Sheffield Health and Social Care NHS Foundation Trust

Policy:

NPCS 007 Resuscitation

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Policy Owner	Resuscitation Officer
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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 2

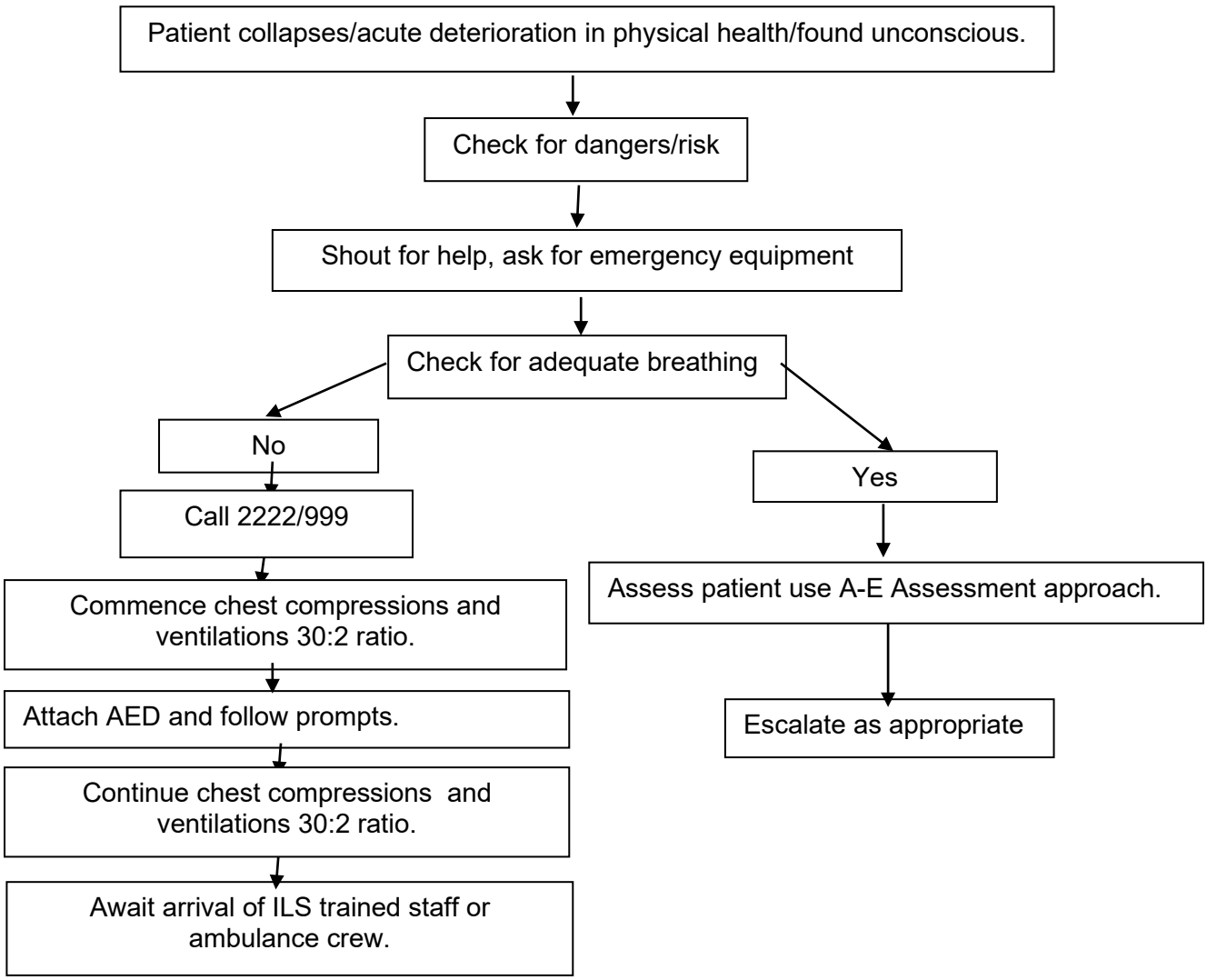
Storage & Version Control
Version 6.0 of this policy is stored and available through the SHSC Intranet/internet. This version of the policy supersedes the previous version 5.0. Previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the 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.
5.0	Review and update on expiry of policy	02/2024	Update of addition of ReSPECT form and equipment checklists.
6.0	Full review and update	02/2025	Full review completed. Additional and updated checklists added.

