Policy:

NPCS 007 Resuscitation

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Policy Owner	Resuscitation Officer
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Document type	Policy
Document status	Version 4.1
Date of initial draft	September to December 2018
Date of consultation	04 July to 18 July 2020 and 14th to 25th January 2022
Date of verification	27th February 2023 PGG
Date of ratification	9 January 2022
Ratified by	QAC
Date of issue	February 2023
Date for review	27th February 2024

Summary of policy.

Sheffield Health and Social Care NHS Foundation Trust has an obligation to provide an effective and efficient resuscitation service and to ensure that staff receive training and regular updating appropriate to their role.
All persons covered by the policy will be presumed to be for resuscitation in the event of a sudden collapse due to cardio-pulmonary arrest unless a Do Not Attempt Cardio-Pulmonary Resuscitation decision has been made. The Trust also has an obligation to ensure that an individual's wishes are respected should they decide that they do not want to be resuscitated.

Target audience	All SHSC employees, or contracted staff from other NHS Trusts or private individuals working with SHSC service users.

Keywords	Resuscitation, physical health, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR), deteriorating patient, NEWS2 National Early Warning Scoring

Storage & Version Control

Version 4.1 of this policy is stored and available through the SHSC Intranet/internet. This version of the policy supersedes the previous version 4.0. Previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance. Any printed copies of the previous versions should be destroyed and if a hard copy is required, it should be replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
0.1	New draft policy created	12/2018	New policy commissioned by EDG on approval of a Case for Need.
1.0	Approval and issue	28/01/2019	Amendments made during consultation, prior to ratification.
2.0	Review / approve / issue	25/01/2022	Early review undertaken to update the policy to in order to comply with new regulatory requirements.
2.1	Review on expiry of policy	01/2022	Full review completed.
3.0	Approval / issue	01/2022	Final amendments made prior to issue.
4.0	Review on expiry of policy.	02/2023	Full review completed.
4.1	Update	06/2023	Update of agreed changes to the emergency drug box contents.

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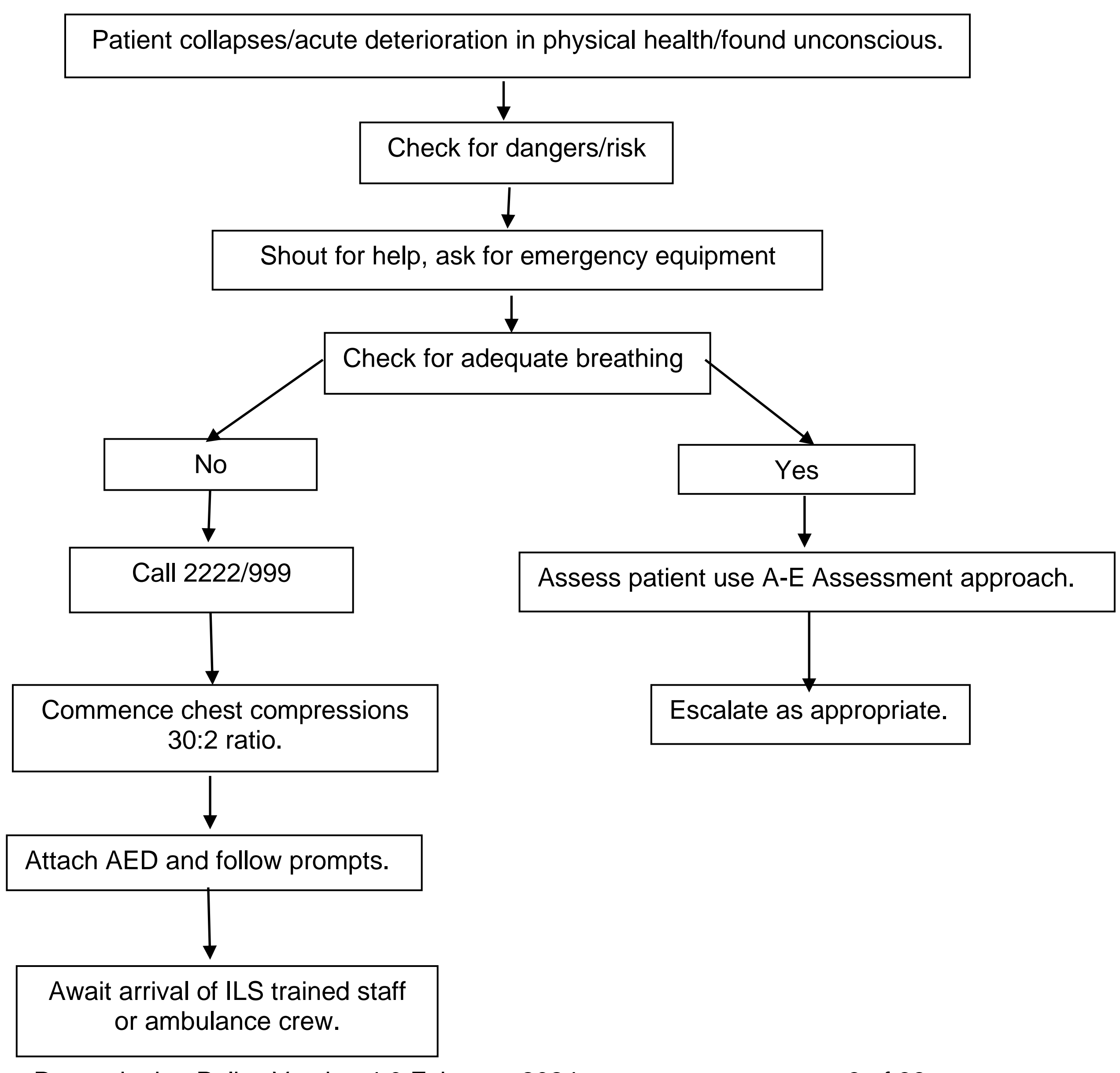
Flowchart



1. Introduction

1.1 Healthcare organisations have a responsibility to deliver quality resuscitation care, and to ensure that staff are trained and updated regularly to a standardised level of capability appropriate to everyone's expected role. It is recognised that all employees of Sheffield Health and Social Care NHS Foundation Trust may be involved in a resuscitation procedures during their work.

1.2 Sheffield Health and Social Care NHS Foundation Trust must provide a resuscitation service for patients, service users, visitors and staff on all its sites. The aim is that all staff must be able to provide basic Cardiopulmonary Resuscitation as a minimum standard.

1.3 As a provider of specialist adult Mental Health, Learning Disability, Primary Care and Community Services it is essential that Sheffield Health and Social Care NHS Foundation Trust provides resuscitation at an appropriate level of care. For effective life support, standardised equipment, training and protocol Sheffield Health and Social Care NHS Foundation Trust follow evidence based national guidelines provided by:

- The Resuscitation Council (UK) Quality Standards: Mental Health Inpatient Care (2020) clearly sets out the expected standards for compliance with leadership, resuscitation committee membership and level of training for all staff.

- The Resuscitation Council (UK) Quality Standards: Community Hospital Care (2020) clearly sets out the expected standards for compliance with leadership, resuscitation committee membership and level of training for all staff within nursing homes.

- The Resuscitation Council (UK) Quality Standards: CPR and AED Training in the Community (2020) clearly sets out the expected standards for compliance with leadership, resuscitation committee membership and level of training for all staff within nursing homes.

- Resuscitation Council (UK) 2021 Guidelines provide evidence-based guidelines for the practice of cardiopulmonary resuscitation within the United Kingdom following the evidence presented by the International Liaison Committee on Resuscitation (ILCOR) consensus.

- NICE (2007) CG50 Acutely ill adults in hospital: recognising and responding to deterioration gives guidance on how patients in hospital should be monitored to identify those whose health may become worse suddenly and the care they should receive aiming to reduce the risk of patient's risk of needing to stay in hospital longer in hospital, not recovering fully or dying.

- NICE (2015) NG10 Violence and aggression: short-term management in mental health, health and community settings recommends the level of resuscitation equipment that should immediately be available in the event of restrictive interventions being used and the level of training for the staff involved.

