Trust Policy

Resuscitation Policy

Issue Date	Review Date	Version
May 2018	January 2023	8.1

Purpose

This policy provides expected standards and protocols pertaining to the management of risks associated with the deteriorating patient and individuals requiring cardiopulmonary resuscitation (CPR). It ensures that University Hospitals Plymouth (UHP) NHS Trust Staff will receive training that is up to date and relevant to their role, using equipment that is fit for purpose.

It also clarifies the decision regarding the appropriateness of resuscitation following cardiac or cardiorespiratory arrest and describes the process for documenting and communicating the decision via a Resuscitation Decision Record (RDR) and Treatment Escalation Plan (TEP).

Who should read this document?

All Clinical UHP Staff

Key Messages

- All clinical UHP staff should be trained in resuscitation to a level that is compatible with their expected degree of competence and clinical role.
- Clinical managers are responsible to ensure that all staff within their responsibility receive induction and mandatory training in resuscitation compatible with their role.
- All UHP clinical staff must ensure emergency equipment is ready for use and the required operational checks are completed.
- Every decision about CPR must be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.
- Any decision about CPR should be communicated clearly to all those involved in the patient's care.
- The aim of a cardiopulmonary resuscitation (CPR) decision is to ensure that resuscitation is appropriate for each patient. A Resuscitation Decision Record (RDR) which highlights that the individual is 'not for resuscitation' is intended to avoid subjecting a person, whose death is likely or expected, to an undignified and futile intervention.
- A decision regarding CPR must be made on all adult in-patients (exempted clinical areas Critical Care Units, Maternity, Day Case Surgery unless for palliative symptom control then a TEP form must be completed) and based on individual assessment of each patient's needs.
- If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussions about CPR with patients.
- For many people anticipatory decisions about CPR are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.

Key Messages (continued)

- The 'Not for Resuscitation' decision is entirely separate from any decision to withdraw all active medical treatment. A person under a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order may still receive full active medical and nursing care, including fluids, nutrition, antibiotics and other supportive care, where appropriate.

- The resuscitation decision must be non-discriminatory and compliant with the Human Rights Act 1998. An appropriately applied resuscitation decision is entirely compatible with effective ethical and humane care and complies with professional codes of conduct and practice.

- When no resuscitation decision has been documented, and when the wishes of the patient is unknown, there will be an initial presumption in favour of CPR with resuscitation started in the event of an unexpected cardiorespiratory arrest.

- When a 'Not for Resuscitation' decision is made, a Resuscitation Decision Form (RDR) / Treatment Escalation Plan (TEP) should be completed in its entirety.

- A DNACPR decision does not override clinical judgement in the likely event of reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when the decision was made and recorded. Examples of such reversible causes include but are not restricted to: choking, a displaced tracheal tube or a blocked tracheostomy tube.

- Recorded decisions about CPR should accompany a patient when they move from one care setting to another.

Core Accountabilities

Owner	Matron for Resuscitation & Clinical Education, Consultant Jamie Fulton
Review and approval	Resuscitation Committee UHP
Ratification	Medical Director
Dissemination (Raising Awareness)	Matron for Resuscitation & Clinical Education. Responsibility for dissemination is with all lead clinicians, ward and area managers, service leads and resuscitation service.
Compliance	Resuscitation Department UHP

Links to other policies and procedures

Living Wills (Advance Decisions) Policy
Medical Devices Training Policy
Trust Training Needs Analysis
Serco service procedure cardiac arrest/emergency calls (Appendix 1/Document 15)
The Management & Use of Medical Devices Policy
Clinical Risk Classification Scheme for Medical Devices
Workforce Induction and Training Policy

Version History of Resuscitation Policy		
4	June 2011	Approved by the Clinical Governance Steering Group
5	August 2012	Review supporting structural change within the Trust and to deliver compliance with CQC and NHSLA expectations
Last Approval		**Due for Review**
September 2012		September 2015
Version History of Cardiopulmonary (CPR) Decision Policy		
1	September 2008	Jamie Fulton. CGSG.
2	September 2009	Jamie Fulton. CGSG. No Changes
3	May 2010	Jamie Fulton. CGSG. Trust policy format + EIA. Clarification around involvement of relatives
4	September 2011	Jamie Fulton. CGSG. No changes. Further changes to occur on introduction of Treatment Escalation Plan.
5	September 2012	Updated Document
Version History of Resuscitation Policy Amalgamated Resuscitation Policy & Cardiopulmonary (CPR) Decision Policy		
6	January 2015	Amalgamation of policies
7	January 2016	Resuscitation Guideline Changes 2015
8	May 2018	Introduction of Version 11 Treatment Escalation Plan
8.1	August 2020	Minor Amendment
Last Approval		**Due for Review**
January 2016		January 2023

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on the Trust Documents Network Share Folder (G:\TrustDocuments). Larger text, Braille and Audio versions can be made available upon request

	Document 11 - Post Resuscitation Care
	Document 12 - Procedure for checking bleeps
	Document 13 - Switchboard Procedure
	Document 14 - Exception to standard trolley
	Document 15 - Serco procedure
	Document 16 - Version 11 / Resuscitation Decision Record (RDR) Treatment Escalation Plan (TEP)
	Document 17 - Mental Capacity Act
	Document 18 - Paediatric EWS Chart(s) 18a 0 – 12 months 18b 1 – 4 years 18c 5 – 11 years 18d Over 12 years
	Document 19- TEP completion approval form for non-medical practitioners .
Appendix 2	Dissemination Plan
Appendix 3	Review and Approval Checklist
Appendix 4	Equalities and Human Right Impact Assessment

1 Introduction

This policy provides expected standards and protocols pertaining to the management of risks associated with the deteriorating patient and individuals requiring Cardiopulmonary Resuscitation (CPR). It ensures that the provision of resuscitation for any individual in whom cardiac or respiratory function has ceased or is threatened, will be carried out following the current Resuscitation Council (UK) guidelines, unless a valid Treatment Escalation Plan (TEP) / Resuscitation Decision Record (RDR) highlights that the individual is not for resuscitation or an advance decision has been agreed and recorded.

This policy also ensures that University Hospitals Plymouth (UHP) NHS Trust staff are trained appropriately in resuscitation and regularly updated to a level compatible with their expected degree of competence and clinical role using equipment that is fit for purpose.

Cardiopulmonary arrest is an extreme and severe complication of illness. Immediate CPR may, in some individuals, restore spontaneous breathing and circulation. It is essential to distinguish clearly between the situation when the heart and breathing fade naturally as part of the dying process - for example, in a person with terminal cancer or heart failure - and the sudden crisis in the course of a serious illness when the heart and/ or breathing stops and might be restored by immediate action i.e. CPR. CPR includes external chest compression, artificial ventilation to help breathing, defibrillation and advanced life support. A 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision indicates that, in the event of a cardiopulmonary arrest, these measures will not be initiated nor undertaken. The success of CPR is inversely related to the delay in its initiation following cardiopulmonary arrest. It is important that it is recognised that outcome from cardio-respiratory arrest often is adverse, principally with regard to survival but also, in the survivor's outcome with persistent organ eg brain failure or dysfunction. Survival rate is relatively low, particularly in the context of asystolic or pulseless electrical activity, the main mechanisms of cardiorespiratory arrest in hospital. Data from the National Cardiac Arrest Audit published in April (2014) highlighted a 18.4% overall survival-to-discharge rate.