Contents

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 procedure 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 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.
Cardiac Arrest	The sudden cessation of mechanical cardiacactivity characterised by a patient who is unresponsive and not breathing normally.
Choking	The occlusion of the airway by a foreign body, causing the inability to breathe.
CPR – Cardiopulmonary Resuscitation	An emergency procedure that may include chest compressions and ventilations in an attempt to maintain cerebral and myocardialperfusion.
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 care such as fluid replacement, feeding, antibiotic.
ILS – Immediate Life Support	ABCDE assessment & management. Undertaking the skills and management 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.
ReSPECT – Recommended Summary Plan for Emergency Care and Treatment	A form that is based on conversations with the person and what is recommend in the event of an emergency situation and the person is unable to express their health and care needs.
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 Executive Director of Nursing, Professions and Quality.

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 M) 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.

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).

5.11 **Medical Devices Safety Officer**

- Ensure all resuscitation equipment is appropriately procured via approved channels.
- Ensure staff have access to appropriate resuscitation equipment in their working areas.
- Some pieces of equipment may require additional training on safe use. Medical Devices Safety Officer to reiterate this to clinical areas/clinical staff upon any requests.
- Ensure that all devices are well maintained, stored appropriately, regularly serviced (including PAT testing), decontaminated as per decontamination policy.
- Ensure good coordination/communication between all staff teams. This is to ensure that everyone is aware of any plans/changes etc in relation to equipment.
- Action any hazard and safety notices received in relation to resuscitation equipment.

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 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) 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 (Appendix C - ABCDE Assessment) and appropriate medical aid sought at the earliest opportunity.

6.7 Resuscitation must be initiated if a cardiac arrest occurs where a ReSPECT form, Recommended Summary Plan for Emergency Care and Treatment - Appendix D), decision is unknown or 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 essential emergency equipment for medical emergencies and resuscitation Is standardised across all inpatient areas the Trust should include the

- Emergency Red Bag
- AED
- Laerdal Suction Unit (LSU).

The essential emergency equipment for medical emergencies and resuscitation is standardised across all community base areas the Trust should only include the

- AED

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 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.

Additional equipment available in inpatient areas only is (not Birch Ave or Woodland View)-

- Air driven nebuliser (Appendix H).
- Dynamap (Appendix I)
- Standard Emergency Drug Box & Anaphylaxis box (Appendix K)
- Hypobox (Appendix L)

6.11 The emergency red bag equipment must be stocked in accordance with the standardised list issued by the Physical Health team.

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 but remain sealed until needed in an emergency situation (Appendix K). 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 not contain sundries e.g. needles. A diabetic hypobox must be available in areas with emergency drugs should be check on a weekly basis (Appendix L).

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 bereadily available and accessible in the event of a medical emergency or cardiac arrest to all staff.

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 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 were 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 defib will be recalled following incident.
This is to allow collection of the data from the AED, audit and incident review for staff training purposes. While data is being retrieved a spare defib will be provided.

6.17 The Trust provides AED training via its resuscitation course programme but does acknowledge the following statement:
"The Resuscitation Council (UK) advice 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

6.19 All resuscitation equipment purchasing is subject to the organisation's standardisation strategy. The Physical Health 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 have an agreed managed service for all emergency equipment through the Medical and Therapeutic Devices Policy MD 021 June 2024 to maintain and service all emergency equipment.

6.21 The Trust has a managed service for all the emergency equipment consumables, this is through 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 the earliest stage where appropriate.

7.1.2 All 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. ReSPECT forms in place if applicable.
- 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 ReSPECT form is either valid or invalid or not in place.
- 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 2021.

