Resuscitation and ReSPECT (Recommended Summary Plan for Emergency Care & Treatment) Policy

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Executive summary

This Policy sets out the principles by which patients who have suffered a cardiac arrest whilst under the care of Ashford & St Peter’s NHS Foundation Trust are managed in accordance with current European and UK Resuscitation Council guidelines. This policy is fully in accordance with the recommendations for clinical practice and training in cardiopulmonary resuscitation published by the Resuscitation Council (UK 2017) and has been constructed to promote compliance with regulatory requirements and best practice.

This Policy also sets out the principles and guidance on a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) decision. ReSPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment.

All clinical areas where a cardiac arrest may occur must have adequate resources available and clearly visible. All cardiac arrest equipment must be checked on a daily basis and also after each use, this being documented in order to ensure continual availability of emergency equipment in those areas. All staff must be familiar with the resuscitation equipment located in their workplace or know where the nearest resuscitation equipment is located. All clinical staff must attend adult basic life support training and those working in an area which routinely deals with children, must also be trained in paediatric basic life support.

The Trust will support the resuscitation training it delivers by ensuring adequate resources are available to provide relevant levels of training to staff members specific to their role and speciality in managing a cardiac arrest. This will include having experienced Resuscitation Officers, a dedicated resuscitation training room and appropriate resuscitation training equipment.
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1. INTRODUCTION

This resuscitation policy fully supports the recommendations for clinical practice and training in cardiopulmonary resuscitation published by the Resuscitation Council (UK) (2015) and has been constructed to promote compliance with the principles underpinning the NHSLA Risk Management Standards (NHSLA, January 2011) and CQC.

2. PURPOSE AND OBJECTIVES

The purpose of this policy is to provide direction and guidance for the planning and implementation of a high-quality and robust resuscitation service to the Trust. It aims to promote

- Early recognition and prevention of cardiac arrest in the deteriorating patient
- A standardised approach to cardiopulmonary resuscitation
- To optimise clinical outcome following cardiopulmonary resuscitation attempt.
- That decisions relating to treatment escalation and cardiopulmonary resuscitation are documented in the clinical notes using the appropriate document

The strategy for resuscitation incorporates the current published guidelines for resuscitation (Resuscitation Council (UK) 2015).

3. SCOPE

3.1 Inclusions

This policy relates to the recognition of patients at risk of cardiopulmonary arrest (use of the National Early Warning Scoring (NEWS) system), the management of a cardiopulmonary arrest, including special considerations and post resuscitation care.

It includes guidance about decisions relating to treatment escalation and resuscitation, including appropriate use of the approved documentation Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

This policy applies to substantive and temporary clinical and non-clinical staff working within the Trust.

3.2 Exceptions

Some specialist areas may not use the NEWS scoring system as part of their monitoring of patients.

3.3 Definitions

The following terms are used and apply to this policy:

Cardiopulmonary Resuscitation relates to the delivery of chest compressions, artificial ventilation, the delivery of energy using a defibrillator and use of emergency drugs to support resuscitation.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process refers to a document and process for creating a personalised recommendation for individual patients
4. **DUTIES AND RESPONSIBILITIES**

**4.1 Chief Executive**
Has overall responsibility for ensuring suitable arrangements are in place for the development of a robust resuscitation service which assists the trust in complying with its legal, statutory requirements and good practice.

**4.2 Trust Board**
Has overall responsibility for the strategic development and effective implementation of the policy across the Trust.

**4.3 Resuscitation Committee**
Must ensure the development, monitoring and auditing of a safe and effective resuscitation policy within the Trust. (See appendix 3 for Resuscitation Committee terms of reference)

**4.4 Resuscitation Services Manager**
The Trust Resuscitation Service is led by the Resuscitation Services Manager who is assisted by a team of Resuscitation Officers and administrative staff. The Resuscitation Service has four main areas of activity: clinical, training, research and audit.

The Trust Resuscitation Services Manager is the designated resuscitation advisor for the Trust and has day-to-day responsibility for the management of all aspects of resuscitation issues. They are responsible for advising all staff throughout the organisation on issues relating to resuscitation and adverse incident management. They will oversee the implementation of the Trust Resuscitation Policy and Procedures and advise appropriate managers and departments of non-compliance.

Together with the Chair of the Resuscitation Committee the Resuscitation Services Manager will advise the Trust on adherence to National Resuscitation Standards.

They are responsible for liaising with other key staff within the Trust (e.g. Chair of Resuscitation Committee, Directorate Managers, etc.) in relation to the management of the Trust Resuscitation Policy and Procedures, and with national and international bodies (e.g. Resuscitation Council (UK), Advanced Life Support Group and the European Resuscitation Council) and other relevant organisations.

The Trust Resuscitation Manger will provide reports to the Resuscitation Committee detailing monitoring and audit of compliance and non-compliance with the Resuscitation Policy and Procedures and adverse incident reports in relation to resuscitation.

The Resuscitation Manager will utilise the Resuscitation Officers and other staff as required to implement the provisions of this policy.

They will also be responsible for:

- Ensuring development and provision of resuscitation training courses for various staff groups in order to meet the training requirements.
- Maintaining records of staff attendance at resuscitation training courses.
- Monitoring implementation of the policy through data collection and audit activities - either undertaken by Resuscitation Service or delegated to appropriate department.
• The trust-wide notification of new and revised working documents with regard to Resuscitation Services.

4.5 General Managers, Operational Managers, Clinical Directors and all Managers
Directorate Managers, Clinical Directors and all other managers are responsible for overseeing resuscitation activities within the areas of their responsibility at a local level and ensuring that these areas comply with all aspects of the Trust’s Resuscitation Policy and Procedures. This applies particularly to attendance at resuscitation training. They are also responsible for ensuring that all staff under their management (including bank, agency, contracted, locum and volunteers) are aware of and meet their individual responsibilities under the policy.

4.6 Trust Employees
All staff are responsible for:
• Ensuring that they operate within their own professional scope of practice
• Ensuring that they are following current guidelines for resuscitation
• Attending training sessions according to the individual’s training needs analysis in relation to resuscitation

5. CARDIOPULMONARY RESUSCITATION AND GENERAL

Statement
Cardiac Arrest may be defined as the abrupt cessation of cardiac function that is potentially reversible. All patients who suffer cardiopulmonary arrest and/or respiratory arrest at Ashford & St Peter’s Hospitals NHS Foundation Trust will be resuscitated in line with Resuscitation Council (UK) Guidelines unless the decision has been made by the patient, the patient’s Consultant or his/her nominated deputy not to resuscitate.