A DNACPR decision is clearly distinguished from a decision to withdraw all active medical treatment. A patient with a DNACPR decision should continue to receive all appropriate active medical, nursing and feeding support required to treat their medical condition. The DNACPR decision refers exclusively to the action to be taken by the health-care staff in the event of cardio-respiratory arrest. There are certain circumstances where withdrawal of all active treatment is appropriate; this constitutes a separate order where treatment is aimed solely at alleviating symptoms rather than treating the underlying disease. Consideration of this is not within the remit of this document.

2 Purpose, including legal or regulatory background

This policy applies to University Hospitals Plymouth NHS Trust namely: Derriford Hospital, Peninsula Medical School, Plymouth Medical Centre, Health and Leisure Centre, on-site Car Parks, Glenbourne Unit, Kingstor House, Child Development Centre and the Satellite Haemodialysis Unit.

This policy is Trust wide and covers all University Hospitals Plymouth NHS Trust (UHP) staff.

The emergency teams attend calls to the Glenbourne Unit but all other aspects e.g. staff training and equipment provision for this unit is the responsibility of Plymouth Community Health Care.

Trust staff working in another Trust's premises are expected to follow local protocols.

Compliance with external regulations

Training programmes will be designed to incorporate the recommendations from the Medicines and Healthcare Products Regulating Agency (MHRA) and the National Patient Safety Agency (NPSA). This policy will assist in ensuring that resuscitation services are based on the requirements of the Care Quality Commission (CQC), the National Health Service Litigation Authority (NHSLA) and the National Institute for Health and Care Excellence (NICE).

Training programmes will be designed to incorporate the following guidelines and standards:

- Resuscitation Council (UK) Guidelines.www.resus.org.uk
- Resuscitation Council (UK) Guidelines. Statement on the training required to use an automated external defibrillator. http://www.resus.org.uk/pages/AEDtrnst.htm
- Resuscitation Council (UK) Guidelines. Cardiopulmonary Resuscitation –Standards for Clinical Practice and Training Joint Statement from the Royal College of Anaesthetists, the Royal college of Physicians of London, the Intensive Care Society and the Resuscitation Council (UK). http://www.resus.org.uk/pages/standard.htm
- The Prescription Only Medicines (Human Use) http://www.legislation.gov.uk/uksi/1997/1830/article/7/made
- Standards for Children and Young People in Emergency Care Settings 2012 http://www.rcpch.ac.uk/emergencycare

The process used to produce the Resuscitation Council (UK) Guidelines 2015 has been accredited by the National Institute for Health and Care Excellence (NICE).

The use of the Treatment Escalation Plan/ Resuscitation Decision Record (TEP/RDR) is applicable to the care of adult patients only (exempted clinical areas; Critical Care Units, Maternity, Day Case Surgery unless for palliative symptom control then a TEP form must be completed). Children are automatically assumed to be for resuscitation unless particular individual circumstances apply - specific paediatric resuscitation DNACPR decisions apply the same principles.

Reasons for introducing a Resuscitation Decision Record (RDR), especially Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), include:

1. The need to respect the wishes of individual patients with regard to their own destiny. It is crucial that particular attention is paid to prior TEP/RDR, advance decisions/ living wills and lasting powers of attorney.
2. The fact that some patients who receive CPR do so with little or no prospect of either recovery from their underlying illness or of eventual discharge from hospital.
3. Unsuccessful CPR robs death of dignity.

4. The fact that an attempt to carry out resuscitation in those people in whom it could have been anticipated to be undesirable or ineffective, is inappropriate, demoralising to staff and upsetting to relatives.
5. CPR itself carries a significant risk of adverse effects including fractures, solid organ rupture or prolonged subsequent treatment in an intensive care unit. Also, there is a significant risk that the patient will be left with brain damage and resultant disability, especially if there is a significant delay in initiation of CPR.

A joint statement from the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) (October 2014) issued guidance on decisions about attempting to resuscitate patients when their heart stops or if they stop breathing. Reference to the Mental Capacity Act 2005 has been included to cover decision-making for patients who lack capacity.

- For a person in whom a CPR decision is being considered there should be a presumption in favour of involvement of the person in the decision making process. If she/he lacks capacity those close to them must be involved in discussions to explore the persons wishes, feelings, beliefs and values in order to reach a 'best interests' decision. It is important to ensure that they understand that (in the absence of an applicable power of attorney) they are not the final decision makers.

The General Medical Council guidance 2010, '*Treatment and care towards the end of life*: *good practice in decision making'*, acknowledges that the most difficult and sensitive decisions in end of life care are those around starting or stopping potentially life prolonging treatments such as CPR. In addition, the NHS end of life care strategy stipulates that all people approaching the end of life needs to have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make recorded.

The Resuscitation Decision Form / Treatment Escalation Plan (RDR/TEP) has been introduced in UHP to facilitate this process. The RDR / TEP (see Appendix 1/Document 16) is where all appropriate treatment options for the patient are documented including those modalities which may be inappropriate. This should be discussed with the patient early in their illness as some will deteriorate and therefore not have capacity to make specific decisions about future life sustaining treatments. It should also be reviewed and updated by the medical team responsible for the patients care as circumstances change.

3 Definitions

Cardiopulmonary arrest is defined clinically by unconsciousness in association with no established breathing pattern and no other signs of life. Resuscitation Council (UK) 2011.

Resuscitation Council (UK) 2011 Early Warning Score (EWS)*:* a patient assessment tool.

CPR - Cardiopulmonary Resuscitation

RDR /TEP - Resuscitation Decision Record / Treatment Escalation Plan

DNACPR – Do Not Attempt Cardiopulmonary Resuscitation

4 Duties

Responsibilities of the Trust Board and Chief Executive:
The Medical Director is ultimately accountable for ensuring that:

- Systems, policies and procedures are in place to manage the clinical response to the deteriorating patient / individual in cardiopulmonary arrest and to define the appropriateness or inappropriateness of CPR.
- Adequate resources are provided to enable instruction and training in resuscitation to take place that will minimise risks and safeguard patients and staff from the hazards associated with the very high /high risk medical devices used within resuscitation.
- A member of the Trust Board will act as the link with the resuscitation committee and provide support in order to achieve compliance with this policy.