7.2 Resuscitation Procedure - Individual Role in inpatient areas within Trust premises

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 Perform basic life support (BLS) should be commenced immediately and continued until immediate life support (ILS) trained staff and/or the emergency service arrive. Using current Resuscitation Council (UK) 2021 guidelines.

7.2.3 Request for the emergency resuscitation equipment, including the AED, Emergency Red Bag and Laerdal Suction Unit.

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

7.2.5 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.

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

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

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

7.2.9 Support other service users and staff where required.

7.2.10 Document the resuscitation attempt on Rio and record on (Appendix M).

7.2.11 Restock the emergency red bag equipment with consumables held in area. (Appendix N).

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

7.2.13 Attend a debrief where offered.

7.2.14 When to stop the resuscitation attempt:

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

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 AED's 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 as per the Medical and Therapeutic Devices Policy MD 021 June 2024. 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 Physical Health Team to recorded compliance and safety risks.

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 valid ReSPECT form 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 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 effort has stopped Respiratory Rate is <5/min Respiratory Rate >36/min
Circulation	All cardiac effort has stopped 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 activity
Other	Any other concerns

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

7.4.3 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.
- The staff member is physically exhausted and unable to continue.
- Whilst resuscitation is being attempted a valid DNACPR form via the ReSPECT form is discovered, and is valid for the patient being treated. Ensuring all parties are happy to stop resuscitation.

7.5 **Lone Workers.**

7.5.1 Once emergency help has been requested all lone rescuers performing CPR must perform chest compressions only.

7.5.2 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.

7.5.3 Continue chest compressions only until more help arrives then at a ratio of 30:2 compressions/gentle breaths ratio, it is not compulsory to use a pocket mask but recommended.

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 within 3 minutes. All clinical areas that administer rapid tranquilisation, seclusion and restrictive practice must also have access to an emergency red bag within 3 minutes.

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

7.6.3 The minimal level of personal protection for all community-based staff is gloves. In response to the current COVID pandemic, use of a pocket mask is not recommended. Pocket masks are available and can be use at the staff members discretion.

7.6.4 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 In areas where service users attend a Trust premises the emergency equipment that must readily be available is an AED. Within inpatient areas an emergency red bag and Laerdal suction unit must also be readily available.

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 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 M) which must be received by the Physical Health Team within 48 hours of the incident via internal mail. Alternatively, a scanned copy of the form can be sent to IPCPH@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 to 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 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 stored in the two emergency drug tray (Appendix K).

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

7.8.1 Once ROSC has been achieved the ABCDE 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 Continual monitoring of the patient until expert help arrives and repeated NEWS2 recordings. Where possible a 12 lead ECG should be taken.

7.8.4 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 where available and hoisting or a manual lift should only be considered as a last resort. 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.

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.

9.3 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 Nov 2023.

10.2 Where there is a concern about a patient's physical health

observation then the Deteriorating Patient Identification and Management Policy Nov 2023 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 Committee
- Physical Health Management Group.
- Medical Staff.
- Medicines Optimisation Committee.

12. Audit, Monitoring and Review

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

- Emergency Resuscitation Equipment.
- ReSPECT 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 2023	Completed by December 2021 then send to PHMG.
Review of updated Policy and ask for feedback.	Physical Health and Management Group.	January 2023	Await feedback.
Ratification of Resuscitation Policy.	Executive Director of Nursing.	January 2024	Next group to send Policy to be able for Policy to 'Go Live'.
Make teams aware of new Resuscitation Policy.	Ward/team managers.	February 2024	-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.

Staff Group	Specific staff members	Minimum training	Frequency of training

		standard	
-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 -Physiotherapists -Occupational Therapists -Occupational Therapists Assistants -Clinical Pharmacists -Clinical Psychologists	Recommended for staff who have prodomintaley patient facing contact.	Minimum of Adult BLS Level 2 is essential, inc AED. Anaphylaxis. Choking. ReSPECT.	On induction, then annually.
-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.
-Corporate Management with limited or no patient facing responsibilities. -Non-clinical staff. -Administrative staff -Estates	Recommended for non-clinical staff who do not have patient facing duties.	E-learning Adult BLS Level 1 RCUK	On induction, then annually.
-Corporate Management with some patient facing responsibilities. -House Keepers -Domestics	Recommended for staff who have some patient facing contact.	Minimum of Adult BLS Level 2 is essential, inc AED. Anaphylaxis. Choking. ReSPECT.	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 AED and pocket 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 (J).