- National Patient Safety Agency, NPSA (2008) Resuscitation in mental health and learning disabilities settings gave guidance to organisations on training and equipment provision for these settings and the inclusion of regularclinical practices or drills to support classroom teaching.

1.4 Across Sheffield Health and Social Care NHS Foundation Trust the provision will be determined by the location of the healthcare facility, the type of healthcare provided in that location and the staff available in that location and will always be supported by the local ambulance service.
Failure to provide an effective service is a failure in the corporate duty of care that is a clinical risk which contravenes the principles of clinical governance.

2. Scope

2.1 This policy applies to all staff, clinical and non-clinical, of all services within Sheffield Health and Social Care NHS Foundation Trust

2.2 This policy applies to all staff whether they are on Trust premises or in a community settings.

2.3 Sheffield Health and Social Care NHS Foundation Trust staff who provide care within other healthcare or social care organisations, need to be familiar with all policies related to the provision of patient care within those organisations including resuscitation policy and/or procedure.

2.4 Within Sheffield Health and Social Care NHS Foundation Trust it is recognised that most of service users are over are over the age of 18 years.

3. Purpose

3.1 The purpose of this policy is to enable staff to provide effective high-quality resuscitation care for all of our service users, staff and visitors. It applies to all Sheffield Health and Social Care NHS Foundation Trust employees, agency staff, locum staff and trainees.

3.2 This policy is to set out the arrangements for managing the risks associated with the provision of resuscitation care.

3.3 This policy is to ensure there is an effective system in place to support effective resuscitation provision for service users, staff and visitors.

3.4 To outline the duties and responsibilities of all staff members to comply with relevant legislation and guidance (Resuscitation Council UK Guidelines 2021).

4. Definitions

Glossary of Terms	Definition
ABCDE Assessment – Airway, Breathing, Circulation, Disability, Exposure	A standardised systematic approach to immediately assess and treat a critically ill or injured person.
ADRT – Advanced Decision to RefuseTreatment.	A decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding for healthcare staff.
AED – Automated External Defibrillator	A sophisticated, reliable, safe, computerised device that delivers electric shocks to a victimof cardiac arrest when the ECG rhythm is one that is likely to respond to a shock.
Anaphylaxis	Severe, life threatening, generalised, or systemic hypersensitivity reaction.
BLS – Basic Life Support	Implies that no equipment is required to givecardio-pulmonary resuscitation, other than protective device to allow the responder to give ventilations without the risk of infection transmission. BLS training includes the management of choking.
Cardiac Arrest	The sudden cessation of mechanical cardiacactivity characterised by a patient who is unresponsive and not breathing normally. Rescuers need to be aware that immediately following cardiac arrest blood flow to the brain is reduced to virtually zero, which may cause seizure-like episodes and these patients should be carefully assessed to see if theyare breathing normally.
Choking	The occlusion of the airway by a foreign body, causing the inability to breathe, it is a medical emergency and can, if not treated cause cardiorespiratory arrest.
CPR – Cardiopulmonary Resuscitation	An emergency procedure that may include chest compressions and ventilations in an attempt to maintain cerebral and myocardialperfusion, which follows recommended current Resuscitation council (UK) guidelines.
DNACPR – Do Not Attempt Cardiopulmonary Resuscitation. Previously known as DNAR or DNR	Refers to a decision not to make efforts to restart breathing and /or the heart in cases of respiratory/cardiac arrest. It does not refer to any other interventions, treatment and/or caresuch as fluid replacement, feeding, antibiotic.
ILS – Immediate Life Support	ABCDE assessment & management. Undertaking the skills of quality CPR and defibrillation (AED) and simple airway manoeuvres.
NEWS2– National Early Warning Score 2	A track and trigger system to efficiently identify and respond to patients who present with or develop acute illness. Used when patients present acutely to hospital. May also be used in certain pre-hospital assessments by primary care and ambulance service.
SOP – Standard Operational Procedure	Agreed operational procedure for the delivery care in any given area.
SHSC	Sheffield Health and Social Care NHS Foundation

	Trust.

5. Duties.

5.1 Chief Executive

The Chief Executive on behalf of the Trust retains ultimate accountability for the health, safety and welfare of all service users, carers, staff and visitors; however key tasks and responsibilities will be delegated to individuals in accordance with the content of this policy.

5.2 Director of Nursing and Professions

The Director of Nursing and Professions is required to be responsible for resuscitation care structure. This service must be part of the Trust management/governance structure. Responsible for implementation and monitoring of the policy within the Trust.
Ensure there is defined financial support for an effective resuscitation service and training.

5.3 Resuscitation Officer

The Resuscitation Officer for SHSC oversees the resuscitation service throughout the Trust and respond to any issues raised. Duties include to:

- Update the policies and guidelines for resuscitation within the Trust, reflecting national recommendations and guidelines outlined by Resuscitation Council (UK).
- Provide a variety of training courses to meet the needs of the organisation. Such as Immediate Life Support, for registered nurses and doctors working in areas where restraint or rapid tranquilisation may be used.
- Quality assures the training of both ILS and BLS.
- Communicate with managers to update responsibilities regarding the management of resuscitation delivery and training.
- Communicate with ward managers develop action plans for staff members who do not meet the requirements.
- Provide specialist advice for managers and staff.
- Audit compliance with this policy and monitor effectiveness.
- Maintain the resuscitation website.
- Review incident report forms involving resuscitation/DNACPR and contribute to their investigation. Feedback any issues to the relevant Trust groups and or external bodies as required.
- Collate data about incidents involving life support and/or resuscitation events
- Offer a debrief to staff involved in any medical emergency if required.

5.4 Physical Health Committee, PHC.

The IPCPH group will meet quarterly and in line with the terms of reference and will determine the level of resuscitation training required at an individual and team level;
- Ensuring annual review takes place.
- Oversees the training plan for the provision of training in resuscitation care.
- Determines requirements for and choice of resuscitation equipment.
- Promoting adherence to national resuscitation guidelines and standards.
- Oversees the audit compliance with any policy and/or procedure related to resuscitation.
- Develops and implements policies relating to resuscitation.
- Commissioning audits of resuscitation practice.

- Working collaboratively with patient safety and other service leads to ensure the timely reporting and review of critical incidents in relation to resuscitation.

5.5 **Mandatory Training Lead**

Is responsible for ensuring that the educational governance arrangements within SHSC and those models of teaching, learning and assessment are fit for purpose. That educational arrangements are in line with advice from the Resuscitation Officer inclusive of any national guidelines. Ensuring that job specific mandatory training is delivered in accordance with the training needs analysis in collaboration with the Physical Health and Resuscitation team. They are responsible for ensuring all attendance of training is recorded onto the Electronic Staff Record system.

5.6 **Service Managers, Matrons and Ward Managers**

Responsible for ensuring that high standards are maintained within their areas of responsibility and the standards set out in this policy are adhered to. It is the responsibility of each line manager to ensure staff attend relevant statutory and mandatory training; and to monitor attendance on a routine basis, ensuring systems are in place for staff to be followed up in relation to resuscitation training. They must ensure all appropriate resuscitation equipment is available and in good working order. Ensure risk assessment forms are completed in accordance with the Clinical Risk and Management of Harm Policy and incidents are managed in accordance with the incident management policy.

An incident report and Resuscitation Record Form (Appendix J) must be completed for every resuscitation attempt.

5.7 **Clinical Educators, Physical and Resuscitation team.**

Are responsible for delivering high quality teaching, learning and assessment of staff in respect of resuscitation practice in line with national guidance.

5.8 **Employee**

It is the responsibility of each staff member to ensure they attend all relevant mandatory training and other training if relevant for their role and keep themselves up to date**.** It is the responsibility of all staff to ensure that they act in accordance with their sphere of competence and acknowledge limitations of practice.

5.9 **Consultants and Medics**

Overall responsibility for decisions relating to resuscitation rests with the Consultant or medic in charge of the person's care.
In relation to DNACPR this must where possible include input from the service user or if not possible their relatives/carer/Power of Attorney for health and wellbeing. This should be a multidisciplinary team decision and be in the best interests of the patient and in accordance with their previously expressed wishes or Advanced Statements. The DNACPR policy must be adhered to alongside this policy.