5.1 The Deteriorating Patient
The Trust has a documented plan for vital signs monitoring that identifies which variables must be measured and includes the frequency of measurement. Please see Guidelines for the Recognition of and Response to Acutely Ill Adult Patients in Ward Environments (Trustnet)

5.1.1. Adult Patients
The Trust uses the National Early Warning Scoring system (NEWS) (Appendix 4) for the recognition of, and response to, the acutely unwell adult and or adult patients at risk of deterioration who are located within clinical areas.
It incorporates a physiological track and trigger system with an agreed minimum set of physiological parameters, which are measured and recorded on the VitalPAC system. Use of the NEWS score and VitalPAC does not replace the need for sound clinical judgement.

5.1.2 Maternity Patients
All severely ill Maternity patients should have regular observations and, if necessary, heart monitoring and all observations should be recorded and interpreted using the Maternity VitalPAC system.
5.1.3 Paediatric Patients
All Paediatric patients should have regular observations and be recorded and interpreted using a Paediatric Early Warning Score Chart (PEWS). According to the PEWS score, necessary action should be taken including assessment by the senior paediatric nurse and/or senior paediatric doctor.

5.2 The Emergency Team Response
The hospital site is serviced by appropriate emergency teams. The emergency team MUST be summoned by using the national emergency number 2222 for every patient deterioration, collapse or cardiac arrest. The precise location of the patient must be communicated promptly and clearly to the switchboard operator:

- For Adult patients state ADULT PRIORITY TO../ OBSTETRIC PRIORITY TO..
- For Paediatric patients state PAEDIATRIC PRIORITY TO...
- For Neonates state NEONATAL PRIORITY TO...
- For Trauma patients state ADULT or PAEDIATRIC TRAUMA TO...

It is imperative that if a patient collapses in an area that is duplicated on both sites such as OPD / X-Ray / Physio etc. you must state on which site the call is being made.

The team leader at the priority or resuscitation attempt must hold, as a minimum, a recognised in date qualification / certification from the relevant body (Resuscitation Council, Advanced Life Support Group, Royal College of Surgeons). Please see table below.

<table>
<thead>
<tr>
<th>Event type</th>
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<tr>
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<td>Newborn Life Support</td>
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All emergency on-call bleeps will be alerted simultaneously by the switchboard operator via a speech channel. Each member of the appropriate emergency team must respond at their earliest opportunity.

For identified on-call bleep holders there will be a 10am test bleep.

5.2.1. Composition of the Resuscitation Team
The composition of the respective emergency teams (Adult / Obstetric / Paediatric / Neonatal/Trauma) is detailed within Appendix 5.

5.3. Resuscitation Guidelines
Any resuscitation attempt must adhere to the current published guidelines by the Resuscitation Council (UK) 2015. For management of cardiac arrest see Appendix 6,7 & 8.
5.3.1. Oxygen Delivery to Critically Ill Patients
For critically ill patients, high concentrations of oxygen should be administered as soon as it is available by all staff and help must be summoned to assess and stabilise the patient. Oxygen is classed as a drug and therefore requires prescribing EXCEPT in an emergency situation.

- In the critically ill patient or peri-arrest situation, treatment should commence with oxygen at 15L min via a reservoir mask.
- As soon as arterial blood oxygen saturation can be monitored reliably (by blood gas analysis and/or pulse oximetry), titrate the inspired oxygen concentration to maintain the arterial blood oxygen saturation in the range of 94–98%. Or within a range normal for the individual patient.
- In those situations, where pulse oximetry is not available to monitor critically ill patients, oxygen should continue to be given via a reservoir mask until definitive monitoring is available.

For further information, see Policy for the Prescription and Administration of Emergency Oxygen in Adults. (Trustnet)

5.3.2. Drugs during cardiac arrest
Current Advanced Life Support (ALS) providers or someone competent under direct supervision of the ALS certified team leader can administration Intravenous / Intraosseous Adrenaline and Amiodarone according to current Resuscitation Council (UK) guidelines without prescription.

5.3.3. Anaphylaxis
The management of suspected anaphylaxis should be conducted in accordance with the Resuscitation Council (UK) Guidelines for the management of anaphylaxis (Appendix 10).

5.3.4. Intraosseous Access
EZ-IO Drills to establish IO access are available on certain resuscitation trolleys within the trust. To use the drill, the user must have received training and achieved competence. For further information and training please contact the Resuscitation Service.

5.3.5. Maternal Cardiopulmonary Resuscitation
Specific considerations have to be taken into account when dealing with cardiopulmonary resuscitation in the pregnant patient. (Appendix 11)

- Early involvement of an obstetrician and neonatologist is crucial when dealing with cardiopulmonary arrest in the pregnant patient.
- Particular attention should be paid to minimising aortic and vena caval compression caused by the gravid uterus by left lateral tilt or manual displacement.
- Peri-mortem Caesarean section may have to be undertaken early in the resuscitation attempt (within 5 minutes) and equipment should be immediately available.

5.3.6. Paediatric Cardiopulmonary Resuscitation
For guidelines on paediatric cardiopulmonary resuscitation please see Appendix 8. An adult and paediatric bag valve mask is available by each lift and on every floor within the Trust.
5.3.7. Relatives Present at a Resuscitation Attempt
Relatives may wish to be present at a resuscitation attempt. It is the responsibility of the Team Leader to ensure a senior member of staff is available to support them and ensure the team is aware. This must in no way affect the interventions required nor the clinical discussion and decisions made. The Team Leader may choose not to allow relatives to be present if it is felt it affects the performance of the team.

5.3.8. Documentation of Cardiac Arrests
Following each priority, a 2222 Record of Events form (Appendix 2) MUST be completed, if this document is not filled in at the time of the arrest it must be completed by staff retrospectively immediately afterwards. It is the responsibility of the Team Leader to ensure it has been completed correctly and provides an accurate account of the event. They must take a photocopy of the form which is then placed in the patient’s notes and the original sent to the Resuscitation Service.

5.3.9. Post Resuscitation Care
The goal of post resuscitation care is to restore normal cerebral function, stabilise the cardiac rhythm and ensure adequate organ perfusion. Continual assessment and in depth reviews of the patient’s base line observations must be made and treatment initiated on any abnormal parameters. The ABCDE system-orientated approach to management should be followed in the immediate post resuscitation phase pending transfer to an appropriate high care area. The Trust must make provisions for safe continuity of care and where necessary, safe transfer following resuscitation of the patient. The final decision for transfer to a critical care bed is made by the Intensive Care Consultant on-call or a designated member of the critical care team following discussion with the on-call Critical Care Consultant.

5.3.10. Targeted Temperature Management
Following a return of spontaneous circulation (ROSC) and following initial assessment and stabilisation, targeted temperature management should be considered. This should be continued for 24-36 hours. Tracheal intubation, sedation and controlled ventilation should be considered in any patient where targeted temperature management has been initiated. Consultation with a Critical Care Consultant on-call must be made at the earliest opportunity.

