Resuscitation Policy

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Lincolnshire Community Health Services NHS Trust

Resuscitation Policy

Quick Reference Guide

This policy must be followed at all times to ensure that there is a high quality and robust resuscitation service available for patients, staff and visitors at all times.

For quick reference the guide below is a summary of the principals of LCHS resuscitation practice and actions.

This is not a substitute for correct local induction processes for temporary or locum staff and it does not negate the need for all staff to be aware of and follow the full detail of this policy

1. All patients, staff and visitors will receive safe, early and appropriate Cardiopulmonary Resuscitation, including early defibrillation, when required unless specifically precluded by a ReSPECT process document.

2. All staff must know how to summons assistance and initiate the call to the emergency services in any area in which they work.

3. All staff will attend annual resuscitation training relevant to their role to include Basic Life Support actions and an awareness of Automated External Defibrillators (AED). However, the use of AED's is not restricted to trained personnel, as 'such restrictions are against the interests of the cardiac arrest victim' (Resuscitation Council, 2009)

4. All resuscitation equipment must be checked on a daily basis and after use by a registered practitioner or a person designated to do so and appropriate records of the checks made completed.

5. To enable the monitoring of compliance to this policy a Datix report will be completed for any situation requiring life support actions. All cardiac arrests will be recorded on the Current Arrest Audit Form, and all patient deaths will be reviewed by the Mortality Review Panel.

Lincolnshire Community Health Services NHS Trust

Resuscitation Policy

Version Control Sheet

Version	Section/Para/Appendix	Version/Description of Amendments	Date	Author/Amended by
2	10.7	Change to wording to reflect responsibilities	13.08.10	J Anderson
2	12.0	AND Policy Number added	13.08.10	J Anderson
3	2.4	Resuscitation Council Guideline reference changed to October 2010	06.01.11	J Anderson
3	6.1	Skegness response changed to '999 call to Emergency Services'	06.01.11	J Anderson
3	8.2	Wording changed to reflect current guidelines.	06.01.11	J Anderson
3	Appendix 1	Updated to reflect Resuscitation Guidelines (October 2010)	06.01.11	J. Anderson
3	Appendix 2	Updated to reflect Resuscitation Guidelines (October 2010)	06.01.11	J. Anderson
3	Appendix 3	Updated to reflect Resuscitation Guidelines (October 2010)	06.01.11	J. Anderson
3	Appendix 4	Added Adult Bradycardia	06.01.11	J. Anderson
3	Appendix 5	Added Adult Tachycardia (with pulse)	06.01.11	J. Anderson
3	Appendix 6	Updated to reflect Resuscitation Guidelines (October 2010)	06.01.11	J. Anderson
3	Appendix 7	Updated to reflect Resuscitation Guidelines (October 2010)	06.01.11	J. Anderson
3	Appendix 8	Updated to reflect Resuscitation Guidelines (October 2010)	06.01.11	J. Anderson

3	Appendix 10 (previously Appendix 9)	Updated to reflect Resuscitation Guidelines (October 2010)	06.01.11	J. Anderson
3	10.2	Wording amended to reflect change in Resuscitation Guidelines (October 2010)	06.01.11	J. Anderson
3	Trust Logo	Logo update to reflect change to LCHS NHS Trust	1.4.11	J Anderson
3	Appendix 10	ALS Algorithm added to reflect practice in some areas of the organisation.	17.4.11	J Anderson
3	Appendix 11	Training Matrix updated by Lincolnshire Learning Academy.	21.4.11	J. Anderson
4	Policy Statement	Personnel Titles changed in line with new organisation	3.1.12	J. Anderson
4	2.1	Wording added to reflect use of Unified DNACPR Policy principles	3.1.12	J Anderson
4	3	Wording change – Resuscitation Committee	3.1.12	J. Anderson
4	4	Wording changed to reflect current practice	3.1.12	J. Anderson
4	5.2	Wording changed to reflect current guidance	3.1.12	J Anderson
4	10	Revised and wording changed to provide clarity on equipment provision.	3.1.12	J Anderson
4	13.1 – 13.3	Names changed to reflect current organisation	3.1.12	J. Anderson
4	2.1	Wording amended to reflect NEWS	16.11.12	J. Anderson
4	4.6/7	Wording amended	16.11.12	J. Anderson
4	10.7/9	Amended to reflect equipment checking process	16.11.12	J. Anderson
5		Full policy review	2.3.14	J. Anderson
6		Full Policy Review	1.5.16	T. Balderstone