Responsibilities of the Resuscitation Committee:

- To advise the Trust Board and Clinical Staff on all matters pertaining to the management of the deteriorating patient, peri-arrest and resuscitation of patients within the Trust and maintain standards relevant to that.
- To advise the Trust on all matters pertaining to CPR decisions.
- To ensure publication and dissemination of up-to-date policies and guidelines relating to resuscitation, anaphylaxis and CPR decisions.
- To seek assurance of compliance to this policy to monitor delivery of action plans to address any issues arising and to escalate any matters for concern to the Clinical Effectiveness Group.
- To determine the requirements for, choice of and availability of resuscitation equipment for practice and training.

Responsibilities of the Procurement Department:

- To liaise with the Resuscitation Department regarding any plans to introduce new medical equipment in relation to resuscitation into the Trust.

Responsibilities of the Resuscitation Department through the Resuscitation Matron and Resuscitation Officers:

- To ensure that all training events follow current national resuscitation guidelines.
- To provide sufficient training places to all Trust clinical staff to attend, as a minimum, annual Basic Life Support (BLS) training (including demonstration of modified BLS for Paediatrics).
- To provide Trust clinical staff who require, in addition to adult BLS training, specific paediatric BLS training (as specified in the training needs analysis).
- To provide Immediate Life Support (ILS) training for clinical staff who require this level of training (as specified in the training needs analysis).
- To ensure access for Trust clinical staff requiring newborn resuscitation training (as specified in the training needs analysis) is delivered in collaboration with the Resuscitation Department, Maternity and Neonatal Departments. This includes mandatory training and registered Neonatal Life Support (NLS) courses.
- To ensure that resuscitation training records are maintained on the Trust Learning Management System and in collaboration with the Workforce & Organisational Development Team generate reports to the Resuscitation and End of Life (EoL) Care Committees regarding staff training.

- To provide clinical areas with a resuscitation resource folder.
- To collate and enter data for the National Cardiac Arrest Audit (NCAA) to enable the Trust to be benchmarked against other Trusts.
- To review the notes of patients post cardiac arrest / medical emergency calls and report areas of concern to the risk and incident team, clinical team members and the Resuscitation Committee and to work collaboratively to aid investigations into untoward incidents.
- To monitor compliance with this Policy on an annual basis and report the findings to the Resuscitation Committee.
- To hold regular meetings with the Resuscitation Link staff to provide updates on resuscitation, changes to policy, equipment and staff training.
- To ensure that there are systems in place for maintaining resuscitation equipment in good working order. This is delegated through the Trust to clinical areas and audited twice yearly by the Resuscitation Matron and Resuscitation Officers.
- To attend emergency calls and cardiac arrests to support the clinical teams on a week to week basis.

Responsibilities of the Cardiac Arrest Team:

- Core personnel of the arrest teams are responsible for ensuring that they are familiar with the emergency equipment available (including location of nearest strategic manual defibrillator) and how to use any item or piece of equipment relevant to their role. All members of the team are expected to be familiar with the contents of the Trust standardised red emergency trolley, emergency back packs and know how to use the standardised Vac sax suction unit.
- Core team personnel must respond to the daily bleep test by ringing switchboard (the call to switchboard may be delegated). If a test call has not been received it is the responsibility of the person holding the bleep to recognise this and take the appropriate steps to check that their bleep is working (e.g. check the battery, call switchboard to have the bleep tested). If there is no response to the test, bleeps will be tested a second time and failure to respond will be investigated by the Resuscitation Officers. If necessary, an incident form will be generated (See Appendix 1/Document 12).
- All core personnel must attend any call they receive with all possible haste whilst maintaining their own, and others', safety.
- It is the responsibility of the team leader (usually the most senior doctor on the team (see Appendix 1/Document 2) to manage the event to which they have been called. On occasion, it may be appropriate for the arrest team leader to hand over management to another doctor. Before doing so the team leader must assure him or herself that the person to whom they are handing over is able to manage the event.
- In the event of a 'false alarm' (i.e. CPR is not required) it is the responsibility of the team leader to assess the patient. This should follow an A-E approach as recommended by the RC(UK).
- All interventions should be recorded in the patient's notes. If the notes are unavailable, a Trust continuation sheet with the individual's details should be completed including the person's name, DOB and hospital number if known.
- The responsibility of the doctor attending from the Intensive Care Unit (ICU) for adult arrest calls , the nurse attending from (ICU) for paediatric arrest calls and the Acute Care Team (ACT) for adult arrest calls are outlined in Appendix 1/Document 3.
- The team leader is responsible for arranging the return of a strategic manual defibrillator as soon as is practicable after use (this may be delegated).

- Core personnel of the arrest teams are responsible for ensuring that there is familiarity and awareness with the policy and its implementation.
- It is the responsibility of the team leader to manage the resuscitation event and to ensure the appropriateness of resuscitation of that individual.
- All interventions should be recorded in the patient's notes.

Responsibilities of Clinical Directors and Heads of Departments:

- To ensure compliance of their teams/staff with this policy.
- To ensure that new clinical staff receive the required training on the Trusts corporate and local induction.
- To ensure that all staff attend their mandatory training in resuscitation and monitor compliance taking appropriate action to address non-attendance.

Responsibilities of Consultants and Senior Clinicians:

- To ensure that there is an appropriate and current CPR decision for all adult in-patients (exempted clinical areas Critical Care Units, Maternity ,Day Case Surgery unless for palliative symptom control then a TEP form must be completed) .
- To ensure staff awareness of this policy.
- To ensure that there is suitable application of the TEP/RDR components of the policy.
- To ensure designated Non-Medical Consultant Practitioners and Advanced Clinical Practitioners at Band 8A and above are authorised and appropriately trained to undertake TEP discussions and to complete the TEP/RDR form. (see Appendix 1/ Document 19).

Responsibilities of Ward and Department Managers:

- Ensure staff have the appropriate skills to use the relevant resuscitation equipment that they have been trained to use. This includes all new staff, permanent, NHS professionals, students, ministry of defence (MOD) and agency staff.
- They know the level of competency their staff have in resuscitation within their clinical area and that they are up-to-date with training.
- Ensure that all clinical staff on duty are able to initiate an emergency call and are physically /or medically fit to undertake (CPR). Those members of staff who state that they cannot fulfil their duties in CPR must be referred for assessment to the Staff Health & Well Being Team.
- Nursing staff working in Level 1 or high observation bays are expected to hold a current Immediate Life Support (ILS) certificate. Ward/ department managers are responsible for decisions regarding who is allocated to work in these areas and the level of training or support required.
- To release staff for training, monitor attendance in resuscitation training and take appropriate action if non-attendance is highlighted.
- Allocate and support 1-2 staff members as Resuscitation Link Staff for their clinical area.
- When no resuscitation link staff is nominated for the clinical area the ward/ department manager is expected to take on the responsibility.
- To ensure an incident form is completed for all cardiac arrests.
- To report and manage any identified risk associated with management of a deteriorating patient or resuscitation call.
- Inform the resuscitation department of pending clinical area moves or reconfiguration of clinical teams to ensure that appropriate equipment can be sourced and installed.

- To ensure that daily, weekly and post use equipment checks are completed.
- Ensure that staff have the appropriate awareness of the policy.