15.4 For restocking and ordering of partially/empty oxygen cylinders is to contact Procurement Department.

15.5 Ensure minimised injury to staff or patient it is advised that standard manual handling procedures are followed during resuscitations.

15.6 Resuscitation Equipment:

15.6.1 Designated Trust premises will be equipped with resuscitation equipment as deemed appropriate by the Resuscitation Committee and Physical Health Management Group in consideration of services provided within those premises.

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

15.6.3 The specifics of equipment will be in keeping with Resuscitation Council (UK) guidance 2021 and 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.

15.6.4 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.

15.6.5 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 Patient Safety Incident Response Policy 2023.
- SHSC Physical Health Policy 2024.
- SHSC End of Life Policy 2023.
- SHSC Deteriorating Patient Identification and Management Policy 2023.
- SHSC Capacity and Consent to Care Support and Treatment Policy 2022.
- NICE CG134 – Anaphylaxis: assessment and referral after emergency treatment 2020.
- NICE NG51- Sepsis: recognition, diagnosis and early management 2024.
- NICE CG176 – Head injury: assessment and early management 2019.
- NICE CG50 – Acutely ill adults in hospital: recognising and responding to deterioration 2007.
- NICE NG10 – Violence and aggression: short term management in mental health, health and community settings 2015.
- NICE CG137 – Epilepsies: diagnosis and management 2021
- Regional guidance on the completion of DNACPR - The Yorkshire and Humber Regional Forum for Adults and Young people aged 16 and over.

<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 Quality standard – Violent and aggressive behaviours in people with mental health problems - (June 2017) nice.org.uk/guidance/qs154

17. Contact Details

Title	Email
Interim Head of Physical Health & Resuscitation Officer	Mo.mackenzie@shsc.nhs.uk IPCPH@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 20/12/24