7	All	Changes to reflect ReSPECT process adoption and policy updates	5.11.18	T. Balderstone

Policy Statement

Lincolnshire Community Health Services NHS Trust (the "Trust") is committed to ensuring that there are robust processes for effective, clear and consistent evidence based guidance to LCHS staff to ensure an effective response to, and the management of a cardiac arrest or medical emergency, with in place to respect the individual rights of patients during emergency situations, which are understood by any staff involved in delivering care to patients.

This document has been developed to set out the essential key aspects of the systematic approach required to ensure that the Trust does deliver services that promote best practice and that ensures that the Trust complies as a minimum with its statutory legal requirements.
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This document must be read in conjunction with associated portfolio of core documents as detailed within the Document Portfolio that serve to provide detailed guidance and to ensure that the Trust responsibilities in relation to Resuscitation Guidelines are embedded.
In some cases documents may feature within the portfolio of multiple policies where overlapping situations and processes exist.

Responsibilities

This document applies to all staff employed (or contracted) by the Trust.
All staff are required to ensure that they work within the boundaries set out by this policy

Dissemination

This policy will be available/accessible via the LCHS website.

Links with other policies

This policy should be read in conjunction with other local and national documents to include but not exclusively:

P-CS-54 - ReSPECT Policy
P-CS-32 – Anaphylactic Reaction- Management Procedure
P-CS-16 – Physiological Observations
P-CS-49 – Sepsis Screening Policy
P-CS-46 – Medical Gases Policy

Supporting documents are detailed within the Document Portfolio.

Resource implication

The resource implications of this policy are primarily related to the provision of training and equipment to support the delivery of resuscitation care within the Resuscitation Council (UK) Resuscitation Guidelines.
Failure to meet published guideline standards could lead to patient harm and reputational damage and imposition of financial penalties.

Contents

Resuscitation Policy

1. Introduction

It is the aim of Lincolnshire Community Health Services to provide a high quality, consistent and evidence based response from appropriately skilled staff to any sudden collapse, medical emergency or cardiopulmonary arrest within their work environments.

In the context of this document the term resuscitation applies to and includes cardiopulmonary arrest, paediatric and medical emergencies involving life support actions.

Summary

LCHS recognises that an effective response to, and the management of a cardiac arrest or medical emergency is a key objective

The Trust will aim to achieve the core standards for Resuscitation, (*Quality Standards for cardiopulmonary resuscitation practice and training, Resuscitation Council, 2013, 2016*) :

➢ Ensuring effective communication arrangements to summon an appropriate response
➢ An early warning system is in place for the recognition of patients at risk of cardiac arrest (Patient Safety First, NPSA, 2009) LCHS uses the National Early Warning Score.
➢ Ensure access to appropriate equipment, including defibrillators / Automated External Defibrillators to ensure defibrillation can be achieved in 3 minutes
➢ Provide access to appropriate training and development to ensure the competencies of staff
➢ Ensure all training in accordance with Resuscitation Council (UK) Resuscitation Guidelines 2015
➢ Ensure staff understand decisions specific to cpr and ReSPECT Policy is in place.
➢ Reporting of all Life Support actions using Datix and review of all deaths following cardiac arrest where LCHS staff are present by the Mortality Review Panel.

2. Key Responsibilities

Chief Executive
The Chief Executive has overall accountability for life support actions within the Trust.

Heads of Clinical Service
Each Head of Clinical Service is accountable for promoting this policy to staff.

Resuscitation Lead
The Resuscitation Lead is responsible for reporting implementation of this policy and relevant audit processes to the Safeguarding & Patient Safety Committee.

