CONTROLLED DOCUMENT

University Hospitals Birmingham NHS Foundation Trust

Resuscitation Policy

CATEGORY:	Policy
CLASSIFICATION:	Clinical
PURPOSE	To ensure that the Trust provides appropriate care to people who suffer clinical deterioration and all cardio-respiratory arrests.
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Will this Controlled Document impact upon any contracts held by the Trust?	☐ Yes[1] ☒ No
Approved By:	Chief Executive
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Distribution: • **Essential Reading for:** • **Information for:**	All Trust Clinical Staff All Staff

[1] If this Controlled Document will have an impact on any contracts held by the Trust, once approved, this will need to be sent to the Procurement Team requesting that it be added to the Procurement Policy Portal.

Contents

1. Policy Statement

The Resuscitation Policy and its associated procedures will ensure that University Hospitals Birmingham NHS Foundation Trust (the 'Trust') provides appropriate care to people suffering from cardio-respiratory arrest in line with the person's wishes and the current Resuscitation Council UK Guidelines.

2. Scope

This policy applies to all areas and activities of the Trust and to all staff including permanent and temporary staff, contractors, volunteers, students, locum and agency staff and staff on honorary contracts.

3. Framework

3.1 This section describes the broad framework for the management of resuscitation throughout the Trust. Detailed operational instructions for the resuscitation services are provided in site specific Resuscitation Procedural documents.

3.2 The Clinical Service Lead/Chair of the Resuscitation Committee shall, under the Medical Director's delegated authority, approve all procedural documents associated with this policy, and any amendments to such documents, and is responsible for ensuring that such documents are compliant with this policy.

3.3 The Resuscitation Service shall facilitate the interpretation of National & International resuscitation guidelines into clinical practice within the Trust, under the direction of the Resuscitation Committee Chair and be key stakeholders in the facilitation and quality management of all life support training, practice, audit and outcomes within the Trust.

3.4 The Trust shall adopt and implement an agreed 'Early Warning System', into clinical practice, to aid the prevention of cardio-respiratory arrest and the recognition of the critically ill and/or deteriorating patient. This shall be approved by the Medical Director.

3.5 <u>The Emergency Response Team</u>

3.5.1 The Trust will provide a dedicated Rapid response to attend all emergencies (calls) that occur on Trust sites, as designated in Appendix 1.

3.5.2 Community-based sites that must access emergency assistance via 999 are detailed in Appendix 2.

3.5.3 The on-site response will only consist of appropriately trained members of staff, who will be managerially and clinically responsible to their own consultant, clinical lead/line manager & to the Clinical Service Lead for the Resuscitation Service across all areas of the Trust.

3.5.4 A minimum of 2 members of the Emergency Response Teams will be Advanced Life Support (ALS) providers and at least 2 of them will be medically qualified, of which at least one must be at ST3 level or equivalent, or above.

3.5.5 Heartlands Hospital and Good Hope Hospital will also have dedicated Paediatric Emergency Response Teams. These teams will respond to paediatric emergencies. A minimum of 2 members of a Paediatric Emergency Response Team will hold advanced levels of paediatric resuscitation training and at least 2 of them will be medically qualified, of which at least one must be at ST3 level or equivalent, or above. However, at Queen Elizabeth & Solihull Hospitals, the Adult Emergency Response Team must attend all Paediatric emergency calls made on these sites.

3.6 Training/Guidance

Training will be provided for staff in the management of patients to prevent, be prepared for, and deal with all deteriorating patients and cardiac arrest situations when they occur. All staff will be required to attend appropriate training in line with the Mandatory Training Needs Analysis and be cognisant with their individual roles as follows:

a) **Clinical staff:** - All doctors, nurses, midwives, allied health professionals and health care assistants, must be adequately and regularly trained in cardiopulmonary resuscitation in accordance with the Training Needs Analysis set out in the associated site-specific Resuscitation Procedures, and Mandatory Training policies.

b) **Non-Clinical staff with direct patient care contact** – Non-clinical staff with direct patient care contact, e.g. Porters, will be trained to recognise cardiorespiratory arrest; summon help; and initiate basic life support with manual external chest compression.

3.7 Recommended Summary Plans for Emergency Care and Treatment and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

3.7.1 Emergency treatment and resuscitation recommendations must be considered and recorded as appropriate and documented as set out in the associated site-specific procedure document, including: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and Do Not Attempt Cardiopulmonary Resuscitation (Adults).

3.7.2 Emergency treatment plans (including resuscitation) must be considered in all acute admissions. A conversation about treatment options and resuscitation must be completed for all those at risk of deterioration or cardiac arrest or who want to have their wishes documented. Approved documentation relating to these decisions may be in paper or electronic format and may vary dependent on site, therefore it is the individual's responsibility to ensure they are familiar with this process on specific sites across the trust.