Appendix B

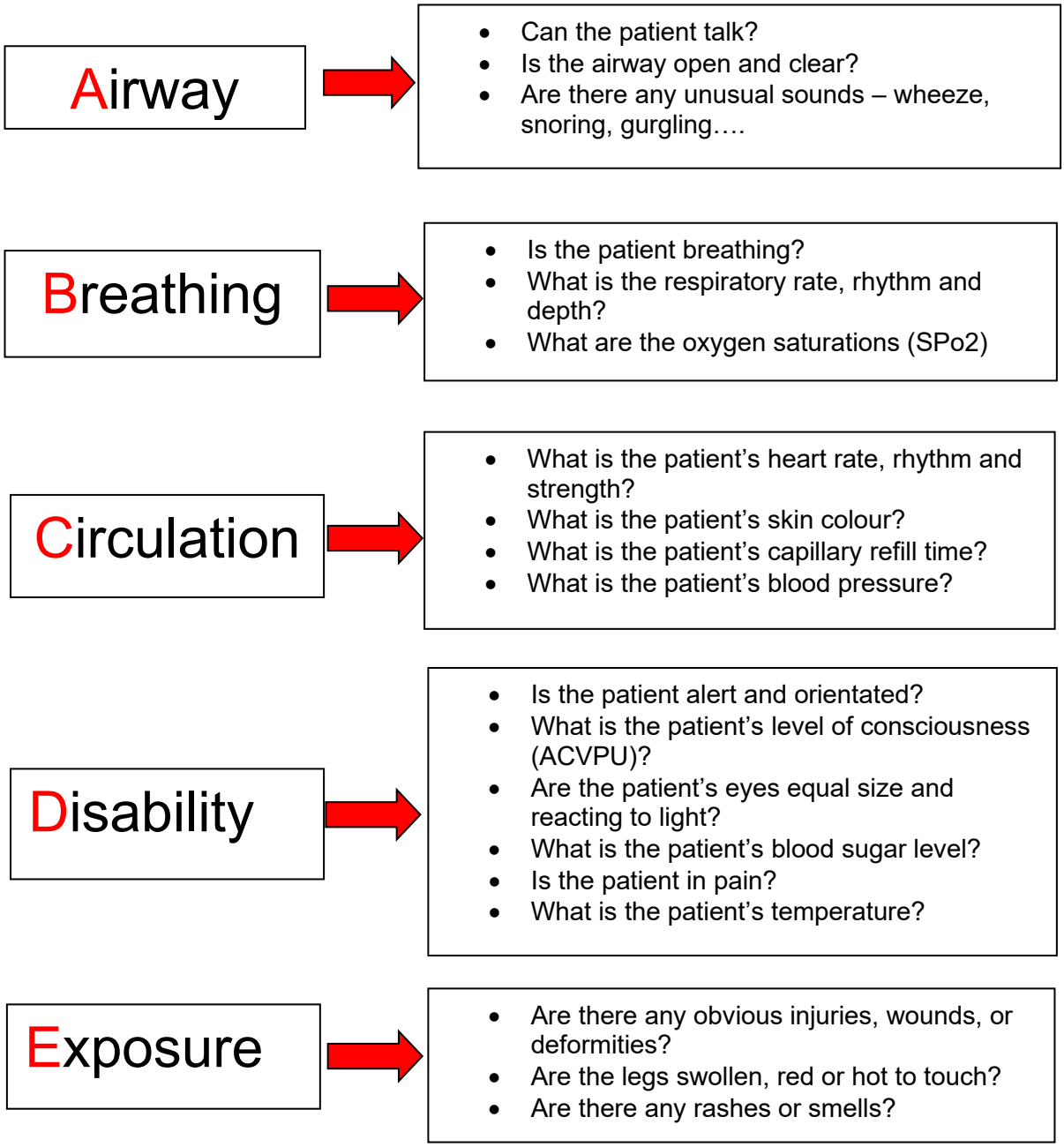
Review/New Policy Checklist

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.