5.4. Process for Ensuring Continual Availability of Resuscitation Equipment
Resuscitation trolleys are located in ward and departmental areas, usually centrally, near to the nurse’s station or high dependency area. The equipment and trolleys are standardised, allowing for some minor differences in certain specialist areas.

All staff are required to familiarise themselves with the location and use of emergency equipment within their clinical area. Any locum, agency or newly appointed staff must be informed of the emergency telephone number and the location of any resuscitation equipment. The ward / unit / departmental manager or person in charge should provide this information at the beginning of their duty / shift.

The Resuscitation Service has a support system in place to ensure the continuing availability of both disposable & non disposable specific resuscitation equipment.
A daily and weekly check of each trolley MUST be made and documented on the appropriate trolley checklists. These checklists must be kept at ward level for 3 years. All resuscitation trolleys must be maintained in a state of readiness at all times. The defibrillator, suction and Oxygen equipment should be checked by a trained member of staff at least once in every 24 hours. Ideally this should be done immediately after handover or on arrival in the department. Responsibility to ensure that trolley checking is undertaken lies with the Sister/Charge Nurse or departmental managers as appropriate.

A full check of all equipment and expiry dates must be completed on:
   a) Once a week.
   b) Nearest Monday for departments which are not open at weekends and within 24 hours of opening.
   c) Immediately following conclusion of a resuscitation event.
   d) All areas should aim to have the resuscitation trolley ready for use within one hour of previous use.

The resuscitation trolleys should be stocked in accordance with the standardised list issued by the Resuscitation Service. Disposable items should be replenished at the earliest opportunity from the resuscitation cupboard (both sites) or from ward stock as appropriate. The defibrillator will perform a daily self-test at 3am every day and print out the result. Staff must ensure that when they perform the daily check, they confirm that the defibrillator has ‘passed’ the daily test by referring to the printout. If the defibrillator fails the test, the staff member must inform the Electrical Mechanical Engineers department and the Resuscitation Service as soon as possible.

Pharmacy items must be replenished from within the Ward stock, Pharmacy or the emergency drug cupboard if out of hours and in accordance with the standardised list issued by the Resuscitation Service.

It is imperative that all resuscitation trolleys are kept clean and clear from clutter. They will require a daily wipe down of all visible equipment and surfaces.

5.5. Manual Handling
If the collapsed patient is on the floor, in a chair or in a restricted/confined space, the patient must be treated in this position. Subsequently the Trust guidelines for the movement of the patient must be followed to minimise the risks of manual handling and related injuries to both staff and the patient.

Information also available from the Resuscitation Council (UK): Guidance for safer handling during resuscitation in health care settings. This can be found at [https://www.resus.org.uk](https://www.resus.org.uk)

5.6. Infection Prevention and Control
There are good clinical reasons to avoid mouth-to-mouth ventilation in clinical settings, and it is therefore not advised.
Staff have a responsibility to take appropriate action to ensure their own and others safety during a resuscitation attempt. This includes universal precautions and being aware of sharps and their correct disposal. Health care personnel should wear the appropriate protective clothing, disposable vinyl gloves and goggles whenever exposure to body fluids is anticipated.
5.7. Procurement
All resuscitation equipment purchasing is subject to the Trust’s standardisation strategy; therefore, all resuscitation equipment purchased must be sanctioned by the Resuscitation Service prior to ordering and ratified by the Resuscitation Committee.

6. ReSPECT

6.1. Decisions Relating to Treatment Escalation and Cardiopulmonary Resuscitation (CPR)
The Trust has adopted the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) document (Appendix 9) and approach and should be completed for all patients within a maximum time period of 24hrs after admission. ReSPECT is a process that creates personalised recommendations for a person’s clinical care at a future emergency in which they are unable to make or express choices. It provides healthcare professionals responding to that emergency with a summary of recommendations to help them make immediate decisions about that person’s care and treatment.

The plan is created through an informed discussion between a patient and their healthcare professionals. The plan is recorded on the ReSPECT form and includes personal priorities of care and agreed clinical recommendations about care and treatment that could help to achieve the outcome that they would want, not want or is deemed clinically appropriate.

Emergencies include cardiac arrest, but are not limited to this event. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not CPR should be attempted if the person’s heart and breathing stop. This is a clinical decision discussed with the patient (if deemed to have capacity) or with the patient’s next of kin in the event that the patient does not have capacity with clear documentation of these assessments on the form in the appropriate section.

Early consideration of CPR decisions is recommended in the context of broader advance care planning.
It is essential to identify:
- Patients for whom cardiopulmonary arrest is an expected part of the process of dying and in whom CPR is inappropriate
- Patients who do not wish to receive CPR.

It is emphasised that when healthcare professionals consider making an anticipatory decision about CPR for a person who does not have capacity to participate in the decision-making process:
- In order to make a fully informed decision, where it is both practicable and appropriate, discuss the patient’s situation and the decision with those close to the patient (subject to any confidentiality restrictions expressed if, and when, the patient had capacity).
- Where both practicable and appropriate, there should be minimal delay in contacting those close to the patient in order to do this.
- When it is not possible to contact those close to the patient immediately and an anticipatory decision about CPR is needed in order to deliver high-quality care; that decision should be made in accordance with the relevant legislation.
Where there is genuine doubt as to whether or not CPR would have a realistic chance of success, or if a decision about CPR is being considered on the balance of benefits and risks, in order to comply with the law an IMCA (Independent Mental Capacity Advocate) should be involved in every case, where there is no next of kin.

Clear documentation regarding decision and communication must be entered in the patient’s clinical records. When a decision not to attempt cardiopulmonary resuscitation is reached this must be documented on the ReSPECT form.

