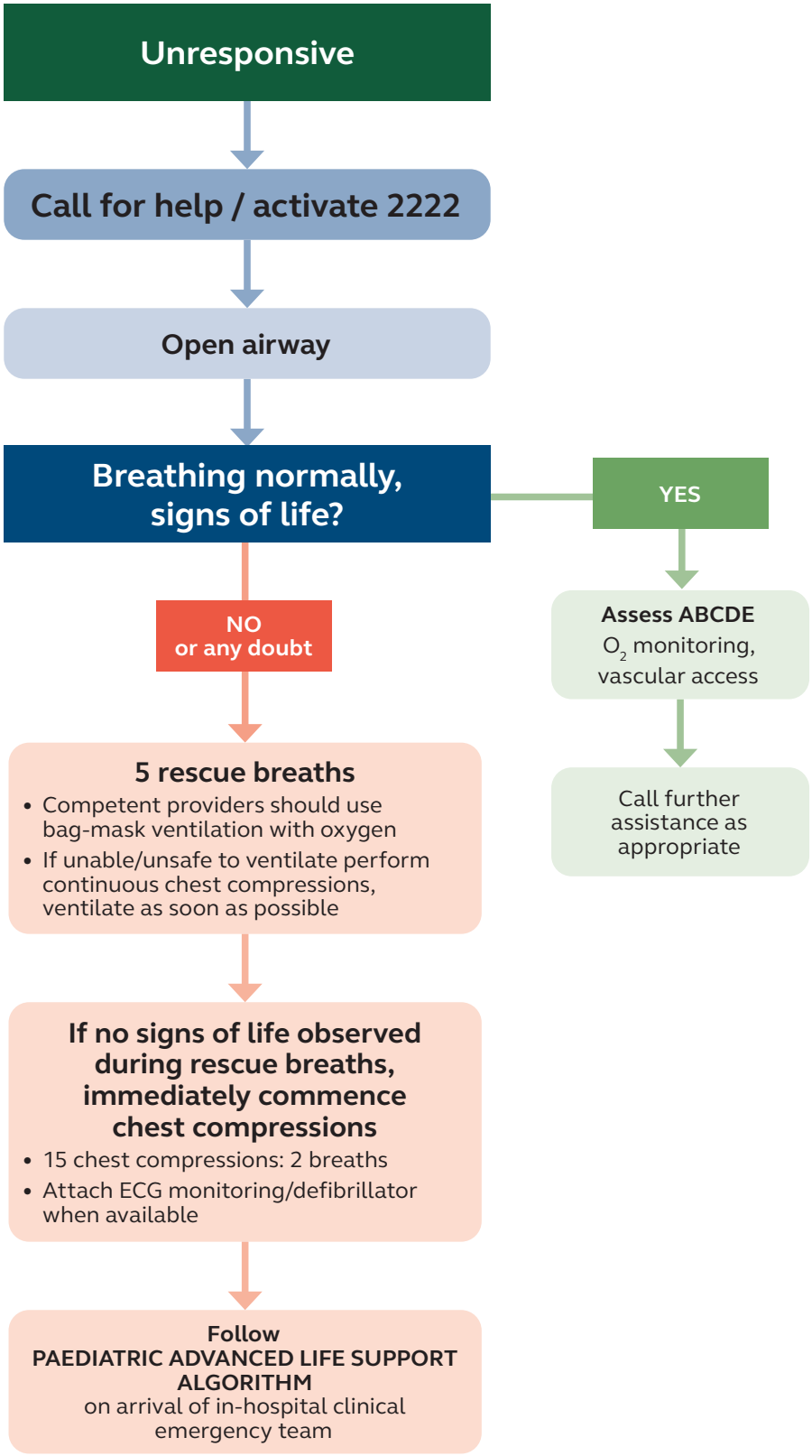
Paediatric basic life support



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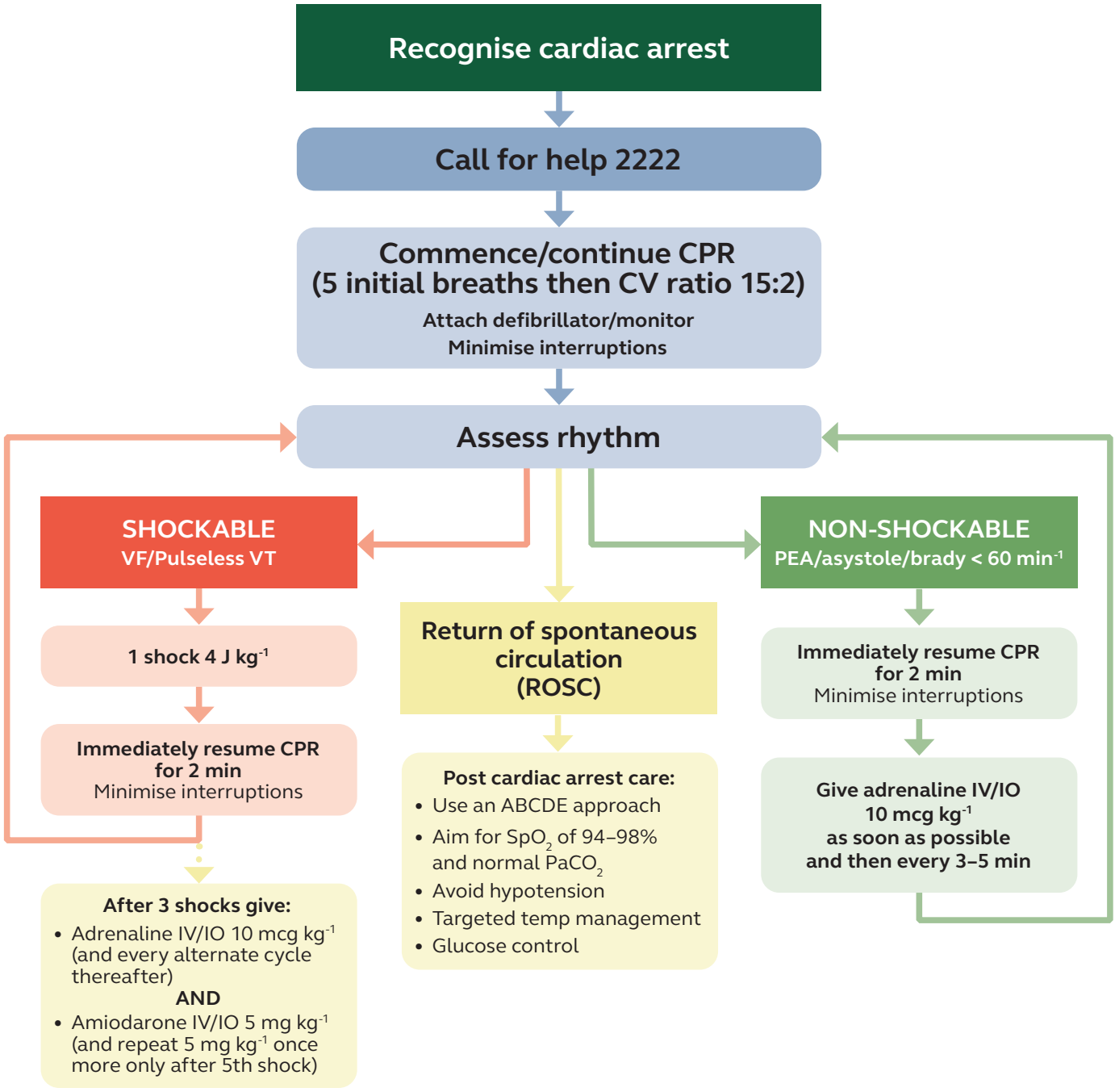
Paediatric advanced life support



During CPR

- **Ensure high quality chest compressions are delivered:**
  - Correct rate, depth and full recoil
- Provide BMV with 100% oxygen (2 person approach)
- Provide continuous chest compressions when a tracheal tube is in place.
- Competent providers can consider an advanced airway and capnography, and ventilate at a rate (breaths minute^{-1}) of:

Infants: 25	1–8 years: 20	8–12 years: 15	> 12 years: 10–12

- Vascular access IV/IO
- Once started, give Adrenaline every 3-5 min
- Maximum single dose Adrenaline 1 mg
- Maximum single dose Amiodarone 300 mg

Identify and treat reversible causes

- Hypoxia
- Hypovolaemia
- Hyperkalaemia, hypercalcaemia, hypermagnesemia, hypoglycaemia
- Hypo-/hyperthermia
- Thrombosis – coronary or pulmonary
- Tension pneumothorax
- Tamponade – cardiac
- Toxic agents

Adjust algorithm in specific settings (e.g. special circumstances)

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Newborn life support

(Antenatal counselling)
Team briefing and equipment check

Preterm < 32 weeks

Place undried in plastic wrap + radiant heat

Inspired oxygen
28–31 weeks 21–30%
< 28 weeks 30%

If giving inflations, start with 25 cm H_2O