5.10 **Resuscitation Training**

All clinical staff should receive training and at least annual updates to ensure that, when a cardiorespiratory arrest occurs, they can:

- Recognise a cardiorespiratory arrest.
- Summon help and know how to do this.
- Commence CPR; attempt defibrillation (if appropriate) with an automated external defibrillator (AED)whenever possible within 3 minutes of collapse.
- Provide ventilation to the patient through a pocket mask or Bag-valve-mask(depending on location and level of training).

6. Process

6.1 In the event of a cardiopulmonary arrest, basic life support and calling for appropriate help are two of the actions that can save lives.

6.2 Cardiopulmonary arrest can cause premature death. The earlier that effective treatment is provided, the more likely the casualty is to survive. All Trust clinical staff are required to be able to carry out CPR in line with their agreed job role and responsibilities. If a member of staff is unable to perform CPR, they should be supported under the appropriate Trust Policy.

6.3 All bed-based areas and areas that administer rapid tranquilisation, seclusion and restrictive practice with SHSC must have at least one registered staff member trained in Immediate Life Support per shift.

6.4 Community based clinical staff who work within the SHSC will as a minimum be able to call for appropriate help, recognise cardiac arrest, commence chest compressions and use an Automated External Defibrillator (AED) (if available) wherever Trust business is carried out.

6.5 Any member of SHSC staff who conduct Trust business in other premises is required to make themselves aware of all emergency procedures relating to that location.

6.6 Patients at risk of suffering a cardiorespiratory arrest should be adequately assessed by a competent person for the following criteria: (A to E approach assessment Appendix C) airway obstruction, breathing problems, circulation problems, disability (neurological changes) and exposure (evidence of other contributing factors)and appropriate aid sought at the earliest opportunity.

6.7 Resuscitation must be initiated if a cardiac arrest occurs where a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR (Appendix D)) decision is unknown and the express wishes of the casualty are not known. Anyone initiating cardiopulmonary resuscitation (CPR) in such circumstances must be supported by their senior medical and nursing colleagues.

6.8 For inpatient services, the decision to stop resuscitation is a clinical decision that is made by the ILS trained member of staff or doctor in charge of the cardiac arrest and will take into account the views of all in attendance. If no ILS trained staff or doctor are present, the resuscitation will continue until the arrival of a paramedic, ILS trained staff or doctor who will assume responsibility for the resuscitation attempt.

6.9 The equipment for medical emergencies and resuscitation is standardised across the Trust. The resuscitation equipment should include the

Emergency Red Bag, AED, Laerdal Suction Unit.

6.10 All cardiac arrest equipment must be maintained in a state of readiness at all times. The emergency red bag, AED and Laerdal Suction Unit must be checked on a weekly basis by the person(s) identified to as most appropriate to undertake this responsibility (Appendix E, Appendix F and Appendix G). A record is maintained of the checks carried out by ward staff and are archived within the practice area for 3 months.

6.11 The emergency red bag equipment must be stocked in accordance with the standardised list issued by the Physical Health and Resuscitation team (Appendix E).

6.12 If the emergency drugs are used or due to expire in the next week, they must be ordered immediately with the Pharmacy department. These must be checked on a weekly basis (Appendix I). A spare Emergency box is located in the Emergency Out of Hours Drug Cupboard at Longley Centre and Michael Carlisle Centre. If required when pharmacy is not open. The Emergency drug boxes do <u>not</u> contain sundries e.g. Needles.

6.13 It is accepted that in certain clinical areas it will be appropriate to keep the resuscitation equipment in a secure location although equipment will need to be readily available and accessible in the event of a medical emergency or cardiac arrest.

6.14 The decision to administer emergency drugs, including oxygen, contained in the bag and emergency drug box will be taken by the individual and will be based on their level of competence, skills and knowledge of the particular drug and its intended effect. All registered professionals are required to work within their professional bodies' scope of practice and this should influence their decision making.

6.15 All defibrillators used within the Trust will be biphasic, hands free and of type approved by the Resuscitation Officer. Where defibrillators are provided they should be stored and accessible within an area where the Resuscitation Council (UK) guidance of a maximum of three minutes delay between collapse to first shock can be met.

6.16 Where an Automated External Defibrillator (AED) has been used, the Resuscitation Officer will collect the data from the AED, audit and incident review for staff training purposes.

6.17 The Trust provides AED training via its resuscitation course programme but does acknowledge the following statement:
"The Resuscitation Council (UK) advices that NHS Trusts should ensure that no restrictions is placed on the use of an AED by an untrained NHS employee confronted with a patient in cardiac arrest when no more highly trained individual is present. The administration of a defibrillatory shock should not be delayed waiting

for more highly trained personnel to arrive. The same principles should apply to individuals whose period of qualification has
expired.”

6.18 In situations where a collapsed patient is on the floor, in a chair or in a restricted/confined space, the organisational guidelines for the movement of the patient must be followed to minimise the risk of manual handling and related injuries to both staff and the patient. Please also refer to the Resuscitation Council UK advice on manual handling during resuscitation in hospitals which can be found at:

http://www.resus.org.uk/publications/guidance-for-safer-handling-during-cpr-in-healthcare-setting/.

6.19 All resuscitation equipment purchasing is subject to the organisation’s standardisation strategy. The Physical Health and Resuscitation team will produce recommendations in relation to the type and specification of resuscitation equipment. Advice should be sought from the Resuscitation Officer prior to the purchase of any resuscitation or medical emergency related equipment.

6.20 The Trust has a managed service for all the emergency equipment consumables, this is through Medical Devices Safety Officer (MDSO). To order replacement or expired equipment an order must be completed through the MDSO.

7. Procedure

7.1 Summoning Emergency Assistance.

7.1.1 All staff members should recognise the importance of summoning help at an early stage where appropriate.

7.1.2 All non–clinical staff within the Trust must be aware of how to summon assistance and call for an emergency ambulance when required to do so.

7.1.3 Staff are accountable for their own working practice and behaviour and this is implicit in contracts of employment and reflected in individual job descriptions. It is the individual’s responsibility to:

- Communicate any areas of concern relating to resuscitation to the appropriate manager.
- Maintain annual training in accordance with their training needs analysis.
- Perform and document resuscitation equipment checks in accordance with this policy.
- Have an awareness of their service users resuscitation status in accordance with this policy.

- Identify the patient at risk of or in a cardiorespiratory arrest and respond/treat in accordance with the Resuscitation Council (UK) Resuscitation Guidelines 2021.
- Know when a DNACPR order is either not in place or is invalid.
- Community staff carrying out immunisations or administering drug (including depo injections must be trained in the management of anaphylaxis in accordance with the current Resuscitation Council (UK) guidelines.

7.2 Resuscitation Procedure - Individual Role

7.2.1 Call for help and ask a member of staff to call an ambulance by dialling 2222 stating, ‘ambulance service and the location of the incident’.

7.2.2 Request for the emergency resuscitation equipment, including the AED this will be an FRx defibrillator, emergency red bag and Laerdal Suction Unit.

7.2.3 Ensure the ambulance crew can access the department and direct the ambulance crew to the service user.

7.2.4 Support the ambulance crew where possible preferably the person in charge of the service users care or the individual who initiated the 2222 call should be available.

7.2.5 Provide a brief handover of the patient using the SBARD Communication Tool, (www.resus.org.uk/library/abcde-approach).

7.2.6 Assist with the safe handling of the patient in accordance with Resuscitation Council UK) Guidance for safer handling during resuscitation in healthcare settings (2015)

7.2.7 Inform the Next of Kin of the patient, if known.

7.2.8 Support other service users and staff where required.

7.2.9 Document the resuscitation attempt on Rio/Insight and record on (Appendix J).

7.2.10 Restock the emergency red bag equipment with consumables held in area. (Appendix K).

7.2.11 Ensure that the emergency red bag, defibrillator and Laerdal Suction Unit are ready for use.

7.2.12 Attend a debrief where offered.

7.2.13 In the community and patients homes, ensure a 999 ambulance has been called; perform basic life support with automated defibrillation if available, adhering to Adult Basic Life Support and The use of Automated External Defibrillators guidelines Resuscitation Council (UK) 2021. Until ambulance arrives and care is handed over to the ambulance service. Inform senior staff/manager and next of kin.