3.7.3 The default position within the Trust is always to initiate cardiopulmonary resuscitation, i.e: chest compressions and ventilations, in the absence of any valid DNACPR/ReSPECT documentation being present and/or where the staff in immediate attendance is uncertain as to the resuscitation status of any given arrested patient/person.

IF IN DOUBT:- RESUSCITATE

3.7.4 Cardiopulmonary Resuscitation is not always appropriate in all cases of Cardiac Arrest. This policy relates to all patients over the age of 18 years within the Trust, and the formal decision NOT to resuscitate any such individuals must be based strictly on the following principles:

a) Patients with Capacity

- The patient with mental capacity (or welfare attorney) refuses 'Cardiopulmonary Resuscitation' ie: it is the patient's wishes.

- Resuscitation will not be successful. The clinical team has good reason to believe that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and that CPR will not restart the heart and breathing for a sustained period.

b) Patients who lack Capacity

- An assessment of the balance of benefits and burdens made by the lead clinician present, must be informed through discussion with the patient (unless they refuse such discussion) or those close to patient who lacks capacity.

3.7.5 For DNACPR guidance on patients under 18 years of age, please refer to the Trust's site-specific Paediatric Resuscitation Procedure.

3.7.6 Adherence to the Mental Capacity Act (2005) which came into force on the 1st April 2007 is a legal requirement and must always be referred to when considering DNACPR orders and Advanced Decisions. Clinical teams are reminded of their legal responsibility to inform the patient (or those close to the patient if the patient lacks capacity) as soon as is practical, of a decision to withhold CPR, unless to do so would cause the patient physical or psychological harm.

3.8 Witnessing Resuscitation

The needs of the arrested patient are paramount and if a relative being present during resuscitation compromises this, healthcare workers must refuse admission or request that they leave at any point. The ultimate decision as to whether or not they are permitted to witness resuscitation lies with the cardiac arrest team leader; however, staff should ask if a relative wishes to be present.

3.9 Emergency Equipment, Replenishment & Cleaning

3.9.1 All clinical areas must hold Trust standard resuscitation equipment as outlined in the associated Resuscitation Procedures. The resuscitation equipment must be checked on a daily basis, ('daily' being the frequency with which the department is open – therefore a department that is open Monday to Friday would be expected to check the Trolley on a Monday to Friday basis) remain in a state of readiness at all times, and all areas within the previously specified sites must have access to an emergency resuscitation response and key equipment within 3 minutes.

3.9.2 The Resuscitation service has initiated a sealed tray system on some sites, which will be constructed and sealed centrally. All areas currently issued with sealed trays must ensure daily checks ('daily' being the frequency with which

the department is open – therefore a department that is open Monday to Friday would be expected to check the Trolley on a Monday to Friday basis) are carried out to ensure use-by dates, and integrity of, the trays is monitored. Guidance on this can be found in the on the Resuscitation service intranet site.

4. Duties

4.1 Medical Director

The Medical Director has delegated responsibility for the implementation and monitoring of the policy and the approval of all associated procedural documents to the Clinical Service Lead for Resuscitation.

4.2 Resuscitation Committee

Members of the Resuscitation Committee will ensure that:

4.2.1 This policy adheres to the current National (Resuscitation Council UK guidelines) and International Guidance, and ensure appropriate procedural documents required to implement this policy are developed;

4.2.2 In line with National Patient Safety Agency, best practice recommendations, the emergency response process for adults and paediatric teams at each site will be monitored and tested through 'live' simulation audits. The frequency will be determined by the Resuscitation committee as defined by clinical need. This process will aim to provide continued assurances of safe systems for emergency response teams and patient safety;

4.2.3 Clinical leadership and advice on the implementation of the above guidance is provided; and

4.2.4 The Chair of the Resuscitation Committee will ensure that any material concerns or non-compliance regarding the implementation of this policy and the operation of the Trust's resuscitation services are brought to the attention of the Board of Directors via the agreed site-specific reporting structures.

4.3 Divisional Directors

Divisional Directors will ensure that:

4.3.1 All reported concerns relating to compliance with this policy are dealt with in accordance with current Trust procedures;

4.3.2 There is an agreed process in place to ensure all staff are aware of how to summon the cardiac arrest teams; and

4.3.3 The Trust's Emergency Response Teams are staffed appropriately in line with this policy via the medical management structures and relevant staff sickness within this response is communicated and covered appropriately.

4.3.4 In line with section 10 of the professional leave policy, where the Trust relies on the support of senior medical staff to undertake specific supportive or internal roles eg. Examination of medical students and core curriculum courses (eg. ALS/Simulation), that additional professional leave will be agreed.