Responsibilities of Resuscitation Link Staff:

- Assist the Resuscitation Department in maintaining the resuscitation resource folder within their designated clinical area.
- Keep up-to-date with resuscitation training to a level compatible with their expected degree of competence and clinical role.
- Work with and assist their line manager in ensuring that each staff member attend their resuscitation training to a level compatible with their expected degree of competence and clinical role.
- Act as a resource and point of contact for familiarising staff with emergency trolley checking, emergency equipment, process and systems for initiating emergency calls.
- Act as a resource to staff in the clinical area with queries / questions regarding resuscitation and refer staff onto the Resuscitation Department when required.
- Attend resuscitation link meetings (approximately twice per year) and conferences/study days arranged by the Resuscitation Department.
- Assist the Resuscitation Department in auditing emergency trolley checking within their designated clinical area.

Responsibilities of All Clinical Staff (this includes all new staff, permanent, NHS professionals, students , Ministry of Defence (MOD) and agency staff:

- To ensure that they attend their induction training / annual mandatory resuscitation requirements at a level compatible with their expected degree of competence and clinical role.
- To use the resuscitation equipment competently that they have been trained to use.
- Ensure they are competent to initiate an emergency call and familiar with the processes and systems involved.
- Have read the current Resuscitation Policy and understand it.
- To ensure they undertake daily, weekly and post use equipment checks.
- To ensure their ability to apply the policy, appropriate to their clinical role.

Responsibilities of the Acute Care Team (ACT):

- The Acute Care Team (ACT) Clinician / Senior Nurse is responsible for providing Trust wide education (including induction for medical/nursing staff) in the use of the EWS chart and the escalation process.
- Attend adult cardiac arrest calls as a core member of the team to assist the (ITU) doctor with Airway Management (See Appendix 1/Document 3).
- The ACT Clinician / Senior Nurse is responsible ensuring application of this policy in the patients that they attend and for contributing to Trust wide education regarding this policy and process.

Responsibilities of Serco Porters:

- Attend the emergency call scene to provide assistance with sourcing equipment for the situation (see Appendix 1/Document 15).

5 Main Body of Policy

Management of Cardiac Arrest and Emergency Calls

- In the event of a cardiac arrest within the Derriford site, staff should follow the procedures outlined in Appendix 1/Document 1 and ensure the relevant emergency team (i.e. adult, paediatric, neonatal, obstetric, cardiothoracic, trauma) is called via switchboard on 2222. Switchboard will follow procedure (See Appendix 1/Document 13).
- In the event of a medical emergency within the Derriford site requiring the immediate attendance of the Derriford site medical emergency team, staff should dial 3333 to request the relevant team (See Appendix 1/Document 1).
- In the event of a cardiac arrest or medical emergency at the Child Development Centre or the Satellite Haemodialysis Unit staff should call (9)999 and follow the procedures outlined in Appendix 1/Document 1.
- There are two main cardiac arrest teams on the Derriford site: adult and paediatric. There are additional emergency teams for neonatal, obstetric, cardiothoracic emergencies and trauma teams for adults and paediatric. The core personnel for these teams are shown in bold in Appendix 1/Document 2.
- If two emergencies requiring the same team occur in quick succession the team leader of the arrest team should split the team at his/her discretion.
- Core team personnel must hand over the emergency baton bleeps to the doctor or nurse taking over each shift.
- Should the individual require moving, for example to the Emergency Department (ED), the team leader must ensure the transfer is accomplished safely with due attention to safe handling and provision of a handover to the receiving team.
  Whenever possible the ED should be notified in advance that a patient is being brought to them.
- An incident form should be completed for all cardiac arrests by the practitioner in charge of the shift/ line manager, the exception being calls where it was reasonable to expect an arrest may occur e.g. patients with acute coronary syndromes, major trauma etc.
- Cardiac arrest and emergency calls may occur in any location, including outside; it is therefore advisable that team members take this into consideration and dress accordingly i.e. wearing footwear that protects the feet and clothing that does not restrict free movement.
- The team leader will make the decision after assessing the patient if an ambulance is required and if required the team will call for an ambulance themselves on 999, so appropriate information can be given.
- If someone is found in the vicinity of a high building / care park and there are no witnesses, the security team must be informed to review all available CCTV to exclude / confirm possible trauma.
- The receiving ED must be informed of possible trauma being bought to them.
- See Appendix 1/Document 11 for guidance on post resuscitation care.

Training

- All basic and advanced life support training, including the use of relevant equipment aligned to the staff member's role is coordinated by the Resuscitation Matron and

Resuscitation Officers who deliver the vast majority of the teaching. Anyone delivering training on behalf of the department must either have been assessed (and documented as such) as capable to deliver the training by the Resuscitation Matron/ Resuscitation Officers or be a RC(UK)/ALSG instructor and follow the appropriate lesson plan.

- Lesson plans/ curricula for national courses, delivered by, or on behalf of the Resuscitation Department, are stored in the Resuscitation Department.
- Training sessions are coordinated by the Resuscitation Department in conjunction with the Workforce Development Team. The Trust Learning Management System is maintained by the Workforce Development Team. Attendance and Non-attendance at mandatory training is managed in accordance with the Workforce Induction and Training Policy.
- All Trust clinical staff must attend, as a minimum, adult BLS on induction and then annually. This includes staff who hold an in date ALS course (unless the ALS was completed that year in this Trust). See the training needs analysis (TNA, Appendix 1/Document 4). It is the responsibility of both the individual and their line manager to ensure this occurs.
- Frequency of updates and training is determined by National resuscitation courses guidelines, the mandatory training review process is described in the Workforce and Induction Training Policy.
- Training session attendance sheets are prepared and attendees must sign, these sheets are returned to the Workforce Development Team to update The Trust Learning Management System. Any individual staff member who does not attend, who fails to complete the session or who fails to achieve the learning outcomes, the Line Manager and Workforce Development Team are notified.
- Staff taking the role of team leader at an adult or paediatric cardiac arrest /medical emergency call, or neonatal emergency call must hold a current advanced course provider certificate in the relevant speciality:

  for adults - a RC(UK) ALS course
  for paediatrics - a RC(UK) EPLS or ALSG APLS course
  for neonatal - a RC(UK) NLS course
  for trauma - a RCS ATLS / ETC course

- It is the individual's responsibility to ensure they have this level of training and to seek additional training/equipment familiarisation from the Resuscitation Department if required in order to fulfil their responsibility at emergency calls.
- All personnel attending any cardiac arrest, medical emergency, paediatric or neonatal emergency call should hold a current valid relevant certificate according to the Training Needs Analysis (see Appendix 1/Document 4).

  for adults - a RC(UK) ALS or ILS certificate
  for paediatrics - either a RC(UK) EPLS or pILS certificate or ALSG APLS/PLS certificate
  for neonatal - a RC(UK) NLS certificate
  for trauma - a RCS ATLS /ETC certificate

- It is the individual's responsibility to ensure they have this level of training and to seek additional training/equipment familiarisation from the Resuscitation Department, if required, in order to fulfil their responsibility at emergency calls. To ensure that members of the various emergency teams obtain the relevant training, it is important

that medical and nursing instructors are released to teach on these nationally-recognised courses.