7.3 Response to a Cardiac Arrest

7.3.1 In all instances where a person is suspected of collapsing due to a respiratory or cardio-pulmonary arrest the ambulance service will be

immediately called using 2222 for all areas which use the Trust telephony system. 999 is to be called by any service which uses mobile telephones e.g. when doing a home visit with a service user.

7.3.2 SHSC do not have a Cardiac Arrest Team (CRASH team) therefore basic life support (BLS) should be commenced immediately and continued until Immediate Life Support ILS trained staff and/or the emergency service arrive. Where available an Automatic External Defibrillation (AED) will be used.

7.3.3 All AEDs and emergency red response bags are risk assessed. Using the likelihood of a cardiac arrest and the consequence of not having a defibrillator or emergency red bag thus being extreme (death or serious injury) therefore all AEDs and emergency red bags in clinical areas have been implemented according to the risk assessment.
As part of the risk assessment all AEDs should be available within a 3-minute radius to deploying a shock if needed. To provide a quick response time of 3 minutes or less, as per Resuscitation Council UK guidelines.

7.3.4 All the AEDs are serviced and calibrated for use annually, the emergency equipment is standardised and checked on a weekly basis with a monthly audit carried out by the ward manager. This is supported by a random audit carried out by the Resuscitation and Physical Health Team to recorded compliance and safety.

7.3.5 All patient facing staff that work directly with people using Trust services are expected to recognise cardiac arrest, call for help and initiate BLS. All staff who are trained to use the Trusts AEDs should initiate this procedure as soon as possible.

7.3.6 All patients, visitors, and staff who collapse within the vicinity of SHSC Trust premises are to be resuscitated in line with this policy. All patients being attended by a clinician, whether in hospital, healthcare unit or their own home, are to be actively resuscitated and suitable assistance called, unless they have a ‘Do Not Attempt Cardio-Pulmonary Resuscitation’ (DNACPR) order in place, or there are signs of obvious death, decomposition, rigor mortis, injuries not compatible with life. The temperature and pallor of the person’s skin should not be used as an indicator of the initiation of CPR.

7.4 CPR in the Community

7.4.1 For staff who do not utilise either NEWS2 then the following Ambulance Service criteria can be used to determine if the patient is deteriorating in physical health.

Airway	Threatened
Breathing	All respiratory arrests Respiratory Rate <5/min Respiratory Rate >36/min
Circulation	All cardiac arrests Pulse Rate <40/min Pulse Rate >140/min Systolic blood pressure <90 mmHg
Disability	Sudden decrease in level of consciousness Decrease in GCS > 2 points. Repeated or prolonged seizures
Other	Any other concerns

7.4.2 If trained to do so staff should use the A to E approach assessment (Appendix C) to assess the deteriorating patient. At any one point during the A-E approach assessment there are any signs of immediate threat to life, emergency help should be requested immediately by calling 2222 or 999.

7.4.3 Early intervention and calling for help: On recognition of an unresponsive patient with abnormal/ineffective/absent breathing and no signs of life the attending staff member(s) should call for emergency help as the priority and then is to commence basic life support including the use of an AED where possible.

7.4.4 When to stop the resuscitation attempt:

- The patient shows signs of life.
- Emergency assistance arrives and take over the resuscitation.
- For loan workers the staff member is physically exhausted and unable to continue.
- Whilst resuscitation is being attempted a valid DNACPR form is discovered, and valid for the patient being treated. Ensuring all parties are happy to stop resuscitation.

7.5 Lone Workers.

Once emergency help has been requested all lone rescuers performing CPR must perform chest compressions only. Once 2 rescuers are present apply the AED and minimise any delays in chest compressions. There should be no delay in charging the defibrillator and analysing the rhythm. Continue chest compressions only until more help arrives then at a ratio of 30:2 compressions/gentle breaths ratio with a bag valve mask if possible, it is not compulsory to use a pocket mask.

7.6 Emergency Equipment

7.6.1 All members of staff delivering care from Trust maintained premises, where patients are seen, must have access to an AED and emergency red bag

within 3 minutes.

7.6.2 All clinical areas should have immediate access to bag valve mask that conforms to current recommendation to prevent mouth-to-mouth ventilation.

7.6.3 For lone rescuers chest compression alone should be initiated until help arrives once help has arrived initiate ventilations via a bag valve mask with a ratio of 30 compressions to 2 ventilations.

7.6.4 The minimal level of personal protection for all community-based staff is gloves and apron, In response to the current COVID pandemic, use of a pocket mask is not recommended.

7.6.5 All resuscitation equipment will be audited on an annual basis for which a report will be presented to the Physical Health Committee to ensure all equipment remains fit for purpose and in a state of readiness.

7.6.6 All areas where service users attend the emergency equipment: emergency red bag, AED and Laerdal suction unit, must readily be available in the clinical area.

7.6.7 A record is maintained of the weekly checks of the emergency equipment and is carried out by staff and signed off by the ward manager every 4 weeks. These are to be kept in the weekly checklist folder for 3 months then archived within the practice area and kept for 1 year.

7.6.8 The provision of suitable, standardised equipment is paramount in resuscitation so that staff are familiar, proficient and confident with the use of that equipment. The Resuscitation and Physical Health Team are responsible for re-evaluating the provision of resuscitation equipment within the Trust. The team will use standardised emergency equipment risk assessments, HSE, Resuscitation Council (UK) Standards, NICE guidance and standards, and Patient Safety Alerts to make decisions related to the provision of equipment within the Trust.

7.6.9 All resuscitation attempts must be reported on the Trust Incident Reporting System and by the completion of the Resuscitation Record Form (Appendix J) which must be received by the Resuscitation and Physical Health Team within 48 hours of the incident via internal mail. Alternatively, a scanned copy of the form can be sent to resus@shsc.nhs.uk.

7.6.10 All serious (life threatening) sudden medical emergencies when an emergency ambulance attendance has been requested, e.g. deterioration, choking and anaphylaxis must be reported as an incident.

7.6.11 Any emergency medical equipment failures should be reported using the Trust Safeguard incident reporting system and flagged up to the Medical Devices Safety Officer via email: medicaldevices@shsc.nhs.uk.

7.7 Resuscitation & Emergency Drugs

7.7.1 Medicines Optimisation Committee, in partnership with the Physical Health Management Group (PHMG), will manage the availability of emergency

drugs.

7.7.2 Replacement of used or expired medication must be reported and replaced with oversight from the pharmacy department.

7.7.3 Services administering drugs, and vaccines must have available a suitable source of adrenaline and oxygen for the management of a suspected anaphylactic reaction.

7.7.4 Initial management of a suspected anaphylactic reaction should follow the Resuscitation Council (UK) Initial Treatment Algorithm and guidelines for healthcare providers.

7.7.5 Drugs that are currently stored in the two emergency drug tray are in Appendix I.

7.8 **Post Resuscitation Care:** In the event of Return of Spontaneous Circulation (ROSC)

7.8.1 Once ROSC has been achieved the A-E assessment should be followed, supporting ventilation where needed via a bag valve mask.

7.8.2 The defibrillator should remain on the patient and switched on.

7.8.3 Where possible a 12 lead ECG should be taken.

7.8.4 Continual monitoring of the patient until expert help arrives and repeated NEWS2 recordings.

7.8.5 Patients should not be moved until expert help arrives. Once safe to move it is recommended that the patient is lifted with the aid of a scoop/hoist where available and a manual lift should only be considered as a last resort if a minimum of 7 people with a suitable lifting device (i.e., a lifting sheet or a scoop).
Please refer to the Trust Manual Handling Advisor or the Resuscitation Council website for further guidance. (www.resus.org.uk/pages/safehand.pdf

7.9 **Covid amendments**

7.9.1 Resuscitation Council UK statement on Covid -19 in relation to CPR. https://www.resus.org.uk

7.10 **Special Circumstances**.