4.4 Lead Resuscitation Officer

The Lead Resuscitation Officer will ensure that:

4.4.1 Adequate training provision is maintained to allow staff to fulfil their training requirements according to the current training needs analysis.

4.4.2 A member of the Resuscitation Service Team attends medical emergencies and Cardiac arrest calls whenever practicable.

4.4.3 Compliance with the daily checking and availability of the resuscitation equipment in all areas is logged and mnitored, annually as a minimum requirement. This may be more frequent as determined by operational safety needs.

4.5 Core Resuscitation trainers

The Core Resuscitation trainers will ensure that:

4.5.1 Training within their own clinical areas with support from the Resuscitation Service is maintained to the Trust's mandatory training standards; and

4.5.2 Areas of concern within their own clinical areas relevant to resuscitation training and practice are reported to the

Resuscitation Service department at the earliest opportunity.

4.6 Emergency Response Team Members

The Emergency Response Team Members will ensure that they:

4.6.1 Respond to all Emergency/Cardiac arrest calls at best possible speed.

4.6.2 Are up to date with current Resuscitation Council UK Guidelines and competencies required within the role.

https://www.resus.org.uk/resuscitation-guidelines/

4.6.3 Carry the designated baton bleep during their period of duty with the designated team and hand it over appropriately in line with the site specific guidance protocol, to their replacement or arrange appropriate cover and report to switchboard if they are unable to carry the emergency baton bleep at any time.

4.6.4 Failure of the next designated member to come on duty must be reported to the duty consultant for the relevant discipline. These baton bleeps must not be left for 'someone to just pick up later. Failure to correctly follow this policy and associated procedures has potentially serious consequences and will be considered a disciplinary offence;

4.6.5 Individual directorates will be responsible for ensuring there are robust systems in place for appropriately staffing the emergency response teams, covering absences and ensuring the effective handover of baton bleeps between teams.

4.6.6 Answer all test calls made by switchboard when on duty for the Emergency teams and/or liaise with switchboard relating to any baton bleep concerns or failures.

4.7 Ward/ Departmental Managers

Ward/Departmental Managers will ensure that:

4.7.1 All new staff are made aware of the Resuscitation Policy and related Procedures on local induction to the Ward/Department and support appropriate staff training.

4.7.2 Essential equipment is always available and operational, and that emergency equipment is replenished immediately after use.

4.7.3 All resuscitation equipment is checked daily and after each use in accordance with the site-specific Resuscitation Procedures.

4.7.4 All equipment faults/problems are acted upon immediately and replaced/reported through the appropriate departments, including completion of an incident form where necessary, and in conjunction with the Medical Engineering Department; planned preventative maintenance is carried out routinely via the 24/7 medical engineering services available within the trust.

4.7.5 The nominated core trainer for their local area is given appropriate protected time away from clinical duties to perform their role of facilitating life support training locally.

4.8 Site Management Team

The site Management Team will ensure that:

4.8.1 They respond to the Medical Emergency/Cardiac arrest baton bleep at best possible speed;

4.8.2 Call an Emergency Ambulance, where appropriate, when requested by the appropriate Team Leader in line with the site-specific resuscitation procedure document.

4.8.3 Co-ordinate investigation of non-response to baton bleep test calls and assign alternative staff to fill any gaps in service provision identified.

4.9 Switchboard Supervisor

The Switchboard Supervisor will ensure that:

4.9.1 All switchboard staff are aware of the procedure for dealing with emergency calls and follow the agreed process when the baton bleep system is unavailable.

4.9.2 Test calls are made to all emergency response team members at the pre-arranged times and those team members who do not respond are baton bleeped a second time and this is documented.

4.9.3 If a member of the emergency response team does not respond following a second test call, switchboard staff will inform the following Department/Staff, in order of availability, so this may be investigated and rectified immediately:

- Site Manager on call for the Hospital site
- Medical/ Anaesthetic consultant on call
- Resuscitation Service.

4.10 **All staff**

All staff will ensure that they:

4.10.1 Attend appropriate training in resuscitation relevant to their role, in accordance with current training needs analysis for Resuscitation; and

4.10.2 Are fully aware of the resuscitation policies, site specific procedures and operating guidance in place within the Trust.

5. Implementation and Monitoring

5.1 Implementation

5.1.1 This policy and its associated procedures are available on the Trust intranet and disseminated to staff through the divisional management and internal team structures within the Trust.

5.1.2 All staff are informed about the Resuscitation Policy and its associated procedures during all corporate and local induction processes.

5.2 Monitoring

Appendix A provides full details of how this policy will be monitored by the Trust.