- All medical registrars and team leaders should have knowledge of basic trauma assessment. If further education is required a suitably experienced trauma educator will need to be involved in running trauma training for medical registrars, ACT and F2s who may also lead. E-learning and written information is also available. It is the responsibility of team leaders to seek additional training if required.
- The coordinator of the medical rota will keep an up to date record of the ALS provider status of the medical registrars who carry the arrest bleep and provide this information to the Resuscitation Department.
- The Resuscitation Department will liaise with the neonatal and paediatric rota coordinators to ensure members of the team hold a valid provider certificate for the appropriate course. The Trauma Lead is ultimately responsible for ensuring that appropriate current certification is held by core members of the Trauma Team.
- The (ICU) doctor attending adult arrest calls is responsible for managing the airway of the casualty and must attend airway management training prior to taking on this role. Both ICU and the Resuscitation Officers will usually provide this training. The duties of the (ICU) doctor are outlined in Appendix 1/Document 3.
- Core personnel of the obstetric emergency group are expected to be familiar with management of an obstetric emergency and to maintain the skills required to manage obstetric emergencies e.g. advanced airway skills, readiness to perform a perimortem caesarean section.
- The cardiothoracic registrar carrying the emergency bleep during normal hours must be available to attend immediately and be familiar with the Cardiothoracic Advanced Life Support (CALS) guidelines (See Appendix 1/Document 5) and Emergency Chest Opening procedure (See Appendix 1/Document 6). Out of hours the on call registrar will be alerted via emergency radiopager by switchboard.
- Defibrillation training is managed by the Resuscitation Department through the national courses i.e. ALS, ILS & APLS. The Resuscitation Matron/Resuscitation Officers provide 'in house' training for Departments for Manual/ Automated Defibrillation, for example to the Emergency and Cardiology Departments, as requested. This accords with the Trust's Medical Devices Training Policy regarding Very High Risk/ High Risk medical devices to ensure that the risk category of the equipment is aligned to the level of required training.
- Management of anaphylaxis is covered, in brief on BLS e-learning, and in more depth on ALS, ILS & APLS courses. Additional 'lecture/workshops' are provided by the Resuscitation Department in direct need to clinical pathways and Trust staff training requirements compatible with their expected degree of competence and clinical role. It should be noted that adrenaline for anaphylaxis can be administered by nursing/ allied professional in order to save a life [1,2] i.e. a patient group directive (PGD) is not required (See Appendix 1/Document 7) for algorithm on management of anaphylaxis .
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Equipment

- A standardised emergency trolley suitable for adult and paediatric resuscitation is used across the Trust. The sole exception is general Intensive Care Unit (Penrose & Pencarrow) where alternative arrangements exist (See Appendix 1/Document 14).

- The contents of the emergency trolleys is decided by the Resuscitation Committee and reviewed annually or earlier if required, for example when revised resuscitation guidelines are issued. The contents list and checking book is supplied by the Resuscitation Department to all clinical areas with a trolley (See Appendix 1/Document 8).
- Ward and Department Managers must take steps to ensure all staff, who may assist during a cardiac or medical emergency, are familiar with the trolley contents. To that end, trolley checks must not be completed solely by one particular staff member or group e.g. permanent night staff.
- Ward and Department Managers are responsible to ensure that staff re stock the trolley after use.
- Ward and Department Managers of wards and departments that do not have a trolley must ensure all staff know where the nearest trolley or emergency bag is located and that it is the responsibility of that ward or department to collect and restock the trolley or emergency bag in the event of a cardiac arrest or medical emergency.

  Managers of these areas must also ensure that staff, who may assist during a cardiac arrest or medical emergency, are familiar with the emergency equipment available to them.

- Managers must ensure that all their staff who may assist in a cardiac arrest or any emergency know how to use the Vax Sac suction unit.
- Emergency bags are located at strategic points within the Derriford site. These bags are checked daily and restocked where appropriate and after use by the Resuscitation Matron, Resuscitation Officers and Acute Care Team (ACT) members and documented as such within the relevant checking books.
- Additional manual defibrillators are located at strategic points within the main Derriford building (L3 Mayflower ward, L6 Thrushel MAU & L9 corridor). These defibrillators are for use solely by the arrest team and medical emergency team and should not be used for other events except a peri-arrest situation. They must be returned immediately after use. These defibrillators are checked daily by the Resuscitation Matron, Resuscitation Officers and the Acute Care Team (ACT) members and documented as such within the relevant checking books.
- The nurse in charge of the Intensive Care Unit is responsible for ensuring that daily and post-use checks of the Paediatric rucksack (kept within the unit and taken to paediatric cardiac arrest calls), are completed and documented as such within the relevant checking books (See Appendix 1/Document 3).
- The nurse in charge of the Acute Care Team (ACT) is responsible for ensuring that daily and post-use checks of the Adult rucksack and additional equipment (kept within (ICU) and taken to Adult cardiac arrest calls), are completed and documented as such within the relevant checking books (See Appendix 1/Document 3).

Neonatal Resuscitation:

- The maternity department is responsible for ensuring that sufficient fully stocked resuscitaires or neonatal arrest trolley are available to provide for each active delivery room on the delivery suite – these are checked on a daily basis by maternity department staff.
- It is the duty of ward staff on the neonatal unit, transitional care and maternity wards to ensure that resuscitaires or neonatal arrest trolley and equipment are sufficient and

functional to support any neonatal resuscitation in their designated area. Equipment should be documented as checked on a daily basis.

- In the Emergency Department, equipment appropriate for the resuscitation of a newborn must be available. It is the responsibility of the Emergency Department staff to ensure that equipment is sufficient and functional and it should be checked on a daily basis.

Maintenance and repair of resuscitation equipment is the responsibility of the Medical Equipment Management Service (MEMS). Any staff member that identifies a fault with resuscitation equipment must report electronic equipment to MEMS, drugs and fluids to Pharmacy and disposable equipment to the Resuscitation Department. All faulty equipment must be quarantined for inspection.

Early Warning System (EWS)

- In order to detect early deterioration in a patient's medical condition a standardised colour banded, early warning (EWS) vital observation chart is in use on the adult general wards on the Derriford site (See Appendix 1/Document 9).
- The recording of vital observations on the EWS charts (Appendix 1/Document 9) will measure the following variables, temperature, respiratory rate, oxygen saturation, heart rate, blood pressure, conscious level, blood glucose and pain. The frequency of vital observation measurement will depend on the trigger and the situational variances.
- The EWS charts include a three stage graded escalation process which is based on the level of deterioration observed in the patient's condition. The level of escalation is indicated by the number of observations triggering and the severity of the trigger (ie yellow, amber or red).
- The recording of vital observations on the EWS chart may be delegated to a competent unregistered support worker (for example, health care assistant). However, a Registered Nurse is responsible for reviewing these observations and signing that they have done so at least once per shift.
- The adult general ward EWS chart (Appendix 1/Document 9) is included in lectures and teaching scenarios on both the Acute Life threatening Events Recognition and Treatment (ALERT) course delivered by the Acute Care Team and the RC(UK) Immediate Life Support (ILS) course delivered by the Resuscitation Department.
- Ward Managers/Matrons are responsible for undertaking a monthly audit of both the completeness of observations and that the appropriate escalation has taken place where required.
- Ward managers are responsible for submitting audit information to the Risk and Incident Team. The Risk and Incident Team lead will determine any action required to improve compliance and liaise with the ward manager.