7.10.1 The special circumstances section of the Resuscitation Council (UK) Adult Basic Life Support guidelines 2021 it covers important situations where modifications or additions to existing guidelines may be of benefit to the patient.
www.resus.org.uk/library/2021-resuscitation-guidelines/special-circumstances-guidelines

7.10.2 This covers specific health conditions including:

- Asthma and COPD
- Obesity
- Pregnancy

8 Signage

All inpatient areas are expected to display:

8.1 Signage that informs staff how to summon emergency assistance.
8.2 Location of the nearest AED/resuscitation equipment.
8.3 Signage on the door where portable oxygen is stored.
8.4 Signage on the door where the AED is stored.

All Community Services are expected to display signs that inform staff:

8.5 How to Contact Emergency Services.
8.6 The location of the AED/resuscitation equipment.
8.7 Signage on the door where the AED is stored.
8.8 Signage on the door where portable oxygen is stored (if applicable).

9 Infection prevention and control

9.1 Whilst the risk of infection transmission from casualty 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 is to be avoided.

9.2 All clinical areas must have immediate access to airway devices (e.g. pocket mask or Bag Valve Mask) to minimise the need for mouth-to-mouth ventilation. However, in situations where airway protective devices are not immediately available, start uninterrupted chest compressions must be commenced whilst awaiting an airway device.

10 Deteriorating Patient

10.1 Observations must be taken on admission in accordance with the Deteriorating Patient Identification and Management Policy.

10.2 Where there is a concern about a patient's physical health observation then the Deteriorating Patient Identification and Management Policy must be adhered.

10.3 Medical staff must be informed if a patient's physical health is noted to be deteriorating and an ambulance requested (if necessary).

10.4 Sheffield Health and Social Care Trust uses National Early Warning Score 2 (NEWS2) tool.

11. Development, Consultation and Approval

The following were consulted within the development of this policy:

- Resuscitation Health Management Group.
- Medical Staff.
- Medicines Optimisation Committee.

12. Audit, Monitoring and Review

12.1 The Physical Health and Resuscitation team will be responsible for undertaking the following annual audits:

- Resuscitation Equipment.
- Do Not Attempt Cardiopulmonary Resuscitation forms.

12.2 Any additional audits that are deemed to fall within the scope of the Physical Health Management Group.

12.3 Reports on these audits will be presented to the Physical Health Management Group on completion and to any relevant committees/groups.

12.4 The Physical Health Management Group in conjunction with the individual areas will monitor action plans.

Minimum requirements to be monitored	Process for monitoring e.g. audit	Responsible individual or group.	Frequency of monitoring	Responsible individual or group for review of results	Responsible individual or group for development of action plan	Responsible individual or group for monitoring of action plan
A. Review and implementation of the policy and procedures relating to resuscitation	Annual report	Resuscitation Officer	Annual	Physical Health Management Group	Physical Health Management Group	Physical Health Management Group
B. The provision and readiness of emergency resuscitation equipment	Audit	Resuscitation Officer	Annually	Physical Health Management Group	Physical Health Management Group	Physical Health Management Group
C. Monitoring of Do Not Attempt Cardiopulmonary Resuscitation decisions	Audit	Resuscitation Officer	Annually	Physical Health Management Group	Physical Health Management Group	Physical Health Management Group
D. All individual incident reports of resuscitation	Review of each incident by Resuscitation Officer and respective Services' Manager	Resuscitation Officer and Ward Manager	As they occur	Physical Health Management Group & Service Leads	Physical Health Management Group & Service Leads	Physical Health Management Group & Service Leads

13. Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
Update current Resuscitation Policy.	Resuscitation Officer.	December 2021	Completed by December 2021 then send to PHMG.
Review of updated Policy and ask for feedback.	Physical Health and Management Group.	January 2022	Await feedback.
Ratification of Resuscitation Policy.	Executive Director of Nursing.	January 2022	Next group to send Policy to be able for Policy to 'Go Live'.
Make teams aware of new Resuscitation Policy.	Ward/team managers.	February 2022	-Communications Lead to send out trust wide email. -New policy to be advertised on intranet page banner -Announcement in Trust communications to all staff members

14. Dissemination, storage and archiving (Control)

The policy is available on the SHSC intranet and available to all staff within 10 days of ratification. An "All SHSC" e mail alert will be sent to all staff.

The policy will be sent to Clinical and Associate Directors for dissemination throughout the Trust.

The integrated Risk/Governance Team will keep a paper & electronic version of the previous policy. Managers will be responsible for removing and replacing paper copies of the policy.

15. Training and other Resource Implications

15.1 Mandatory Training Requirements

All patient facing staff will receive annual face to face BLS session this will include Adult BLS, with safe defibrillation (AED) and choking on induction.

Staff Group	Specific staff members	Minimum training standard	Frequency of training
Registered nurses – all patient facing staff. Allied Health Professional Advanced Care Practitioner Trainee Nurse Associate Trainee Physician Associate Support Workers Doctors Psychosocial Intervention Workers Drug and Alcohol Workers		Adult BLS inc AED. Anaphylaxis Choking DNACPR	On induction, then annually.

Physiotherapists Occupational Therapists Occupational Therapists Assistants Clinical Pharmacists Clinical Psychologists			
Registered nurses (bed-based) Advance Clinical Practitioner Nurse Associate Physician Associate Doctors Allied Health Professional, where appropriate	Recommended for staff members who take charge of ward areas and essential for staff involved in rapid tranquilisation, restraint, or seclusion.	Minimum of ILS training is essential.	Annually.
Non-clinical staff. Administrative staff, (including, Estates)	Recommended for non- clinical staff who do not have patient facing duties.	Information on how to call for help	On induction.
Corporate Management with some patient facing responsibilities. House Keepers and Domestics	Recommended for staff who have some patient facing contact.	E-learning Adult BLS RCUK	On induction. Then annually
Non-qualified / clinical staff working in administration.	Recommended for nonpatient facing staff, who work in administration or are office based.	As per the First Aid needs assessment.	Every 3 years

15.2 In areas delivering services to patients, residents, or clients there should be a minimum of a bag valve mask, this also applies for community staff.

15.3 For in-patient areas, the minimum should be a bag valve mask with an emergency red bag (Appendix E) including oxygen – see how to open the Oxygen cylinder (H).

15.4 For restocking and ordering of partially/empty oxygen cylinders is to contact Procurement Department to minimise injury to staff or patient it is advised that standard manual handling procedures are followed during resuscitations.

15.5 Resuscitation Equipment:

15.5.1 Designated Trust premises will be equipped with resuscitation equipment as deemed appropriate by the Physical Health Management Group in consideration of services provided withinthose premises. All resuscitation equipment will be audited on an annual basis for which a report will be presented to the Resuscitation Committee to ensure all equipment remains fit for purpose and in a state of readiness.

15.5.2 The specifics of equipment will be in keeping with Resuscitation Council (UK) guidance subject to availability of suitably qualified staff who are trained in its usage and basic maintenance. Additionally, placement of equipment will be based on clinical need basis.

15.5.3 In designated premises all members of staff must know the exact location of resuscitation equipment and signs must be displayed detailing the location of AED and Oxygen.

15.5.4 All designated Trust premises that hold resuscitation equipment must have access to spare equipment to ensure service continuity. Each area will agree a process for the provision of replacement equipment following an emergency and this will be known by all staff within those designated areas.