6.2. Principles Underpinning Cardiopulmonary Resuscitation Decisions

- Detailed guidance on decisions relating to CPR was published in 2016 in the publication “Decisions relating to Cardiopulmonary Resuscitation” by the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing (see www.resus.org.uk).
- A Cardiopulmonary Resuscitation Policy or similar document must be available to all staff and, on request, to patients and those close to them.
- Consultants should ensure that there is a clear and explicit resuscitation and escalation plan for all patients, clearly stating either ‘CPR attempts recommended’ or ‘CPR attempts NOT recommended’ on the ReSPECT form.
- Advance care planning, including making decisions about CPR, is an important part of good clinical care for those assessed at risk of cardiopulmonary arrest or for those for whom death is not unexpected and for patients that express specific views on the process.
- CPR would be inappropriate for patients in the final stages of an incurable illness and where death is expected due to the severity of their medical co-morbidity.
- If CPR is unlikely to have a successful outcome, it should not be attempted.
- CPR would be inappropriate if significant co-morbidities and / or significant frailty leads to a decision not to transfer to ICU, CCU or other specialist area prior to or post resuscitation. Or when a decision is made that intubation and ventilation would be inappropriate by a senior clinician or the Critical Care Team. These decisions should be documented clearly in the medical notes and on the ReSPECT form.
- Where successful CPR may not be followed by a length and/or quality of life, as judged by the patient. The informed views of a patient with capacity are of paramount importance in planning decisions about CPR.
- If cardiopulmonary arrest occurs in a patient for whom a resuscitation plan has not been established, and the wishes of the patient are unknown, cardiopulmonary resuscitation must be initiated.
- CPR decisions apply only to CPR and not to any other aspects of treatment. It should be made clear to patients, next of kin and to members of the healthcare team that all other appropriate treatment will continue to be considered and provided as appropriate.
- For some patients with a decision not to attempt CPR, a cardiopulmonary arrest may develop from a readily reversible cause such as choking, induction of anaesthesia, anaphylaxis or a blocked Tracheostomy tube. In such situations CPR would be appropriate while the immediate reversible cause is treated unless the patient has specifically refused intervention in these circumstances.
• If a clinician believes that a procedure or treatment would not be successful or would be unacceptably hazardous with the decision not to attempt CPR still in place, it would be reasonable not to proceed.

6.3. Responsibility for ReSPECT document and CPR Decision and Review
• The overall responsibility for a ReSPECT document and CPR decision rests with the Consultant responsible for the patient’s care. No foundation doctors or equivalent grades can make or record decisions regarding resuscitation. A CT1/2 may initiate and document a ReSPECT conversation but the document itself must be signed by an ST3 equivalent or above and the consultant must be made aware of the agreed treatment escalation plan. The consultant should review and endorse the recommendations by adding their signature as soon as practicable.
• The Supportive and Palliative Clinical Nurse Specialists’ may also undertake and complete the ReSPECT process for patients in their care and again the responsible consultant must be made aware of the agreed treatment escalation plan. The consultant should review and endorse the recommendations by adding their signature as soon as practicable.
• If a decision not to attempt CPR is made on initial admission a consultant must be involved at that time.
• Relatives must be reassured that they are not responsible for the decision, but may be key to ascertaining the patient’s wishes.
• Neither patients nor relatives can demand treatment which the healthcare team judges to be inappropriate, this includes CPR.
• Careful exploration of patients or relatives understanding of the illness and CPR may be required if the patient or relative express concerns regarding a decision not to attempt CPR or specific therapies that have been discussed.
• The ReSPECT document and CPR status must be reviewed if there is a significant change in the patient’s clinical condition (positive or negative) as part of the care planning process and clearly documented in their clinical records. Otherwise, it remains indefinite.
• All patients who have a Personalised End of Life Care Plan must have a ReSPECT document completed indicating a decision that CPR attempts are not recommended.
• 16 and 17-year-olds: Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.

6.4. Communicating Decision Relating to Treatment Escalation
Communication and the provision of information are essential parts of good quality care. The patient must be provided whenever appropriate, with information about ReSPECT and resuscitation decisions and must be offered advice and support from clinical staff. Decisions about resuscitation and treatment escalations should be recorded clearly in the relevant sections of the ReSPECT document, together with the reasons for it and the names and designation of those involved in the discussion and decision. Discussion about treatment escalation planning and resuscitation should not be forced on patients who indicate that they do not wish to discuss this topic. However, it should be highlighted that the clinicians responsible for care may need to act in the patient’s best interests if the patient deteriorates and does not have the capacity at the time to be involved in the ReSPECT process.
It is not always necessary to discuss ReSPECT or decisions relating to CPR with a patient, their family and or carers, where end of life care is being provided and death is imminent. However, clinicians have to justify their actions and record this on the form. All reasonable efforts must be made to inform the next of kin, if the patient does not have capacity, of a ReSPECT plan and CPR decision as soon as is practicable or if the patient has expressed this wish. A summary of communication must be entered on the ReSPECT Document and must be supported with further details in the clinical notes. If you are unable to contact next of kin, this must be recorded on the form and must be supported with further detail in clinical notes.

If no discussion takes place, either with the patient or with those close to them, the reasons for this must be recorded on the ReSPECT Document. Decisions concerning the treatment escalation and resuscitation status of a patient must be clearly communicated to the appropriate members of the multidisciplinary team involved in the patient’s care. This involves documentation in the clinical records, completing the relevant section on the form and ensuring information is shared verbally at handovers relating to the patient.

If a patient is transferred between departments or wards, any treatment escalation plans must be communicated and the ReSPECT document must be available for staff to see within the clinical records.

The ReSPECT document must be stored inside the front cover of the patient’s current medical notes whilst clinically relevant and the patient is an in-patient.

6.5. Discharge of Patients with a ReSPECT document
The ReSPECT process and document can be used help facilitate a patient’s wishes to die at home and avoid an inappropriate transfer to hospital at the end of their life. On discharge from hospital, the decision relating to treatment escalation must be reviewed and either continued or cancelled.

If the decision is still clinically relevant this must be entered on the Trust electronic discharge form as “Patient discharged with a ReSPECT document”.

The original ReSPECT document follows the patient to their destination: Care Home, Hospice or private residence and is the patient’s property. A photocopy of the form must be made and retained in the clinical notes as a reference clearly marked as COPY which will be scanned onto the electronic patient record and filed under the Resuscitation tab.

If, on discharge to a private place of residence and the team have been unable to discuss the ReSPECT document (despite all reasonable efforts) with either the patient and or the relatives, the decision should be cancelled and the GP informed of the reason for cancellation. This should be included in the discharge summary.

6.6. Admission of a Patient with a decision not to attempt CPR
The Trust will accept active ReSPECT or DNACPR forms (red border outline). The acceptance of the Red Border form initiated in another care setting is an interim process until ReSPECT has been introduced into the wider care setting.

Any patient accepted with a DNACPR form must be reviewed on admission and a ReSPECT form completed within four hours.

No Red Border DNACPR forms will be issued from the Trust after 30th September 2018 but existing forms may stay in place until a patient review has occurred and if still valid, transferred to a ReSPECT form. If a different form (not a ReSPECT or red border DNACPR) is presented the decision will be reviewed and if upheld a ReSPECT form written. This is to avoid any misunderstanding and confusion at the time of deterioration of a
patient’s condition. The original form may be stored in clinical records but must be returned to the patient on discharge if still relevant. If, on admission, when the patient’s condition is reviewed, and the decision is no longer clinically appropriate, the decision may be cancelled and the form filed in the patient’s notes with clear documentation about the rationale for cancellation. If the decision not to attempt CPR was the patient’s wishes and they had not changed their view, the decision must be upheld.