Clinical Leads
Clinical leads responsibilities include:
➢ Bringing the policy to the attention of all departmental staff

- ➢ Accountability for implementing the Resuscitation policy within their area of responsibility
- ➢ Ensuring appropriate actions are taken following receipt of any Resuscitation related risk assessments
- ➢ Ensuring that all staff undertake the necessary training to fulfil their specific roles within the organisation in accordance with the Resuscitation Training Matrix
- ➢ Ensuring staff undertake incident reporting (Datix & Cardiac Arrest Audit as appropriate) for all incidents involving life support actions.

Staff
- ➢ All staff members have a responsibility to:
- ➢ Maintain competence in resuscitation techniques through participation in training in accordance with the Resuscitation Training Matrix.
- ➢ Responding to cardiac arrest and medical emergencies in accordance with Resuscitation and ReSPECT policies.
- ➢ Report and take part in audit processes for cardiac arrests and medical emergencies in accordance with LCHS policies and procedures
- ➢ Ensure they are aware of the location of, and have easy access to personal protective equipment.

Resuscitation Committee
Resuscitation Committee functions will be undertaken as part of the Safeguarding and Patient Safety Committee.
Responsibilities will include:
- ➢ Establishing the standards of all resuscitation training.
- ➢ Evaluating the effectiveness of the service through clinical audit
- ➢ Monitoring the implementation of the policy and taking appropriate action
- ➢ Equipment – needs, risk assessment and deployment

Reports including resuscitation matters to be standing agenda items.

3. Training and Competency

All resuscitation training will be delivered to current Resuscitation Council (UK) guidelines.

Staff will undertake regular resuscitation training at a level appropriate to their expected clinical responsibilities.

Resuscitation training standards for all areas are identified in **Appendix 4** New members of staff will have resuscitation training incorporated into their induction programme.

Specific training for cardiopulmonary arrests in special circumstances (e.g. paediatrics, trauma and pregnancy will be provided for staff working in the relevant specialities.

4. Procedures for Resuscitation

The management of a medical emergency should follow the current algorithms produced by the Resuscitation Council (UK) and contained within the **Document Portfolio**

Mouth to mouth ventilation can no longer be supported. **Only until** appropriate personal protective and airway management equipment (e.g. pocket mask, bag valve mask and supraglottic airway) is available compression-only CPR with manoeuvres to maintain an airway should be carried out.

Chest compressions with ventilations is the minimum standard expected of a Health Care provider.

Resuscitation Council (UK) recommends that standard principles of infection control and droplet precautions are the main control strategies to be used in the resuscitation of patients and should be followed rigorously.

The Resuscitation Council (UK) has issued guidance for *Safer Handling during Cardiac Arrest in Health Settings*, in order to minimise risk to the rescuer as far as is reasonably practicable.

Active treatment will be provided for all patients in the absence of a valid Do Not Attempt CPR order/ADRT.

5. Responsibilities of the care team in the event of a Cardiac Arrest

It is the responsibility of the senior clinician present to ensure that the following record keeping requirements are met in a timely manner;-

- ➢ an incident report, DATIX, is completed

- ➢ where appropriate a resuscitation audit form is completed and submitted

- ➢ comprehensive care notes are made

Record keeping requirements do not diminish in the event of a clinical incident and all normal Trust requirements must be met including records of contact with the next of kin.

Where possible allow the staff involved in the arrest time together to debrief. Managers should facilitate contact with Occupational Health to support the staff if required or requested.

6. Decisions to not attempt CPR (ReSPECT)

It is essential to identify patients for whom cardiopulmonary arrest represents an appropriate terminal event and for whom cardiopulmonary resuscitation is inappropriate.

All decisions regarding the appropriateness of cpr and other resuscitation actions MUST be made with reference to P_CS_54 ReSPECT Policy.

Where an decision has not been made and the wishes of the patient are unknown or undocumented, resuscitation must be initiated if cardiac arrest occurs.

Completion of a ReSPECT form with a decision not to attempt cpr does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded. Examples of such reversible causes include, but are not restricted to, choking or a blocked tracheostomy tube.

ReSPECT process decisions to not undertake cpr **MUST NOT inhibit normal treatment actions such as hydration & nutrition, oxygen** administration or airway suction that may be an expected element of a persons normal care.