16. Links to Other Policies, Standards, References, Legislation & National Guidance

-SHSC Incident Reporting Policy
-SHSC Physical Health Policy
-SHSC End of Life Policy
-SHSC Deteriorating Patient Identification and Management Policy.
-SHSC Consent Policy
-NICE CG134 – Anaphylaxis: assessment and referral after emergency treatment
-NICE NG51- Sepsis: recognition, diagnosis and early management
-NICE CG176 – Head injury: assessment and early management
-NICE CG50 – Acutely ill adults in hospital: recognising and responding to deterioration
-NICE NG10 – Violence and aggression: short term management in mental health, health and community settings
-NICE Shared learning – Improving managing violence training – combining managing violence and life support
-NICE CG137 – Epilepsies: diagnosis and management
-Regional guidance on the completion of DNACPR - The Yorkshire and Humber Regional -Form for Adults and Young people aged 16 and over (v13)

<u>References</u>

-Mental Capacity Act 2005, Department of Health
-National Health Service Litigation Authority (2007)
-NHSLA Risk Management Standards for Mental Health and Learning Disabilities Trusts Resuscitation Policy.
-Health Services Circular (HSC) 2000/028. London. Department of Health
-NPSA Rapid Response Report (RRR010/2008),
-Resuscitation Council (UK) Decisions relating to Cardiopulmonary Resuscitation (3rd edition - 1st revision) (2016) A Joint Statement from the British Medical Association, the -
-Resuscitation Council (UK) and the Royal College of Nursing.
https://www.resus.org.uk/archive/archived-dnacpr-information/decisions-relating-to-cpr-statement/
-Resuscitation Council (UK) Resuscitation Guidelines 2021.
-Resuscitation Council (UK) - Quality Standards for Clinical Practice and Training 2010.
-Resuscitation Council (UK) - Quality standards for Cardiopulmonary Resuscitation Practice and Training - Mental health Inpatient Care, 2014 (updated May 2020)
-Resuscitation Council (UK) - Quality standards for Cardiopulmonary Resuscitation Practice and Training - Mental health Inpatient Care Equipment and Drug list, 2014 (updated May 2020)
-Resuscitation Council (UK) - Quality standards for CPR - Primary care 2013 (updated May 2020)
-Resuscitation Council (UK) - Quality standards for CPR - Community hospitals care 2016 (May 2020)

-Resuscitation Council (UK) - Quality standards - CPR and AED training in the Community 2010 (May 2020)
-NICE guideline – Violence and aggression: short-term management in mental health, health and community settings (May 2015) nice.org.uk/guidance/ng10
-NICE Quality standard – Violent and aggressive behaviours in people with mental health problems - (June 2017) nice.org.uk/guidance/qs154

17. Contact Details

Title	**Email**
Resuscitation Officer	Mo.mackenzie@shsc.nhs.uk Resus@shsc.nhs.uk Physicalhealth@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e., will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement.
I confirm that this policy does not impact on staff, patients, or the public.

I confirm that this policy does not impact on staff, patients, or the public.

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity, and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section.

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	No	No	No
Disability	No	No	No
Gender Reassignment	No	No	No
Pregnancy and Maternity	No	No	No
Race	No	No	No
Religion or Belief	No	No	No
Sex	No	No	No
Sexual Orientation	No	No	No
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by: Resuscitation Officer.
Name /Date: Mo MacKenzie 20/12/21

Appendix B

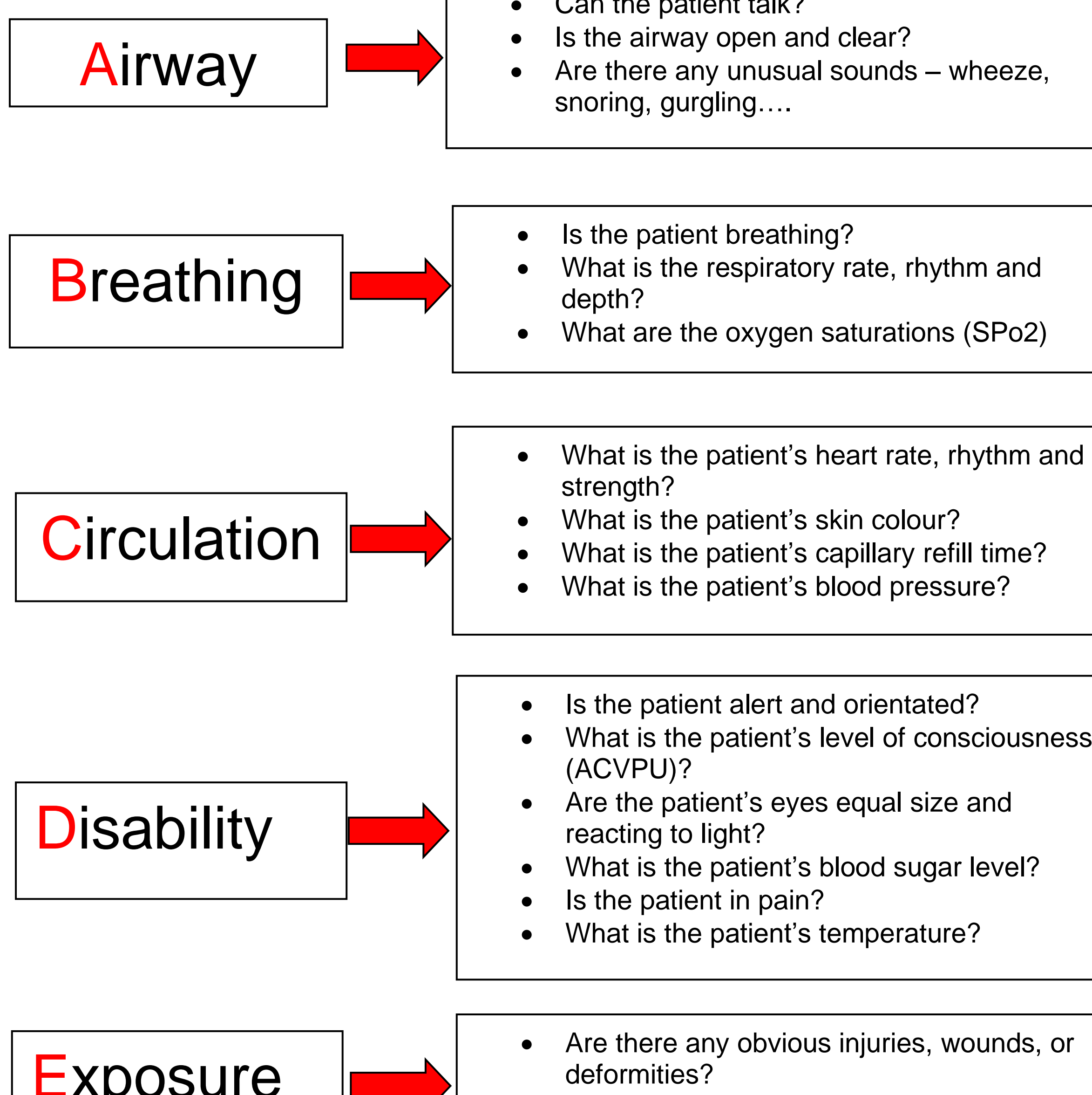
Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Yes
2.	Is the local Policy Champion member sighted on the development/review of the policy?	Yes
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Yes
5.	Has the policy been discussed and agreed by the local governance groups?	Yes
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	Yes
	Template Compliance	
7.	Has the version control/storage section been updated?	Yes
8.	Is the policy title clear and unambiguous?	Yes
9.	Is the policy in Arial font 12?	Yes
10.	Have page numbers been inserted?	Yes
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Yes
	Policy Content	
12.	Is the purpose of the policy clear?	Yes
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Yes
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Yes
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Yes
16.	Does the policy include any references to other associated policies and key documents?	Yes
17.	Has the EIA Form been completed (Appendix 1)?	Yes
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Yes
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Yes
20.	Is there a plan to: i. review ii. audit compliance with the document?	Yes
21.	Is the review date identified, and is it appropriate and justifiable?	Yes

Appendix C

ABCDE Assessment



Appendix D – Do Not Attempt Cardiopulmonary Resuscitation

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Yorkshire & Humber Regional Form for Adults and Young People aged 16 and over (v13)

In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) will be made. All other treatment should be given where appropriate.

NHS No	Hospital No	Next of Kin / Emergency Contact
Name		
Address		Relationship
Postcode	Date of Birth	Tel Number

Section 1 Reason for DNACPR decision: Select as appropriate from A - D

Details of all discussions, mental capacity assessments and MDT decisions must be recorded in the patient's notes.