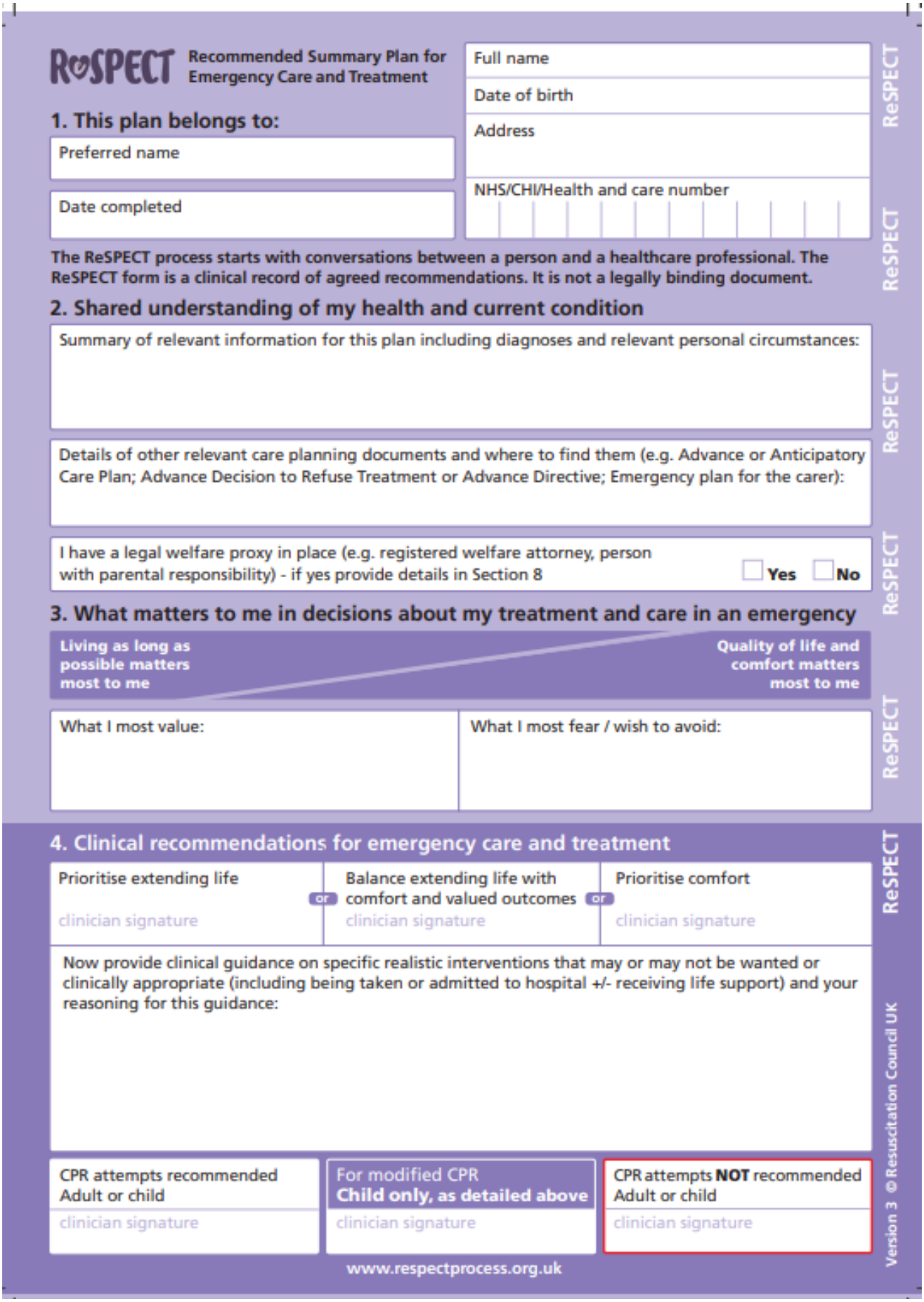
		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Yes
2.	Is the local Policy Champion member sighted on the development/review of the policy?	Yes
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been 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



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 — clinician signature

or

Balance extending life with comfort and valued outcomes — clinician signature

or

Prioritise comfort — 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 — clinician signature

For modified CPR **Child only, as detailed above** — clinician signature

CPR attempts **NOT** recommended Adult or child — clinician signature

www.respectprocess.org.uk

ReSPECT

Version 3 © Resuscitation Council UK

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:**

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Appendix E

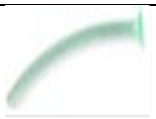
Emergency Red Bag – Weekly Checklist (2025 update)

Ward: …….. Location: …… Year ……

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

Please ensure equipment is present, clean and useable. Please report any issues to Physical Health team by email: IPCPH@shsc.nhs.uk

Date checked and expiry date of equipment		**Date of check**	**Expiry date**	**Date of check**	**Expiry date**	**Date of check**	**Expiry date**	**Date of check**	**Expiry date**
Red Bag									
2 x Adult Non-rebreath 100% oxygen mask									
1 x Single use bag, valve and mask (with Oxygen reservoir)									
1 x Pocket Mask									
1 x Magills Forceps									
1 x CD Portable Oxygen Cylinder									
1 x Tuff Cut Scissors									
1 x Ligature Cutter & Pouch									
1 x Pulse Oximeter									
4 (pairs) x Gloves									

Blue Pouch 1									
Date checked and expiry date of equipment		**Date of check**	**Expiry date**	**Date of check**	**Expiry date**	**Date of check**	**Expiry date**	**Date of check**	**Expiry date**
2 x Oropharyngeal airway Green									
2 x Oropharyngeal airway Orange									
2 x Oropharyngeal airway Red									
1 x Naso-pharyngeal airway 6mm									
1 x Naso-pharyngeal airway 7mm									
2 x Lubricating Jelly (sachet)									

Blue Pouch 2								
Date checked and expiry date of equipment	**Date of check**	**Expiry date**	**Date of check**	**Expiry date**	**Date of check**	**Expiry date**	**Date of check**	**Expiry date**
2 x 1ml Syringe								
2 x 3ml Syringe								
2 x 5ml Syringe								
2 x 10ml Syringe								
2 x 1” Safety Needle **Blue**								
2 x 1.5” Safety Needle **Green**								

Remarks, Problems, Corrective Actions:				
Initials of person inspecting				

*All emergency spare consumables stored in agreed dated tagged box within ward area.