The review of appropriateness of interventional treatments is an anticipated element of the ReSPECT process and guidance for health care providers on the goals of treatment is an intrinsic part of the ReSPECT form.

Some patients may have an advanced decision to refuse treatment (ADRT) and this **must** be brought to the attention of the clinical team as it may have an impact on the ReSPECT process and any cpr decision.

7. Audit and Reporting Standards

Audit of the practice, process and outcomes of resuscitation attempts is essential and accurate data from all resuscitation attempts is required for audit, training and medico legal purposes.

There should be a local review of all resuscitation attempts within the service area.

Completion of the Cardiac Arrest Audit Form and Incident Report (Datix) is essential. These will be considered alongside the service area first stage report as part of the Mortality Review Panel for all incidents where LCHS staff are present.

Any resuscitation attempts deemed inappropriate by clinicians on completion of the Resuscitation Audit form will trigger a full second stage review by the Mortality Review Panel.

8. References

Resuscitation Council (Oct 2015) Resuscitation Guidelines
https://www.resus.org.uk/resuscitation-guidelines/
Last accessed 5/11/18

Resuscitation Council (UK) (2016) Quality standards for cardiopulmonary resuscitation practice and training – Community Hospitals
https://www.resus.org.uk/quality-standards/community-hospitals-care-quality-standards-for-cpr/
Last accessed 5/11/18

Resuscitation Council (UK) (2103) Quality standards for cardiopulmonary resuscitation practice and training – Primary Care
https://www.resus.org.uk/quality-standards/primary-care-quality-standards-for-cpr/
Last accessed 5/11/18

Resuscitation Council (Feb 2016) Advanced Life Support Manual 7th Edition

Resuscitation Council (Jul 2012) Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers
https://www.resus.org.uk/anaphylaxis/emergency-treatment-of-anaphylactic-reactions/
Last accessed 5/11/18

Resuscitation Council (Oct 2009) Cardiopulmonary Resuscitation and Pandemic H1N1 Influenza (Swine Influenza)
https://www.resus.org.uk/archive/archived-cpr-information/first-aid-advice-on-cpr-and-pandemic-h1n1/
Last accessed 5/11/18

Resuscitation Council (Jul 2015) Working Group: Guidance for Safer Handling during resuscitation in healthcare settings.
https://www.resus.org.uk/publications/guidance-for-safer-handling-during-cpr-in-healthcare-settings/
Last accessed 5/11/18

British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing(2016) Decisions relating to Cardiopulmonary Resuscitation (3rd edition - 1st revision)
https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/
Last accessed 5/11/18

ReSPECT Process
https://www.respectprocess.org.uk/
Last accessed 5/11/18

9. Document Portfolio

The documents appearing below are listed in two sections;

- Procedure guides and standing operating protocols – brief guides and excerpts from Trust protocols

- Supporting policies – details of freestanding policy documents held on the LCHS website.

These documents form the basis of the framework within which resuscitation practice should be undertaken within LCHS.

Where items are extracts from websites and full documents reference should always be made to the source to ensure information is up to date and applicable.

Any forms imaged within this portfolio will be found either as downloadable high quality printable image files or direct source links within the Deteriorating Patient/Resuscitation section of the trust intranet site.

Guide 1…..Adult Basic Life Support Procedures

Based on Resuscitation Guidelines 2015.

Lincolnshire Community Health Services operates in diverse environments from patients' homes and community venues to health care premises and hospitals.

Provision of a resuscitation service of true equality is therefore impossible however the principles of basic and life support are the same.

<u>Outside of healthcare premises</u>
For the prehospital, setting procedures can be limited by a combination of factors including a lack of trained staff, the setting (on scene or during transport), equipment availability and physical access to the patient.

This BLS/AED sequence of steps is appropriate for incidents outside healthcare premises where access to additional healthcare staff may be limited.