6.7. Changes to the ReSPECT document
If significant changes to the ReSPECT decisions occur due to change in patient’s condition or expressed wishes, section 9 of the form, Confirmation of Validity (change of condition) MUST be completed by the clinician making the decision. Once this is completed, the ReSPECT document must be crossed through with two lines with the instruction “Cancelled”. The cancelled document must be stored in the patient’s clinical records. This decision must be made by a doctor at ST3 level equivalent or above. A new ReSPECT document must be completed and any change in a patient’s treatment escalation plans must be communicated by documentation in clinical records and at verbal handover of the patient’s care. All forms must remain easily legible, applicable and interpretable by all healthcare providers.

6.8. Advanced Decisions
If CPR is not in accord with a valid Advanced Decision (formerly called advanced directive or “living will”) that is applicable in the current clinical circumstances, or with the recorded, sustained wishes of a patient with capacity, it should not be attempted.
   a) An assessment of mental capacity must be made
   b) A ReSPECT document must be completed to record this decision
   c) It is recommended that if there is any doubt about the clarity of an Advanced Decision for a particular patient, that it should be discussed early with the Trust’s legal advisor as they can be both ethically and legally complex.
   d) Adherence to the Mental Capacity Act (2005), which came into force on 1st April 2007, is a legal requirement and should always be referred to when considering Advanced Decisions and decisions relating to CPR.

6.9. Lasting Power of Attorney (LPA)
A patient over the age of 18 can appoint someone to make decisions about their financial, personal welfare and health matters if, at some stage, they may lack the capacity to make these decisions.

LPA’s are clearly defined as:
   a) A personal welfare LPA - this is for decisions about both health and personal welfare.
      It can include the power for the attorney to give or refuse consent to life sustaining treatment* if this power has been expressly given in the LPA.
   b) A property and affairs LPA - this is for decisions about financial matters.

A personal welfare LPA can only be used once the form is registered at the Office of the Public Guardian (OPG) and the patient has become mentally incapable of making decisions about their own welfare. A copy of the LPA should be provided to the team who should take a copy and record it as part of the medical notes.

*Life-sustaining treatment: definition
‘Life-sustaining treatment’ means care, surgery, medicine or other help from doctors that is needed to keep someone alive. Life-sustaining treatment can include:

- a serious operation, such as heart bypass surgery
- chemotherapy, radiotherapy or another cancer treatment
- an organ transplant
- artificial nutrition or hydration (food or water given other than by mouth)

Whether some treatments are life-sustaining depends on the situation. For example, if someone had pneumonia, a course of antibiotics could be life-sustaining.

Decisions about life-sustaining treatment can be needed in unexpected circumstances. One example is a routine operation that didn’t go as planned.

6.10. Paediatric Specific Considerations

For children under the age of 16, specific considerations need to be taken into account:

a) The Consultant responsible for the patient’s care must make the decision

b) Careful discussion must have taken place with patient (if appropriate) and the parents or legal guardian

c) The ReSPECT document covers all ages and can be used for paediatric patients if the Consultant feels it appropriate. Careful documentation must be made in clinical notes regarding treatment options and this must be communicated to all professionals caring for the child.

7. TRAINING

7.1. Training Strategy

The Resuscitation Services’ strategy for resuscitation training embodies the statements and guidelines published by the Resuscitation Council (UK) and the European Resuscitation Council, incorporating the most recent updates to these guidelines. This explicitly incorporates the identification of patients at risk from cardiac arrest and a strategic approach to implement preventative measures.

The Resuscitation Service will ensure provision of sufficient and appropriate resuscitation training for all staff groups, to enable them to carry out their duties and responsibilities, relating to resuscitation.

A range of training courses and workshops will be made available to all staff, delivered in appropriate surroundings, and with access to specialist training equipment, which will be delivered within the Trust Education Centres or in the clinical environment. This training will be provided using a variety of educational techniques and systems.

The approach to teaching is one of positive encouragement and proven educational efficacy which follows the recommendations for resuscitation teaching advocated by the Resuscitation Council (UK) (Bullock et al, 2008).

Attendance at resuscitation training is registered and monitored.

- Non-attendees are flagged and reported to the line manager.
- Reports regarding non-attendance at training will be presented to the Resuscitation Committee and Mandatory Training Committee for escalation and action.
• Staff will undergo resuscitation training to a level appropriate for their expected clinical responsibilities as described in the training matrix.

7.2. General Training Recommendations
Trust staff are required to undertake resuscitation training as defined by the Trust's Mandatory Training Matrix.

All Doctors, Nurses, Midwives and Allied Health Professionals must be adequately and regularly trained in cardiopulmonary resuscitation appropriate to their discipline

7.3. Clinical staff
All medical staff below the grade of consultant must attend annual basic life support training. Consultants must attend biennial basic life support training.

All medical registrars that are expected to be on the on-call rota MUST hold a current Advanced Life Support (RC UK) certificate.

New nursing staff, HCA’s and AHP’s must attend basic life support training during their induction week, if this is not possible, they must attend training within the first two weeks of their employment.

All nursing staff, HCA’s and AHP’s must renew their basic life support training every two years.

All nursing staff that take charge of a ward or department should hold an in-date ILS certificate.

All members of the cardiac arrest / priority team must hold a Resuscitation Council (UK) (RC UK) Advanced Life Support (ALS) certificate, with junior members (FY1’s, ODP’s) holding (as a minimum) an Immediate Life Support (ILS) certificate.

Site Coordinators at Ashford hospital must hold (as a minimum) ILS certification, at night and at weekends, the Site Coordinator must hold ALS Certification.

It is the responsibility of each manager to ensure that all non-clinical staff are aware how to access and initiate an emergency / cardiac arrest call.

Staff remain accountable for their actions and are responsible for their own professional development. If at any time a member of staff should feel unsure about resuscitation procedures or feels a lack of confidence they should seek re-training immediately.

7.4. Non-clinical staff
There is no requirement for non-clinical staff to receive basic life support training, however training will be offered if capacity and resources allow.

7.5. Defibrillator
Defibrillators must only be operated by persons specifically trained in their use. All staff that would be expected to operate a defibrillator in manual mode must be trained to the standard of Immediate Life Support (ILS) or Advanced Life Support (ALS) and Paediatric equivalent
courses. It is the individual practitioner’s responsibility to ensure they maintain compliance according to Trust policy and professional registration.

The use of an Automatic External Defibrillator (AED) is included in the BLS training sessions.

7.6. ReSPECT Training
It is advised that all staff involved with ReSPECT take part in the online training module which can be undertaken using the web-app at the following link:

https://learning.respectprocess.org.uk/

On completion a certificate can be printed and kept for revalidation purposes.

8. IMPLEMENTATION

This document will be made available to all staff through the TrustNet. The implementation of ReSPECT will be audited with an initial requirement for quarterly audits presented to the Resuscitation Committee.