(Guidance overleaf)

A. ☐ **CPR has been discussed with this patient. It is against their wishes and they have the mental capacity to make this decision.**

(Guidance overleaf)

B. ☐ **CPR is against the wishes of the patient as recorded in a valid advance decision**
The right to refuse CPR in an Advance Decision only applies from the age of 18.

(Guidance overleaf)

C. ☐ **The outcome of CPR would *not* be of *overall benefit* to the patient and:**

i) They lack the capacity to make the decision ☐ **or**

ii) They have declined to discuss the decision ☐

This represents a best interests decision and must be discussed with relevant others

This has been discussed with ………………………… (name) on ……………… (date/time) Relationship to patient:……………

(Guidance overleaf)

D. ☐ **CPR would be of *no clinical benefit* because of the following medical conditions:**

……

In these situations when CPR is not expected to be successful, it is good practice to explain to the patient and/or relevant others why CPR will not be attempted.

This has been discussed with the patient ☐ Date:………/………/……… Time: …………

This has not been discussed with the patient ☐ *Specify Reason* ………………………………………………

This has been discussed with …………………………… (name) on ………… (date/time) Relationship to patient:……………

Section 2 Review of DNACPR decision: Select as appropriate from i OR ii

i) DNACPR decision is to be reviewed by: ………………………… (specify date)

Review Date	Full Name and Designation	Signature	DNACPR still applies	Next Review Date
			☐ (tick)	
			☐ (tick)	
			☐ (tick)	

ii) DNACPR decision is to remain valid until end of life ☐ (tick)

Section 3 Healthcare professionals completing DNACPR form *(Guidance overleaf)*

Date:……………… Time: …………

Signature: ……………………………………………

Print name:……………………………………………

Designation & Organisation………………………………

GMC / NMC No:…………………………………………

(Countersignature if required)

Date:……………… Time: …………

Signature: ……………………………………………

Print name:……………………………………………

Designation & Organisation………………………………

GMC / NMC No: …………………………………………

These guidelines are based on an agreement within the Yorkshire and Humber region.
This form can be red or black-bordered.
For more details refer to your local policy relating to DNACPR.
This is not a legally binding document; the decision may change according to clinical circumstances

Section 1 Guidance (*Please write legibly and with black ink*)

Option A

Record details in the patient's notes, including the assessment of the patient's mental capacity to make this decision.

Option B

The Mental Capacity Act (2005) confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:

1. The decision is in writing, signed, witnessed and the patient is aged 18 or over;
2. It includes a statement that the advance decision is to apply even if the patient's life is at risk;
3. The advance decision has not been withdrawn;
4. The patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
5. The patient has not done anything clearly inconsistent with its terms; and
6. The circumstances that have arisen match those envisaged in the advance decision.

16 and 17-year-olds: Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility

Option C

1. The term "*overall benefit*" is used in the context defined by GMC Guidance 2010 (Treatment & Care towards the End of Life; pg. 40-46; paragraphs 6, 13) and takes into account "*best interests*" as defined by the Mental Capacity Act, 2005.
2. Whenever possible, this situation **must** be discussed with relevant others before completing the form. Record details of your discussion in the patient's notes.
3. The term "*relevant others*" is used to describe a patient's relatives, carers, representatives, people with lasting power of attorney, independent mental capacity advocates (IMCAs), advocates, and court appointed deputies (refer to Mental Capacity Act) http://www.dh.gov.uk

Option D

Record underlying condition/s (e.g. poor Left Ventricular Function, End stage obstructive airway disease, disseminated malignancy) and complete necessary discussions with patient and/or relevant others as soon as possible

Section 2 Review – In accordance with your Local Policy

It is considered good practice to review DNACPR status in the following circumstances:

- At the consultant ward round, MDT or Gold Standards Framework meeting;
- On transfer of medical responsibility (e.g. hospital to community or vice versa); or
- Whenever there are significant changes in a patient's condition.

Cancellation of DNACPR: When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form, writing **CANCELLED** in large capitals and adding your signature and date. It should then be filed in the patient's notes.

Section 3 Authorisation

Responsibility for making the DNACPR decision lies with a senior doctor (e.g. Consultant, GP) who has responsibility for the patient. In some localities, other healthcare professionals who have undertaken the necessary training may make the DNACPR decision.

Countersignature: If junior medical staff or other authorised professionals have been instructed to sign the form by a senior clinician, the form should be countersigned by the senior doctor, as soon as possible or as per local policy.

Any supplementary information (e.g. family informed by nursing staff at later stage) should be signed and dated by the entry.

COMMUNICATING DNACPR DECISIONS

It is the responsibility of the healthcare team completing the form to ensure that the DNACPR status is communicated to all who need to know.

For patients being transferred between different care settings, it is essential that:

1. Where patients are being transferred to community (e.g. home or care home): the DNACPR status and an explanation of the role of the form in an emergency should be communicated to patient (if appropriate) and 'relevant others'.
2. Send **the original form** with the patient. A photocopy or carbon copy version should be retained in the patient's notes for audit, marked with the words 'COPY' in large capitals, signed and dated.
3. For discharges to community settings: communicate to the GP, Out of Hours service and any other relevant services as appropriate.

v13 January 2014
Regional Review Date: January 2017
Regional Lead Contact: Palliative Medicine Consultant
Calderdale & Huddersfield NHS Foundation Trust, West Yorkshire

Emergency Bag – Weekly/After Use Checklist

Ward: ……………………… Location: ………………………………… Year ……………………

Please verify that the emergency bag contains the following items, **in date & full working order**.

Yellow tag must be sealed and the nearest expiry date written on.

Date checked and expiry date of equipment or date service due for Medical Devices		Date	Exp/ Service date	Date	Exp/ Service date	Date	Exp/ Service date	Date	Exp/ Service date
Red Bag									
2 x Adult Non-rebreathing 100% oxygen masks									
1 x Single use bag, valve and mask (with Oxygen reservoir)									
1 x Magills Forceps									
1 x Lightweight Portable Oxygen Cylinder									
1 x Tough-cut Scissors									
1 x Ligature Cutter & pouch									
1 x Neo H Blood Glucose monitor Lancets, Gauze, Test strips, Calibration strip, Black pouch									
1 x Pulse Oximeter									
4 (pairs) x Gloves									

Blue Pouch 1									
2 x Oropharyngeal airway Green									
2 x Oropharyngeal airway Orange									
2 x Oropharyngeal airway Green									
1 x Naso-pharyngeal Airway 6mm									
1 x Naso-pharyngeal Airway7mm									
2 x Lubricating Jelly (sachet)									
Blue Pouch 2									
1 x Micropore tape (2.5cm) – roll									
2 x 1ml Syringe									
2 x 3ml Syringe									
2 x 5ml Syringe									
2 x 10ml Syringe									
2 x 1" Needle **Blue**									
2 x 1.5" Needle **Green**									
Initials of person inspecting									
Team Manager 4 weekly check date:									
Team Manager Signature:									

Please √ if equipment is present, clean and useable.

Version 3, Jan 2023

Appendix F – Automated External Defibrillator – checklist

Heartstart FRx – Weekly/After Use Checklist.

Heartstart FRx Model No: Serial No:

Heartstart FRx Location: Installed battery 'Install before' date:

SHSC Asset Tag No:

To be checked weekly or following any incident involving the Heartstart FRx model. Follow notes overleaf to assist in checking the Heartstart FRx.