A report on the Trust's patient safety improvement programme is presented to the Safety and Quality Committee on a quarterly basis. This report includes the audit data collected by the ward managers and an update on other processes designed to improve care for the deteriorating patient.

- Clinical incident forms should be completed where it is considered there has been a failure to either recognise or respond to deterioration in the patient's condition.

Alternative EWS charts are used for specialised groups of patients within the Derriford site e.g. Neurological EWS (see Appendix 1/Document 10), Newborn EWS (see Appendix 1/Document 10a), Obstetric EWS (see Appendix 1/Document 10b) and Paediatric EWS (see Appendix 1/ Document 18). The frequency of vital observation measurement will depend on the trigger and the situational variances. Review of these EWS charts will be managed within the clinical areas where these charts are used.

Cardiopulmonary Resuscitation Decision – Procedure and Process

- A Treatment Escalation Plan/Resuscitation Decision Record (TEP/RDR) needs to be considered on, with and for each adult patient (exempted clinical areas Critical Care Units, Maternity, Day Case Surgery unless for palliative symptom control then a TEP must be completed) initially by the most senior doctor present and thereafter reviewed preferably by the consultant in charge or a senior deputy. If there is no reason to believe that a patient is likely to suffer a cardiopulmonary arrest, it is not necessary to initiate discussion about CPR. Sensitive discussion, where required, usually is between an appropriate doctor and the patient. With patient agreement, discussion also is preferably with the family/ next-of-kin. Both the discussion and the decisions need to be clearly documented. It may be judged that a patient would be too distressed by these discussions for the discussion to be initiated. Similarly, if patients indicate that they do not wish to discuss these issues then this too should be respected. Again, these issues need to be documented.
- The CPR decision must be completed on a TEP/RDR (see Appendix 1/Document 16) for all adult patients (exempted clinical areas Critical Care Units ,Maternity, Day Case Surgery unless for palliative symptom control then a TEP must be completed).
- The CPR decision must be documented, signed and dated by the Doctor or an authorised Non Medical Consultant Practitioner or Advanced Clinical Practitioner (at 8A and 8B level) on the TEP/RDR .
- The TEP /RDR should be filed at the front of the Living Wills / Consent section of the medical notes, defined by a red divider.
- If a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision is being considered, a senior doctor i.e. the consultant in charge, where available, or, in his/ her absence, an experienced doctor with 5 or more years registration with the GMC, assesses mental capacity (Appendix 1/Document 17).
- If the patient is considered to have capacity, the senior doctor will discuss resuscitation with the patient. It should be established whether the patient wishes the decision to be discussed with his/her relatives or significant others. If so, all reasonable efforts should be made to try and achieve this. Evidence of this discussion will be recorded by the doctor on the TEP/RDR.
- If the patients indicate that they do not wish to discuss these issues then this should be respected. Where a TEP/RDR is completed and there has been no discussion with the patient because he or she has indicated a clear desire to avoid such discussion, this must be documented in the patient's medical records. When a patient is considered not to have capacity (to understand information; to retain said information long enough to

make a decision; to weigh up said information to make a decision; to communicate that decision), the senior doctor will reach a decision "after appropriate consultation and consideration of all aspects of the patient's condition. Decisions must be taken in the best interest for the patient, an assessment of which would include the likely clinical outcome, the perspectives of other members of the medical and nursing team including the GP, the patient and with due regard to patient confidentiality, the patient's relatives or close friends, may all be valuable in forming the decision" (Resuscitation Council UK). All reasonable efforts should be made to involve relatives / next of kin in this decision – in this context, it is desirable to obtain informed assent from the relatives/ next of kin, where possible. When the Mental Capacity Act is implemented, decisions regarding resuscitation for patients who lack capacity must be discussed with relatives holding Lasting Powers of Attorney (welfare attorneys) or an Independent Mental Capacity Advocate (IMCA). A welfare attorney can make health decisions for the patient. This should be documented on the TEP-RDR.

- Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision.
- For a person in whom CPR may be successful, when a decision about future CPR is being considered there should be a presumption in favour of involvement of the person in the decision-making process. If she or he lacks capacity those close to them must be involved in discussions to explore the person's wishes, feelings, beliefs and values in order to reach a 'best-interests' decision. It is important to ensure that they understand that (in the absence of an applicable power of attorney) they are not the final decision makers.
- If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision refusing treatment (ADRT), specifically refusing CPR, this must be respected.
- If the healthcare team is certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted.
- Making a decision not to attempt CPR that has no realistic prospect of success does not require the consent of the patient or of those close to the patient. However there is a presumption in favour of informing a patient of such a decision. The patient and those close to the patient have no right to insist on receipt of treatment that is clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate.
- Effective communication is essential to ensure that decisions about CPR are made well and understood clearly by all those involved.
- There should be clear, accurate and honest communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them.
- It is essential that healthcare professionals, patients and those close to patients understand that a decision not to attempt CPR applies to CPR and not to any other element of care or treatment. A DNACPR decision must not be allowed to compromise high-quality delivery of any other aspect of care.
- Where a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of the multidisciplinary team may avoid the need to offer a further opinion.

- Decisions about CPR must be free from any discrimination, for example in respect of a disability.
- Clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions is an essential part of high-quality care. This often requires documentation in the medical notes of detail beyond the content of a specific RDR (Resuscitation Decision Form).
- A RDR (Resuscitation Decision Form) in itself is not legally binding, the form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision making in the event of a patient's cardiorespiratory arrest or death. The final decision regarding whether or not to attempt CPR rests with the healthcare professionals responsible for the patient's immediate care.
- The use of a resuscitation decision form e.g. (TEP/RDR in Devon) that is used, recognised and accepted across geographical and organisational boundaries may be paper-based or electronic.
- Records of decisions about CPR must be accurate and up-to-date. Systems (whether paper-based or electronic) for recording these decisions must be responsive and reliable, in particular, to any change in the decision about CPR.
- Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.
- Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored.
- Where there is a clear clinical need for a DNACPR decision in a dying patient for whom CPR offers no realistic prospect of success, that decision should be made and, where appropriate, explained to the patient and those close to the patient at the earliest practicable opportunity.
- Triggers for review should include any requests from the patient or those close to them, any substantial change in the patient's clinical condition or prognosis and transfer of the patient to a different location e.g. Transfer out of the intensive care unit to a general ward.
- Any decision about CPR should be communicated clearly to all those involved in the patients care e.g. during clinical handover.
- Where DNACPR has been recorded, the level of further escalation of care and rationale should be recorded by the Doctor on the TEP/RDR.
- The TEP/RDR will be reviewed by a senior doctor as the patient's condition changes, particularly if there is a return of mental capacity. If there is a change in decision, the original decision must be clearly scored through, signed and dated. It should then be filed to the rear of the notes. A new TEP/RDR showing the current decision must be completed and placed in the Living Wills / Consent section of the medical notes, as defined by the red divider. All decisions need to be recorded, dated and justified in the medical and nursing notes.
- The TEP/RDR is intended to be patient-held and community-wide in Devon. A TEP/RDR introduced during one hospital admission must be reviewed at any

subsequent admission to hospital by the medical team responsible for the patient's new episode of care.