9. REVIEW, RATIFICATION, AND ARCHIVING

This policy will be reviewed every 3 years or whenever national policy or guideline changes are required to be considered (whichever occurs first), following which, it will be subject to re-ratification. The policy is developed by the Resuscitation Service and ratified by the Resuscitation Committee and is accepted as a Trust-wide policy.

10. DISSEMINATION AND PUBLICATION

Dissemination of the final policy is the responsibility of the author. They must ensure the policy is uploaded on the TrustNet. The Head of Communications is then responsible for Trust-wide notification of new and revised working documents. Clinical Directors, Associate Directors or supporting services management teams, Ward Managers and Heads of Department as applicable are responsible for distributing this policy and ensuring that all staff under their management (including bank, agency, contracted, locum and volunteers) are aware of the policy.

11. REFERENCES

Mental Capacity Act 2005 Department of Health
National Health Service Litigation Authority (20011/12) NHSLA Risk Management Standards for Acute Trusts
Resuscitation Council (UK) (2015) Quality standards for cardiopulmonary resuscitation practice and training
NCEPOD Time to Intervene? A report by the National Confidential Enquiry into Patient Outcome and Death (2012).

12. Useful Websites

www.resus.org.uk
www.alsg.org
www.erc.edu
www.respectprocess.org.uk
www.rcplondon.ac.uk
www.rcoa.ac.uk
www.rcseng.ac.uk
www.swlandstn.com

13. Monitoring compliance

<table>
<thead>
<tr>
<th>Measurable Policy Objective</th>
<th>Monitoring/Audit method</th>
<th>Frequency of monitoring</th>
<th>Responsibility for performing the monitoring</th>
<th>Monitoring reported to which groups/committees, inc responsibility for reviewing action plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy will be reviewed by their author at least annually to ensure that they remain valid and in date.</td>
<td>Annual</td>
<td>Resuscitation Services Manager</td>
<td>Resuscitation Committee</td>
<td></td>
</tr>
</tbody>
</table>

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Appendix 1

Equality Impact Assessment Summary

Name and title: Paul Darling-Wills, Resuscitation Manager
Policy: Resuscitation and ReSPECT Policy

<table>
<thead>
<tr>
<th>Background</th>
<th>Who was involved in the Equality Impact Assessment</th>
</tr>
</thead>
</table>

This policy sets out the process to be followed with regards to Resuscitation and ReSPECT (Recommended Summary Plan for Emergency Care & Treatment).

The policy is applicable to all staff and all patients.

Equality Impact Assessment carried out by Paul Darling-Wills, Resuscitation Services Manager.

<table>
<thead>
<tr>
<th>Methodology</th>
<th>A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The data sources and any other information used</td>
</tr>
<tr>
<td></td>
<td>The consultation that was carried out (who, why and how?)</td>
</tr>
</tbody>
</table>

A review of the policy failed to identify any adverse or potentially adverse impacts for any equalities groups

<table>
<thead>
<tr>
<th>Key Findings</th>
<th>Describe the results of the assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Identify if there is adverse or a potentially adverse impacts for any equalities groups</td>
</tr>
</tbody>
</table>

The policy does not involve any adverse or potentially adverse impacts for any equalities groups

<table>
<thead>
<tr>
<th>Conclusion</th>
<th>Provide a summary of the overall conclusions</th>
</tr>
</thead>
</table>

There are no identified adverse or potentially adverse impacts for any group of patients.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>State recommended changes to the proposed policy as a result of the impact assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Where it has not been possible to amend the policy, provide the detail of any actions that have been identified</td>
</tr>
<tr>
<td></td>
<td>Describe the plans for reviewing the assessment</td>
</tr>
</tbody>
</table>

None.
# 2222 RECORD OF EVENTS FORM

This form must be completed after every 2222 event.

## 1. Location of event

- Pre-hospital
- In hospital
- Location / Ward

## 2. Reason for admission / visit

- In-patient
- Outpatient
- Medical
- Trauma
- Visitor
- Emergency / urgent surgery
- Obstetric
- Others

## 3. What was the event?

- Respiratory arrest
- Cardiac/respiratory arrest
- Collapsed patient
- Face Alarm
- ⏳

If it was a false alarm stop completing details here. Complete section 9 and return form to Sansum Docs.

**Did Patient receive CPR?**

- Yes
- No

**Time resuscitation stopped**

**Any additional information, please continue on reverse**

## 4. MEWS Scoring / Outreach Assessment

- What was the last MEWS score before the event?
- Score:
- Time:
- Date:

**Had the patient been reviewed by outreach team / CRNP?**

- Yes
- No

## 5. Initial Arrest Rhythm

- Ventricle fibrillation
- Shockable – unknown rhythm
- Ventricle tachycardia
- Non-shockable – unknown rhythm
- PEA
- Non-shockable Bradycardia
- Asystole
- Unknown

## 6. Intervention Log – What was done?

- Time
- Rhythm
- Shock
- Adrenaline
- Genralised /epinephrine (1mL)
- LUCAS

**LUCAS Time started**

**EZ O2 used?**

- Yes
- No

**Temp:**

**Time resuscitation stopped**

**Any additional information, please continue on reverse**

## 7. Why was resuscitation stopped?

- Survived – return of spontaneous circulation for 24hrs or more
- Died – return of spontaneous circulation for less than 24hrs
- Died – no return of spontaneous circulation
- Died – DNR identified
- Died – suicide

## 8. Post Cardiac Arrest Location

- **Transient Location (if applicable):**
  - CT Scan
  - Imaging
  - Theatre
  - Catheter Lab

- **Longer term Post Arrest Location:**
  - CCU
  - ITU
  - HDU
  - Other
  - Mortuary

## 9. Person filling form (print clearly) / Event team leader (print clearly)

- Print Name
- Signature
- Designation
- Contact no / Bleep

- Print Name
- Signature
- Designation
- Contact no / Bleep
Appendix 3

Resuscitation Committee Terms of Reference

Constitution:
The Clinical Governance Committee hereby resolves to establish a sub-committee to be known as the Resuscitation Committee

Authority
The Resuscitation Committee can authorise and implement operational policies governing cardiopulmonary resuscitation, practice and training. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee.

Membership
Consultant Cardiologist (Chair)
Resuscitation Services Manager and team
Consultants in Anaesthetics, Paediatrics, Medicine and A&E
CPE’s from all disciplines
Clinical Risk Manager
CSNP Lead
Senior Nurse BMI Runnymede Hospital
Others as required

Attendance:
Attendance at meetings is essential. In exceptional circumstances when a member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum, 75% of the meetings per calendar year.

Quorum:
A quorum of 5 is required to conduct the meeting to exercise all or any of the authorities, powers and discretions invested in or exercisable by the committee. The membership split should be 3 Clinical staff and 2 Managers.