6. References

Department of Health, Health Service Circular 2000/028, Resuscitation Policy, 2000, September, 5th, [accessible at]
https://www.icnarc.org/documents/HSC2000-028.pdf

Resuscitation Council United Kingdom, Quality Standards for cardiopulmonary resuscitation and training, [accessible at] https://www.resus.org.uk/quality-standards/

NCEPOD, National Confidential Enquiry into Patient Outcome and Deaths, "Time to Intervene?",2012 [accessible at]
https://www.ncepod.org.uk/2012report1/downloads/CAP_fullreport.pdf

National Institute for Clinical Excellence, Acutely Ill Adults in Hospital: recognising and responding to deterioration, Clinical Guideline [CG50], 2007, July, [accessible at]
https://www.nice.org.uk/guidance/CG50/chapter/1-Guidance

Resuscitation Council United Kingdom, Resuscitation Guidelines, 2015, [accessible at] www.resus.org.uk/pages/guide.htm

Royal College of Nursing, Witnessing Resuscitation: Guidance for Nursing Staff, 2003, June, 27th [accessible at]
https://www.rcn.org.uk/professional-development/publications/pub-001736

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Procedure
https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Mental Capacity Act (2005)
https://www.legislation.gov.uk/ukpga/2005/9/contents

7. Associated Policy and Procedural Documentation

Paediatric Resuscitation Procedure (QEHB)

Paediatric Resuscitation Procedure (BHH, GHH and SOL)

Adult Resuscitation Procedure (QEHB)

Adult Resuscitation Procedure (BHH, GHH and SOL)

Do not attempt cardiopulmonary Resuscitation (DNACPR) Procedure (QEHB)

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Procedure

Mandatory Training Catalogue (Training Needs Analysis)

Appendix A **Monitoring Matrix**

MONITORING OF IMPLEMENTATION	MONITORING LEAD	REPORTED TO PERSON/GROUP	MONITORING PROCESS	MONITORING FREQUENCY
Attendance & non-attendance at mandatory resuscitation training	Lead Resuscitation Officers	Resuscitation Committee Chair & Governance Lead	Mandatory resuscitation training reports from training admin	Quarterly
Availability of emergency resuscitation equipment	Lead Resuscitation Officer	Resuscitation Committee Chair & Governance Lead	Quarterly resuscitation service inspection of resuscitation trolleys in all areas	Quarterly
Response to emergency response team – test calls	Lead Resuscitation Officer	Resuscitation Committee Chair & Governance Lead	Daily retrieval of documented test call responses from switchboard	Quarterly
Response and outcome of all emergency calls	Lead Resuscitation Officer	Resuscitation Committee Chair & Governance Lead	Mandatory completion of emergency response audit forms (all calls) National Cardiac Arrest Audit (Heartlands, Good Hope, Solihull)	Quarterly
Failure to attend medical emergencies / cardiac arrests, clinical incidents or near miss	Lead Resuscitation Officer	Resuscitation Committee Chair & Governance Lead	Monthly report from risk department on clinical incidents and resus officer attendance or review of all cardiac arrests.	Quarterly
Recommended Summary Plans for Emergency Care and Treatment **or** Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit	Lead Resuscitation Officer	Resuscitation Committee Chair / DNACPR sub group chair & Governance Lead	Monthly audit from resuscitation service department on : • Number of DNACPR decisions made in the Trust. • Compliance with the agreed DNACPR documentation process and practice	Quarterly

			• Implementation & Progress of action plans for non-compliance issues.	
All Cardiac Arrests are led by appropriate Team Leaders who are current Advanced Life Support Providers & appropriate grades.	Lead Resuscitation Officer	Resuscitation Committee Chair & Governance Lead	RC (UK) Clinical Standards Quarterly report from the on line pager response system	Quarterly
Critical Incidents during or leading to a cardiac arrest reported through the Datix system will be reviewed by the Resuscitation Service.	Lead Resuscitation Officer	Resuscitation Committee Chair & Governance Lead	RC (UK) clinical standards	Quarterly
Compliance with this policy	Resuscitation Committee Chair & Governance Lead	Board of Directors	An exception report is presented detailing any material concerns or non-compliance regarding the implementation and/or operation of resuscitation service.	By exception

Appendix 1

The Trust will provide a dedicated 24/7 rapid response to attend all emergencies (2222 calls) that occur on Trust sites, These sites are as follows:

- Queen Elizabeth Hospital Birmingham – including All entrances & exits (This does not include designated car parks which must call 999)
- Heartlands Hospital – All site
- Good Hope Hospital – All site
- Solihull Hospital – All site

Appendix 2

Community based sites that must access emergency assistance via 999 are as follows:

- Birmingham Chest Clinic
- Umbrella Sexual Health Community clinics
- Assure renal Dialysis Unit
- Norman Power Re-ablement Unit
- Castle Vale Renal Unit
- Runcorn Road renal Unit
- Solihull Community Services
- Satellite Units – eg: Dental clinics