- Patients who have been deemed DNACPR but for End of Life (EoL) care should be accompanied by the original TEP/RDR on their discharge to their own home or another healthcare setting. To avoid unnecessary distress, it is important that the patient, and preferably their family/ carers, have been involved in the TEP/RDR discussion(s). A photocopy of the TEP/RDR should be filed as above in the patient's clinical record. Whilst it is intended that this is patient-held, it is appreciated that this will not be suitable for all circumstances and alternative arrangements may be necessary e.g. family/ carer held, with GP or 'Care home.'
- The patient's wishes are central to this process and clinicians must seek and respect those wishes. The wishes of the patient usually will be carried out. However, a clinician cannot be required to carry out treatment contrary to his or her clinical judgement, and if a conflict of view occurs which cannot be resolved, it would be appropriate to seek an opinion from another senior doctor, whenever possible.
- The CPR decision making process will involve others including members of the multi-disciplinary team, relatives and carers.
- The overall responsibility for CPR decision making, and the recording of this decision on the TEP/RDR, lies with the consultant responsible for the patients care.
- Awareness of the use of the TEP/RDR forms is an integral part of mandatory resuscitation training for all clinical staff.

Non- Medical staff completing TEP/RDR Forms

University Hospitals Plymouth (UHP) NHS Trust recognise that Doctors are no longer the main care providers for patients. There is a growing multi-professional non-medical workforce who are at the forefront of diagnosing, treating, prescribing and medically escalating patient pathways through the organisation.

This workforce is also at the forefront of having sensitive discussions with patients and family's around treatments, resuscitation and TEP/RDR forms.

UHP wish to acknowledge that a small group of non-medical practitioners are able to discuss TEP/ RDR forms and complete them appropriately as this is within their scope of practice.

The two groups of non-medical staff that have been selected to complete TEP/RDR forms are Non-medical Consultant Practitioners and Advanced Clinical Practitioner's at 8A and 8B level.

There are some clear pre-requisites and these are-

The practitioner should:

- Hold the title of Consultant Practitioner / Advanced Clinical Practitioner
- Be regulated by the recognised professional body , Nursing and Midwifery Council (NMC)
- Have a responsible medical/specialty specific consultant who is co responsible for overseeing TEP/RDR form completion process
- Only complete TEP/RDR forms for patients known to them and linked within their specialty of practice
- Performs a minimum of 50% clinical work within their role
- Undergone appropriate training and aware of associated trust guidelines surrounding TEP/RDR form completion

- Be aware of their overall accountability and responsibility when completing TEP/RDR forms
- Be prepared to have their names added to a non-medical TEP/RDR completion register
- Not be in a Trainee or development role example, Trainee Advanced Clinical Practitioner

At the time of writing only the two selected groups above who fulfil the aforementioned criteria will be considered to be able to complete TEP/RDR forms.

6 Overall Responsibility for the Document

The Trust Resuscitation Committee has overall responsibility for developing, implementing and reviewing this policy.

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Resuscitation Committee and ratified by the Medical Director.

Non-significant amendments to this document may be made, under delegated authority from the Medical Director, by the nominated author. These must be ratified by the Medical Director and should be reported, retrospectively, to the approving Resuscitation Committee

Significant reviews and revisions to this document will include a consultation with named groups and/ or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups and/ or grades who are directly affected by the proposed changes

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the named Medical Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

- It is Trust Policy that all cardiac arrests are reported as incidents via the Datix system. The Risk and Incident Team will review all incidents to ensure that an appropriate level of investigation occurs. Any incidents related to issues around vital observations, the use of the EWS charts and the appropriate response to the monitoring will be reviewed by the Risk and Incident Team Lead and Acute Care Team Education Lead to ensure that an appropriate investigation takes place. Completed investigation reports for all incidents classified as serious will be circulated to the Resuscitation Committee.
- Compliance with the resuscitation policy will be undertaken by the resuscitation department through a retrospective quarterly audit of all emergency calls. The TEP/RDR forms will be monitored for compliance that the form has been signed, dated, and if a decision has been made for DNACPR whether the rationale for the decision is documented and discussions with either patient and / or relatives/ advocate. Reports will be submitted to the Resuscitation and End of Life (EOL) Committees where action plans will be agreed for improvement.
- The outcome of the monitoring, recommendations to address any issues arising and any resultant action plans will be discussed as an agenda item at the Resuscitation Committee Meetings and with the clinical and management teams responsible
- Achievement of the actions identified will be the responsibility of the matrons and the Clinical/Service leads for the wards/ departments and this will be monitored by the Resuscitation Committee.
- Compliance with checking trolley, emergency back packs and strategic defibrillators will be undertaken by the Resuscitation Department and the Acute Care Team (ACT). Compliance is checked daily with the emergency back packs and strategic defibrillators. A formal audit of compliance with the checking book procedure of trolleys, emergency back packs and strategic defibrillators will be performed twice a year. Audit results will be reported back to the Resuscitation Committee and individual managers/matrons of wards/ departments.
- The Resuscitation Department will monitor through switchboard, no less than weekly, the response to the daily test of the adult and paediatric cardiac arrest bleeps , obstetric , neonatal and trauma emergency bleeps this will be reported twice yearly to the Resuscitation Committee.
- Compliance with the mandatory training requirements described in this policy will be monitored by the Workforce Development Team in line with the Workforce and Induction Training Policy.
- The Resuscitation Department will spot check annually the training status of those staff on the cardiac arrest teams.
- The Resuscitation Department will review the training provision in terms of content, frequency of update in accordance with the Resuscitation Guidelines (UK) or in direct response to any internal incident or equipment upgrade or change.
- Ward Managers/Matrons are responsible for undertaking a monthly audit of both the completeness of observations and that the appropriate escalation has taken place where required (Fundamentals of Care). Matrons are accountable for local actions that may be required as a result of these audits.
- In addition, an annual snap shot audit of completeness of observations is undertaken by the Acute Care Team which generates a corporate improvement action plan led by the Head of Nursing for Surgery.