Frequency and Conduct:
The committee will meet regularly. Items for the agenda should be submitted to the secretary 10 days prior to the meeting. The agenda, minutes and papers will be sent out one week before the meeting.
Membership and terms of reference will only be changed with the approval of the committee and will be reviewed and agreed annually.

Duties:
1. Healthcare organisations admitting acutely ill patients must have a Resuscitation Committee with clearly defined terms of reference.
2. The organisation must have an executive board member responsible for resuscitation services. According to Health Services Circular 2000/028, Chief Executives must ensure that a non-executive Director of the Trust is given designated responsibility on behalf of the Trust Board to ensure that a resuscitation
policy is agreed, implemented, and regularly reviewed within the clinical governance framework.

3. The Resuscitation Committee must be part of the organisation’s management structure (e.g. clinical governance, clinical risk, quality improvement, education committees).

4. The Resuscitation Committee must include representatives from stakeholder groups and appropriate specialties. The exact composition of the committee will depend on local needs and arrangements.

5. The chair of the Resuscitation Committee must be a senior clinician with an active and credible involvement in resuscitation. This individual would be expected to have the authority to drive and implement change.

6. The Resuscitation Committee must have administrative support.

7. The Resuscitation Committee is responsible for implementing operational policies governing cardiopulmonary resuscitation, practice and training.

8. In the absence of other organisational arrangements, the Resuscitation Committee must also be responsible for implementing operational policies governing the prevention of cardiac arrest.

9. According to local arrangements, it is recommended that the Resuscitation Committee provides advice to other local healthcare organisations that do not have the necessary expertise in resuscitation issues. In some healthcare communities this is achieved very effectively by having a Resuscitation Committee that spans all the relevant organisations.

10. The Resuscitation Committee must determine the level of resuscitation training required by staff members.

11. At least twice-yearly meetings of the Resuscitation Committee are recommended.

12. Responsibilities of the Resuscitation Committee include:
   a. ensuring implementation and adherence to national resuscitation guidelines and standards;
   b. defining the role and composition of the resuscitation team;
   c. ensuring that resuscitation equipment for clinical use is available and ready for use;
   d. ensuring that appropriate resuscitation drugs (including those for peri-arrest situations) are available and ready for use;
   e. planning adequate provision of training in resuscitation;
   f. determining requirements for and choice of resuscitation training equipment;
   g. preparing and implementing policies relating to resuscitation and treatment of anaphylaxis;
   h. preparing and implementing policies relating to prevention of cardiac arrest;
   i. preparing and implementing a policy on resuscitation decisions, (e.g. DNACPR decisions), and advanced care planning (this is usually in collaboration with palliative care teams);
   j. quality improvement - action plans based on audits, e.g. review of audit data using National Cardiac Arrest Audit data for benchmarking;
   k. recording and reporting of patient safety incidents in relation to resuscitation.

The Resuscitation Committee must ensure that there is defined financial support for the resuscitation service.
Appendix 4

National Early Warning Score

<table>
<thead>
<tr>
<th>Physiological parameter</th>
<th>Score 0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiration rate (per minute)</td>
<td>≤8</td>
<td>9–11</td>
<td>12–20</td>
<td>21–24</td>
</tr>
<tr>
<td>SpO₂ Scale 1 (%)</td>
<td>≤91</td>
<td>92–93</td>
<td>94–95</td>
<td>≥96</td>
</tr>
<tr>
<td>SpO₂ Scale 2 (%)</td>
<td>≤83</td>
<td>84–85</td>
<td>86–87</td>
<td>88–92</td>
</tr>
<tr>
<td>Air or oxygen?</td>
<td>Oxygen</td>
<td>Air</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic blood pressure (mmHg)</td>
<td>≤90</td>
<td>91–100</td>
<td>101–110</td>
<td>111–219</td>
</tr>
<tr>
<td>Pulse (per minute)</td>
<td>≤40</td>
<td>41–50</td>
<td>51–90</td>
<td>91–110</td>
</tr>
<tr>
<td>Consciousness</td>
<td>Alert</td>
<td>Alert</td>
<td>Alert</td>
<td>Alert</td>
</tr>
<tr>
<td>Temperature (°C)</td>
<td>≤35.0</td>
<td>35.1–36.0</td>
<td>36.1–38.0</td>
<td>38.1–39.0</td>
</tr>
</tbody>
</table>
Appendix 5

**Composition of 2222 Priority Teams**

The composition of 2222 priority teams is decided by the Resuscitation Services Manager and team and ratified by the Resuscitation Committee.

The use of the 2222 priority system must be exclusively used by the teams listed below.

Priority bleeps should be configured to include only those persons below.

**The Resuscitation Team**

At least two members of the Adult Resuscitation Team should have a current Advanced Life Support (ALS) qualification. The team will consist of the following staff:

- Medical Registrar
- Anaesthetist
- FY2 x 2
- FY1 x 1
- Resuscitation Officer
- Anaesthetic assistant (ODP)
- Outreach Nurse
- Clinical Site Nurse Practitioner (outside of office hours)

**Trauma Team**

At least two members of the Trauma Team should have a current Advanced Trauma Life Support (ATLS) qualification. The team will consist of the following:

- A&E Consultant
- Anaesthetist
- A&E FY2
- Surgical SpR / Speciality Trainee / plus FY2
- Orthopaedic SpR / Specialist Trainee / plus FY2
- Resuscitation Officer
- Anaesthetic assistant (ODP)

**Paediatric Team**

At least two members of the Paediatric Team should have a current Advanced Paediatric Life Support (APLS) qualification (or equivalent). The team will consist of the following:

- Paediatric Consultant
- Paediatric SpR / Specialist Trainee
- Anaesthetist
- Paediatric FY2 x 2
- Senior Nurse from A&E and the paediatric ward.
- Resuscitation Officer
- Anaesthetic assistant (ODP)
**Neonatal Team**
At least two members of the Neonatal Team should have a current Advanced Resuscitation of the Newborn Infant (ARNI) or Neonatal Life Support (NLS) qualification. The team will consist of the following:

- Neonatal Consultant
- Neonatal Registrar
- NICU Shift Leader
- Anaesthetist
- Neonatal Nurse
- Resuscitation Officer

**Obstetric Team**
At least one member of the Obstetric Team should have a current Advanced Life Support in Obstetrics (ALSO) or Managing Obstetric Emergencies & Trauma (MOET) qualification. The team will consist of the following:

- Adult Cardiac Arrest team (as above).
- Neonatal Team
- On-call Obstetric Registrar.
- On-call Obstetric Anaesthetist
Appendix 6

Adult Cardiac Arrest Algorithm

Unresponsive and not breathing normally

Call resuscitation team

CPR 30:2
Attach defibrillator/monitor
Minimise interruptions

Assess rhythm

Shockable (VF/Pulseless VT)