Appendix F

Heartstart AED – Weekly Checklist (2025 Update)

Heartstart (FRx/FR2/HS1) Location: ……..……

SHSC Asset Tag No: ……

Battery Expiry Date ……..... Spare Battery 'Install Before' date:……....

'Live' Defibrillation Pads Expiry Date……

Spare Defibrillation Pads Expiry Date ……..……

To be checked weekly or following any incident involving the AED. Please ensure all equipment is present, clean and useable. Tick checklist as appropriate.

Please report any issues to Physical Health team by email: IPCPH@shsc.nhs.uk

	Date of check	Date of check	Date of check	Date of check	Date of check
Date of check					
Ensure the device is clean with no visible dirt or contamination.					
Ensure defibrillation pads are connected (as appropriate for model)					
1 x Razor					
1 x Tuff Cuts					
Status indicator shows blinking green light above 'On/Off' button. (**Indicates self-test has passed.**					
Ensure there is appropriate 'AED' signage near defibrillator.					
Remarks, Problems, Corrective Actions:					
Initials of person inspecting					

Appendix G

Laerdal Suction Unit (LSU) – Weekly Checklist (2025 Update)

Laerdal Suction Unit Location: ……...……

SHSC Asset Tag No: ……..

To be checked weekly or following any incident involving the LSU. Please ensure all equipment is present, clean and useable. Tick checklist as appropriate.

Please report any issues to Physical Health team by email: IPCPH@shsc.nhs.uk

	Date of check	Date of check	Date of check	Date of check	Date of check
Date of check					
Ensure the device is clean with no visible dirt or contamination.					
Ensure the LSU is connected to mains charge.					
Suction tubing is unopened and within expiry date.					
Yankaeur is unopened and within expiry date.					
Ensure the canister liner is dry and fully in place.					
Self-test passed.					
Remarks, Problems, Corrective Actions:					
Initials of person inspecting					

*All emergency spare consumables stored in agreed dated tagged box within ward area.

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. Then the 1st LED light should be illuminated.

2. **When 2nd LED light lights up, block the suction tubing adaptor with your finger.**

   - Keep the tubing adaptor blocked until pressure inside the canister reaches 500mmHg.
   - Ensure a good seal around the adaptor.
   - Only the 2nd LED light should be illuminated.

3. **Once the lights have gone all the way to 500mmHg on the pressure scale, release the tubing adaptor.**

   - Then only the 3rd LED light will be illuminated.
   - Release your finger from the adaptor.
   - Allow the unit to carry on running.
   - Do not turn the machine off.

4. **Once the 4th LED light becomes illuminated the unit will stop running.**

   - DO NOT turn the machine off.
   - This stage is to allow the unit to recalibrate.

5. **Once the 1st LED light is illuminated again, switch off the unit by turning the dial back to 0mmHg.**

Appendix H

Air Driven Nebuliser – Weekly Checklist (updated 2025).

Location: …… SHSC Asset Tag No: ……

To be checked weekly or following any incident involving the devices below. Please ensure all equipment is present, clean and useable. Tick checklist as appropriate.

Please report any issues to Physical Health team by email: IPCPH@shsc.nhs.uk

	Date of check	Date of check	Date of check	Date of check	Date of check
Date of check					
Ensure the device is clean with no visible dirt or contamination.					
Ensure the nebuliser is fully operational. (Plug device and switch on 5 secs).					
Ensure the consumables are unopened and within expiry date.					
Remarks, Problems, Corrective Actions:					
Initials of person inspecting					

Appendix I

Dynamap – Weekly Checklist (updated 2025).