10 References and Associated Documentation

NHS Executive, Health Service circular 2000/028, 5/9/2000.

Decisions relating to cardiopulmonary resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. 2007. www.resus.org.uk/pages/DNAR.htm .

Plymouth Hospitals NHS Trust “Do Not Resuscitate” policy, 1996, revision 2000.

Portsmouth Hospital Patient Care Policies And Procedures Manual, “Do Not Resuscitate” Policy, 26/07/2000.

Reference Guide to Consent for Examination or Treatment. Department of Health, 2001.

The Mental Capacity Act 2005.

Treatment and care towards the end of life: good practice in decision making. May 2010. General Medical Council.

Advance care planning. Concise Guidance to Good Practice series, No 12. February 2009. Royal College of Physicians of London. http://www.rcplondon.ac.uk/pubs/contents/9c95f6ea-c57e-4db8-bd98-fc12ba31c8fe.pdf

NHS End of Life Care Strategy. Promoting high quality care for all adults at the end of life. Department of Health, London. July 2008.

The Second Annual Report of the End of Life Care Strategy, National End of Life Care Programme. Department of Health. London, 2010.

National End of Life Care Programme. Achieving quality in acute hospitals. Department of Health. London, 2010.

Quality standards for cardiopulmonary resuscitation practice and training, Acute Care .Resuscitation Council (UK), November 2013.

Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing , 3rd edition. October 2014

Please note these are in a separate document (Resuscitation Policy Appendices 1 – 18D) on Trust Documents.

Document 1 – Cardiac Arrest Procedure

Document 2 – Personnel on Cardiac Arrest Team

Document 3 – ICU/ACT Responsibilities

Document 4 – Training Needs Analysis

Document 5 – CALS Guidelines

Document 6 – Emergency Chest Opening Procedure

Document 7 – Anaphylaxis Algorithm

Document 8 – Emergency Trolley Content List and Checking Book

Document 9 – Adult EWS Chart

Document 10 – Neuro EWS Chart

Document 10a – Newborn EWS Chart

Document 10b – Obstetric EWS Chart

Document 11 – Post Resuscitation Care

Document 12 – Procedure for checking bleeps

Document 13 – Switchboard Procedure

Document 14 – Exception to standard trolley

Document 15 – Serco procedure

Document 16 – Version 11 / Resuscitation Decision Record (RDR) Treatment Escalation Plan (TEP)

Document 17 – Mental Capacity Act

Document 18 – Paediatric EWs Chart(s)

18a	0 – 12 months
18b	1 – 4 years
18c	5 – 11 years
18d	Over 12 years

Document 19- TEP approval form for non-medical practitioners

Dissemination Plan — Appendix 2

Core Information	
Document Title	Resuscitation Policy
Date Finalised	
Dissemination Lead	
Previous Documents	
Previous document in use?	Yes
Action to retrieve old copies.	Removed from Trust Documents by Document Controller

Dissemination Plan

Recipient(s)	When	How	Responsibility	Progress update

Review and Approval Checklist | Appendix 3

Review		
Title	Is the title clear and unambiguous?	
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	
	Does the style & format comply?	
Rationale	Are reasons for development of the document stated?	
Development Process	Is the method described in brief?	
	Are people involved in the development identified?	
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	
	Is there evidence of consultation with stakeholders and users?	
Content	Is the objective of the document clear?	
	Is the target population clear and unambiguous?	
	Are the intended outcomes described?	
	Are the statements clear and unambiguous?	
Evidence Base	Is the type of evidence to support the document identified explicitly?	
	Are key references cited and in full?	
	Are supporting documents referenced?	
Approval	Does the document identify which committee/group will review it?	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	
	Does the document identify which Executive Director will ratify it?	
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	
	Does the plan include the necessary training/support to ensure compliance?	
Document Control	Does the document identify where it will be held?	
	Have archiving arrangements for superseded documents been addressed?	
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	
	Is there a plan to review or audit compliance with the document?	
Review Date	Is the review date identified?	
	Is the frequency of review identified? If so is it acceptable?	
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	

Equalities and Human Rights Impact Assessment	Appendix 4

Core Information	
Manager	Jackie Williams
Directorate	Clinical Management
Date	January 2015
Title	Resuscitation Policy
What are the aims, objectives & projected outcomes?	This policy provides expected standards and protocols pertaining to the management of risks associated with the deteriorating patient and individuals requiring cardiopulmonary resuscitation (CPR). It ensures that PHNT Staff will receive training that is up to date and relevant to their role, using equipment that is fit for purpose. The aim of the policy is to also clarify the decision regarding the appropriateness of resuscitation following cardiac or cardiorespiratory arrest. The policy describes the process for documenting and communicating the decision. The Resuscitation Decision Record (RDR) complements, and is part of, the treatment Escalation Plan (TEP).

Scope of the assessment

Collecting data	
Race	There is no evidence to suggest there is a disproportionate impact on race. However, data is collected for the National Cardiac Arrest Audit (NCAA). This will be monitored as required.
Religion	There is no evidence to suggest there is a disproportionate impact on religion however the patient in cardiac arrest is unable to express their wishes but protocols must be followed.
Disability	Consideration is given to neck breathing patients (laryngectomy). Consideration for staff with physical disabilities who are unable to initiate treatment has been made within the policy.
Sex	There is no evidence to suggest there is a disproportionate impact on sex , however data is collected for the National Cardiac Arrest Audit (NCAA). This will be monitored as required.
Gender Identity	There is currently no data collected for this area; however this area will be monitored through feedback, incidents and complaints.
Sexual Orientation	There is no evidence to suggest there is a disproportionate impact on sexual orientation , however data is collected for the National Cardiac Arrest Audit (NCAA). This will be monitored as required.
Age	There is no evidence to suggest there is a disproportionate impact on age , however data is collected for the National Cardiac Arrest Audit (NCAA). This will be monitored as required.
Socio-Economic	There is currently no data collected for this area; however this area will be monitored through feedback, incidents and complaints.
Human Rights	Consideration is given within the policy with regards to Treatment Escalation Plans (TEP) / Resuscitation Decision Records (RDR) or advanced directives.

What are the overall trends/patterns in the above data?	No trends or patterns have been identified, data will be monitored as required.
Specific issues and data gaps that may need to be addressed through consultation or further research	No gaps at this stage have been identified. Data will be monitored as required
Involving and consulting stakeholders	
Internal involvement and consultation	Lead Consultant for Resuscitation Resuscitation Committee PHNT Medical Director
External involvement and consultation	
Impact Assessment	
Overall assessment and analysis of the evidence	Consideration is given to neck breathing patients (laryngectomy). Consideration for staff with physical disabilities who are unable to initiate treatment has been made within the policy. Consideration is given within the policy with regards to Treatment Escalation Plans (TEP) / Resuscitation Decision Records (RDR) or advanced directives.

Action Plan

Action	Owner	Risks	Completion Date	Progress update
Review of patient data will be undertaken as required	Jackie Williams		On-going	