1 Shock
Minimise interruptions

Immediately resume CPR for 2 min
Minimise interruptions

Return of spontaneous circulation

Immediate post cardiac arrest treatment
- Use ABCDE approach
- Aim for SpO₂ of 94-98%
- Aim for normal PaCO₂
- 12-lead ECG
- Treat precipitating cause
- Targeted temperature management

Non-shockable (PEA/Asystole)

Immediately resume CPR for 2 min
Minimise interruptions

During CPR
- Ensure high quality chest compressions
- Minimise interruptions to compressions
- Give oxygen
- Use waveform capnography
- Continuous compressions when advanced airway in place
- Vascular access (intravenous or intraosseous)
- Give adrenaline every 3-5 min
- Give amiodarone after 3 shocks

Treat Reversible Causes
- Hypoxia
- Hypovolaemia
- Hypo-/hyperkalaemia/metabolic
- Hypothermia
- Thrombosis - coronary or pulmonary
- Tension pneumothorax
- Tamponade – cardiac
- Toxins

Consider
- Ultrasound imaging
- Mechanical chest compressions to facilitate transfer/treatment
- Coronary angiography and percutaneous coronary intervention
- Extracorporeal CPR
Appendix 7

Traumatic Cardiac Arrest Algorithm
Appendix 8

Paediatric Cardiac Arrest Algorithm

---

During CPR
- Ensure high-quality CPR: rate, depth, recoil
- Plan actions before interrupting CPR
- Give oxygen
- Vascular access (intravenous, intraosseous)
- Give adrenaline every 3–5 min
- Consider advanced airway and capnography
- Continuous chest compressions when advanced airway in place
- Correct reversible causes
- Consider amiodarone after 3 and 5 shocks

Reversible Causes
- Hypoxia
- Hypovolaemia
- Hyper/hypokalaemia, metabolic
- Hypothermia
- Thrombosis (coronary or pulmonary)
- Tension pneumothorax
- Taponade (cardiac)
- Toxic/therapeutic disturbances

---

Unresponsive
Not breathing or only occasional gasps

Call resuscitation team
(1 min CPR first, if alone)

CPR
(5 initial breaths then 15:2)
Attach defibrillator/monitor
Minimise interruptions

Assess rhythm

Shockable
(VF/Pulseless VT)

1 Shock
4 J kg⁻¹

Immediately resume
CPR for 2 min
Minimise interruptions

Return of spontaneous
circulation

Immediate post cardiac
arrest treatment
- Use ABCDE approach
- Controlled oxygenation and ventilation
- Investigations
- Treat precipitating cause
- Temperature control

Non-shockable
(PEA/Asystole)

Immediately resume
CPR for 2 min
Minimise interruptions
Appendix 9
ReSPECT Form

1. Personal details

Full name
NHS/CHI/Health and care number

Date of birth
Address
Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort
Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
Focus on symptom control as per guidance below

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended
Adult or child

For modified CPR
Child only, as detailed above

CPR attempts NOT recommended
Adult or child
5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? 

Yes / No

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? 

Yes / No / Unknown

If so, document details in emergency contact section below.

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

A. been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions
B. where appropriate, been discussed with a person holding parental responsibility
C. in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law
D. been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If D has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

7. Clinicians’ signatures

<table>
<thead>
<tr>
<th>Designation (grade/speciality)</th>
<th>Clinician name</th>
<th>GMC/NMC/HCPC Number</th>
<th>Signature</th>
<th>Date &amp; time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior responsible clinician</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Emergency contacts

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Telephone</th>
<th>Other details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal proxy/parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/friend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Consultant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
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9. Confirmation of validity (e.g. for change of condition)

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<th>Clinician name</th>
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Appendix 10

Anaphylaxis Algorithm

Anaphylactic reaction?

Airway, Breathing, Circulation, Disability, Exposure

Diagnosis - look for:
- Acute onset of illness
- Life-threatening Airway and/or Breathing and/or Circulation problems
- And usually skin changes

- Call for help
- Lie patient flat
- Raise patient’s legs

Adrenaline

When skills and equipment available:
- Establish airway
- High flow oxygen
- IV fluid challenge
- Chlorphenamine
- Hydrocortisone
- Monitor:
- Pulse oximetry
- ECG
- Blood pressure

1 Life-threatening problems:
Airway: swelling, hoarseness, stridor
Breathing: rapid breathing, wheeze, fatigue, cyanosis, SpO2 < 92%, confusion
Circulation: pale, clammy, low blood pressure, faintness, drowsy/coma

2 Adrenaline (give IM unless experienced with IV adrenaline)
IM doses of 1:1000 adrenaline (repeat after 5 min if no better)
- Adult: 500 micrograms IM (0.5 mL)
- Child more than 12 years: 500 micrograms IM (0.5 mL)
- Child 6-12 years: 300 micrograms IM (0.3 mL)
- Child less than 6 years: 150 micrograms IM (0.15 mL)

Adrenaline IV to be given only by experienced specialists
Titrate: Adults 50 micrograms; Children 1 microgram/kg

3 IV fluid challenge:
Adult - 500 – 1000 mL
Child - crystalloid 20 mL/kg
Stop IV colloid if this might be the cause of anaphylaxis

4 Chlorphenamine
(IM or slow IV)
- Adult or child more than 12 years: 10 mg
- Child 6 - 12 years: 5 mg
- Child 6 months to 6 years: 2.5 mg
- Child less than 6 months: 250 micrograms/kg

5 Hydrocortisone
(IM or slow IV)
- 200 mg
- 100 mg
- 50 mg
- 25 mg
Appendix 11

Basic Life Support in Pregnancy

SAFE

Stimulate and assess response

Shout for help

Ensure left lateral tilt
Call for help
Assess breathing, P, BP
Regularly reassess

Open Airway

Turn onto back
Check for obstruction
Head tilt
Chin lift

Breathing normally
Turn into recovery position
Check help is on the way
Assess breathing, Pulse, BP, Regularly reassess

Assess for breathing and pulse for up to 10 seconds

If NOT breathing normally, call resuscitation team and start CPR

CPR 30:2 until defibrillator arrives

Ensure resuscitation team and senior obstetrician called

Continue BLS until patient demonstrates signs of life or help arrives to provide ALS

Rate of 100 / 120 min
Centre of chest
Depress 5-6cm
Ensure left lateral tilt or manual uterine displacement

Minimise interruption to chest compressions
Change rescuer every 2 minutes if possible, to avoid fatigue

Look for chest movements
Listen for breath sounds
Feel for air

Assess for breathing and pulse for up to 10 seconds

Ensure left lateral tilt
Call for help
Assess breathing, P, BP
Regularly reassess

Turn into recovery position
Check help is on the way
Assess breathing, Pulse, BP, Regularly reassess

Assess breathing, P, BP
Regularly reassess