Date					
Ensure defibrillation pads are connected.					
Ensure the pad cartridge is unopened and within expiry date.					
Ensure the device is clean with no visible dirt or contamination.					
Ensure there is a spare set defibrillation pads which remain sealed/undamaged and within expiry date.					
Razor x 1 and scissors x 1.					
Ensure there is a spare battery, within 'Install before' date.					
Status Indicator shows blinking green light above 'On/Off' button. **Self-test passed**.					
Ensure there is appropriate 'AED' signage near defibrillator.					
Remarks, Problems, Corrective Actions:					
Inspected by:					

Schedule of maintenance

<table>
<tr><th>Weekly check by staff</th><th>After Each Use</th><th>Maintenance task/response</th></tr>
<tr><td>Y</td><td>Y</td><td>Check for dirt or contamination:

If the Heartstart FRx and casing are dirty or contaminated:
• Clean it the device with a soft cloth dampened in soapy water, or alcohol wipes.
• Carry case can also be cleaned using a soft cloth dampened in soapy water.
• Do not use abrasive cleaners or materials
• Make sure battery is installed (to keep fluid out of the device)</td></tr>
<tr><td>Y</td><td>Y</td><td>Check the connector socket:

• Make sure that defibrillation pads are connected to the Heartstart FRx and ready for use.

(Do not leave the defibrillator without a set of pads connected; the defibrillator will start chirping and the i-button will start flashing).</td></tr>
<tr><td>Y</td><td>Y</td><td>Check for cracks or other signs of damage:

If you see signs of damage - Contact: Clinical Engineering at RHH for technical support, (tel. number is on the yellow sticker).</td></tr>
<tr><td>Y</td><td>Y</td><td>Check the Status Indicator
If you see a flashing green light above the ‘On/Off’ button:

• The Heartstart FRx is ready to use. No action is required

If you see a solid green light above the ‘On/Off’ button:

• The Heartstart FRx is running a self-test. Await self-test to finish and see the green light start flashing.

If the green light is off above the ‘On/Off’ button and the Heartstart FRx is chirping and the ‘i-button’ is flashing:

• The Heartstart FRx is continuing to run a self-test because an error has occurred. Press the ‘i-button’ for instructions.

If the green light is off above the ‘On/Off’ button but the FRx is not chirping and the ‘i-button’ is not flashing:

• The Heartstart FRx has no battery inserted, the battery is depleted, or the defibrillator needs repair.
• Insert/replace battery and run the self-test.
• As long as the Heartstart FRx passes the self-test, you can be assured it is ready for use.</td></tr>
<tr><td>Y</td><td>Y</td><td>Check supplies, accessories, and spares for damage and expiration dates.
Replace immediately by contact medicaldevices@shsc.nhs.uk.</td></tr>
<tr><td></td><td>Y</td><td>If the Heartstart FRx has been used:
Contact: Physical Health and Resuscitation Team, physicalhealth@shsc.nhs.uk</td></tr>
</table>

Appendix G – Laerdal Suction Unit – checklist.

Laerdal Suction Unit (LSU) – Weekly Checklist.

Laerdal Suction Unit Model No: Serial No:

Laerdal Suction Unit Location:

SHSC Asset Tag No:

To be checked weekly or following any incident involving the Laerdal Suction Unit model.

Test Procedure.
1. **Press and hold the 'TEST' button whilst turning the suction unit on to full 500+mmHg.** -Hold to 'TEST' button for 2 seconds. -This will set the machine into test mode. -During the test mode, the 4 power indicator LED lights will start to flash.
2. **When LED 2 lights up, block the suction tubing adaptor with your thumb/finger.** -Keep the tubing adaptor blocked until pressure inside the canister reaches 500mmHg. -Ensure a good seal around the adaptor. -Only LED 2 light should be illuminated.
3. **Once the lights have gone all the way to 500mmHg release the tubing adaptor.** -Then only LED 3 will be illuminated. -Release your thumb/finger from the adaptor. -Allow the unit to carry on running. -Do not turn the machine off
4. **Once LED 4 becomes illuminated the unit will stop running.** -DO NOT turn the machine off. -This stage is to allow the unit to recalibrate. -Once LED 1 light is illuminated switch off the unit by turn the dial back to 0mmHg

Date					
Ensure the LSU is connected to mains charge.					
Ensure the suction tubing and yankaeur are unopened and within expiry date.					
Ensure the canister liner in dry and fully in place.					
Ensure the device is clean with no visible dirt or contamination.					
Ensure there are spare consumables within the clinical area (suction tubing, yankaeur and canister liner).					
Self-test passed.					
Remarks, Problems, Corrective Actions:					
Inspected by:					

Appendix H – How to use O2 Cylinder.

Patient Safety Alert!

REF: NHS/PSA/W/2018/001

Clinical staff please read, print out & display

Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders!

Please ensure you turn on the valve First, picture 1 to ensure the 02 flow is switched on

Then increase the flow rate to 15L picture 2

Picture 1

Picture 2

For further support and guidance please contact the Physical Health & Resuscitation Team.

Appendix I – Emergency Drug Tray – checklist.

Standard Emergency Drug Blue Box	
Drug Name	**Amount held**
Adrenaline 1mg/1ml (1:1000)	2 vials
Aspirin 300mg	2 tablets
Diazepam 10mg rectal tube 2.5ml	2 tubes
GTN spray	1 spray
Ipratropium Bromide 500mcgs nebules	5 nebules
Salbutamol 5mg nebules	5 nebules
Procyclidine 10mg/2ml	1 vial

Locations ofStandard Emergency Drug Blue Boxes

All inpatient wards (this includes the Decisions Unit and the ECT suite)
It does not include the 136 Suite or the community teams.
An additional box has been place in the Out of Hours Drug cupboard at Longley Centre and Michael Carlisle Centre. This is if one is utilsed and needs replacing – whilst pharmacy is not open.

Standard Anaphylaxis Box	
Drug Name	**Amount held**
Adrenaline 1mg/1ml (1:1000)	2 vials
Chlorphenamine 10mg/ml	1 vials
Hydrocortisone suc 100mg with dilient WFI 2ml x 2	2 vials
Salbutamol nebuliser 5mg/2.5ml	5 nebules

Locations of Standard Anaphylaxis Box

- ECT Treatment Suite only as contains IV ampoules

Appendix J – Resuscitation Record Form

NHS	**Resuscitation Record Form**	

Please complete a form following every resuscitation incident

Section 1 - Patient details

Q1 Patient's name	Q2 Date of Birth D D M M Y Y Y Y sex Male Female
Q3 Where incident occurred	Q4 Profession & grade of first staff member to incident Profession Grade

Section 2 - Incident details ***(Actions by anyone other than paramedic/ambulance staff)***

Q5 Date & time the patient found collapsed (use 24 hour clock) D D M M Y Y H H M M	Q6 Time ambulance called? Time ambulance arrived. (use 24 hour clock) (use 24 hour clock) H H M M H H M M
Q7 What time was Basic Life Support (BLS) started? (use 24 hour clock) H H M M not started Patient had a DNACPR form	Q8 Profession and grade of individuals administering resuscitation. Trained in ILS FBLS in last year? Profession Grade Yes No
Q9a Was an automated external defibrillator (AED) used? If Yes, what time (use 24 hour clock) H H M M Yes No **if No, go to Q9c**	Q9b Name of person using AED…………………………… Job Title……………………………………………….. Had the person using the AED had training within the last year? Yes No

Q9c If AED was not used what were the reasons (only applicable where Resuscitation equipment assessment indicates AED should be available)

not required not available no-one to use not working other

Q10 What was the outcome of resuscitation? Died Survived	Q12 please document the incident number

Office use only: AED data Card checked ………………………………………

Appendix K - Emergency Red Bag Stock checklist

Emergency Bag Stock Checklist

Ward: ……………………… Location: ………………………………… Year ……………………

	Maximum amount	Minimum amount
Adult Non-rebreathing 100% oxygen masks	5	2
Oropharyngeal airway Red	5	2
Oropharyngeal airway Orange	5	2
Oropharyngeal airway Green	5	2
Naso-pharyngeal Airway 6mm	5	2
Naso-pharyngeal Airway7mm	5	2
Lubricating Jelly (sachet)	5	2
Single use bag, valve and mask (with Oxygen reservoir)	2	1
Gloves	5	5
Micropore tape (2.5cm) – roll	2	1
1ml Syringe	5	2
3ml Syringe	5	2
5ml Syringe	5	2
10ml Syringe	5	2
1” Needle **Blue**	5	2
1.5” Needle **Green**	5	2