Acceptable pre-ductal SpO_2	
2 min	65%
5 min	85%
10 min	90%

TITRATE OXYGEN TO ACHIEVE TARGET SATURATIONS

Birth
Delay cord clamping if possible

Start clock / note time
Dry / wrap, stimulate, keep warm

Assess
Colour, tone, breathing, heart rate

Ensure an open airway
Preterm: consider CPAP

If gasping / not breathing
- **Give 5 inflations (30 cm H_2O) – start in air**
- Apply PEEP 5–6 cm H_20, if possible
- Apply SpO_2 +/- ECG

Reassess
If no increase in heart rate, look for chest movement

If the chest is not moving
- Check mask, head and jaw position
- 2 person support
- Consider suction, laryngeal mask/tracheal tube
- Repeat inflation breaths
- Consider increasing the inflation pressure

Reassess
If no increase in heart rate, look for chest movement

Once chest is moving continue ventilation breaths

If heart rate is not detectable or < 60 min^{-1} after 30 seconds of ventilation
- Synchronise 3 chest compressions to 1 ventilation
- Increase oxygen to 100%
- Consider intubation if not already done or laryngeal mask if not possible

Reassess heart rate and chest movement every 30 seconds

If the heart rate remains not detectable or < 60 min^{-1}
- **Vascular access and drugs**
- Consider other factors e.g. pneumothorax, hypovolaemia, congenital abormality

Update parents and debrief team
Complete records

APPROX 60 SECONDS

MAINTAIN TEMPERATURE

AT ALL TIMES ASK **"IS HELP NEEDED"**