Location: …… SHSC Asset Tag No: ……

Location: …… SHSC Asset Tag No: ……

Please ensure all equipment is present, clean and useable. Tick checklist as appropriate.

Please report any issues to Physical Health team by email: IPCPH@shsc.nhs.uk

	Date of check	Date of check	Date of check	Date of check	Date of check
Date of check					
Ensure the device is clean with no visible dirt or contamination.					
Ensure the Dynamap is connected to mains charge.					
Ensure standard adult BP cuff present and undamaged.					
Ensure standard large adult BP cuff present and undamaged					
Ensure oxygen saturation probe is present and undamaged.					
Ensure Tympanic thermometer and covers are present and undamaged.					
Remarks, Problems, Corrective Actions:					
Initials of person inspecting					

Appendix J

How to use O2 Cylinder.

Proud to care in Sheffield

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Patient Safety Alert!

REF: NHS/PSA/W/2018/001

NHS
Sheffield Health and Social Care
NHS Foundation Trust

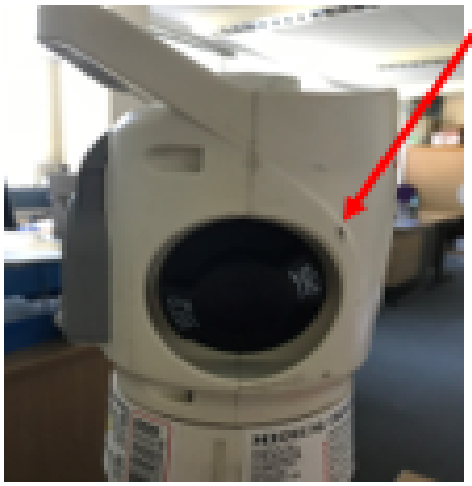
Clinical staff please read, print out & display

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 K

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

Locations of Standard Grey Emergency Drug 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 succinate 100mg with dilient Water for Injection 2ml x 2	2 vials
Salbutamol nebuliser 5mg/2.5ml	10 nebules

Locations of Standard Anaphylaxis Box

- ECT Treatment Suite only as contains IV ampoule

Appendix L

Hypobox – Weekly Checklist (Update 2025).

Location: ……

To be checked weekly or following any incident involving the Hypobox.

Please report any issues or requirements for replacement to Physical Health team by email: IPCPH@shsc.nhs.uk
*Glucagon injection can be replaced via Pharmacy.

	Date of check	Date of check	Date of check	Date of check	Date of check
Date of check					
Ensure the Hypobox is fully stocked (Juices, tablets, gels, Glucagon injection)					
Ensure the consumables are within expiry date. (Juices, tablets, gels)					
Ensure the consumable are within expiry date. (Glucagon injection)					
Remarks, Problems, Corrective Actions:					
Initials of person inspecting					

Locations of Standard Hypoboxes

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.

Appendix M

Proud to care in Sheffield

NHS Sheffield Health and Social Care NHS Foundation Trust

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) H H M M (use 24 hour clock) 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 N

Emergency Consumables Checklist Sealed Spares Box (update 2025)

Location: ……

Nearest Expiry date……...(indicated by ** next to item)

	Maximum amount
Red Response Bag.	
Adult Non-rebreathing 100% oxygen masks	3
Single use bag, valve and mask (with Oxygen reservoir)	1
Blue Pouch 1.	
Oropharyngeal airway Red	3
Oropharyngeal airway Orange	3
Oropharyngeal airway Green	3
Naso-pharyngeal Airway 6mm	3
Naso-pharyngeal Airway 7mm	3
Lubricating Jelly (sachet)	1 box
Blue Pouch 2.	
1ml Syringe	3
3ml Syringe	3
5ml Syringe	3
10ml Syringe	3
1” Needle **Blue**	3
1.5” Needle **Green**	3
Laerdal Suction Unit (LSU)	
Suction Tubing	3
Yankaeur	3
Canister Liner	3