SEQUENCE	Technical description
SAFETY	**Make sure you, the victim and any bystanders are safe**
RESPONSE	**Check the victim for a response** • Gently shake his shoulders and ask loudly: "Are you all right?" If he responds leave him in the position in which you find him, provided there is no further danger; try to find out what is wrong with him and get help if needed; reassess him regularly
AIRWAY	**Open the airway** • Turn the victim onto his back • Place your hand on his forehead and gently tilt his head back; with your fingertips under the point of the victim's chin, lift the chin to open the airway
BREATHING	**Look, listen and feel for normal breathing for no more than 10 seconds** In the first few minutes after cardiac arrest, a victim may be barely breathing, or taking infrequent, slow and noisy gasps. Do not confuse this with normal breathing. If you have any doubt whether breathing is normal, act as if it is they are not breathing normally and prepare to start CPR
DIAL 999	**Call an ambulance (999)** • Ask a helper to call if possible otherwise call them yourself • Stay with the victim when making the call if possible • Activate the speaker function on the phone to aid communication with the ambulance service

SEQUENCE	Technical description
SEND FOR AED	**Send someone to get an AED if available** If you are on your own, do not leave the victim, start CPR
CIRCULATION	**Start chest compressions** • Kneel by the side of the victim • Place the heel of one hand in the centre of the victim's chest; (which is the lower half of the victim's breastbone (sternum)) • Place the heel of your other hand on top of the first hand • Ensure that pressure is not applied over the victim's ribs, just the sternum • Keep your arms straight • Do not apply any pressure over the upper abdomen or the bottom end of the bony sternum (breastbone) • Position your shoulders vertically above the victim's chest and press down on the sternum to a depth of 5–6 cm • After each compression, release all the pressure on the chest without losing contact between your hands and the sternum; • Repeat at a rate of 100–120 min^{-1} • Continue chest compressions until an airway barrier device, *pocket mask*, or bag valve mask is available
GIVE RESCUE BREATHS	**After 30 compressions open the airway again using head tilt and chin lift and give 2 rescue breaths** • Remove the pocket mask from the case and manipulate into the working mask shape • Place the mask on the victims face, pressing the mask to create an airtight seal over mouth and nose, and tilt head back to open airway. • Take a normal breath and place your lips around the pocket mask mouthpiece, making sure that you have a good seal • Blow steadily into the mask while watching for the chest to rise, taking about 1 second as in normal breathing; this is an effective rescue breath • Maintaining head tilt and chin lift, take your mouth away from the victim and watch for the chest to fall as air comes out • Take another normal breath and blow into the victim's mouth once more to achieve a total of two effective rescue breaths. Do not interrupt compressions by more than 10 seconds to deliver two breaths. Then return your hands without delay to the correct position on the sternum and give a further 30 chest compressions Continue with chest compressions and rescue breaths in a ratio of 30:2

SEQUENCE	Technical description
IF AN AED ARRIVES	**Switch on the AED** • Attach the electrode pads on the victim's bare chest • If more than one rescuer is present, CPR should be continued while electrode pads are being attached to the chest • Follow the spoken/visual directions • Ensure that nobody is touching the victim while the AED is analysing the rhythm **If a shock is indicated, deliver shock** • Ensure that nobody is touching the victim • Push shock button as directed (fully automatic AEDs will deliver the shock automatically) • Immediately restart CPR at a ratio of 30:2 • Continue as directed by the voice/visual prompts **If no shock is indicated, continue CPR** • Immediately resume CPR • Continue as directed by the voice/visual prompts
CONTINUE CPR	**Do not interrupt resuscitation until:** • A health professional tells you to stop • You become exhausted • The victim is definitely waking up, moving, opening eyes and breathing normally It is rare for CPR alone to restart the heart. Unless you are certain the person has recovered continue CPR
RECOVERY POSITION	**If you are certain the victim is breathing normally but is still unresponsive, place in the recovery position** • Remove the victim's glasses, if worn • Kneel beside the victim and make sure that both his legs are straight • Place the arm nearest to you out at right angles to his body, elbow bent with the hand palm-up • Bring the far arm across the chest, and hold the back of the hand against the victim's cheek nearest to you • With your other hand, grasp the far leg just above the knee and pull it up,

SEQUENCE	Technical description
	keeping the foot on the ground
	• Keeping his hand pressed against his cheek, pull on the far leg to roll the victim towards you on to his side
	• Adjust the upper leg so that both the hip and knee are bent at right angles
	• Tilt the head back to make sure that the airway remains open
	• If necessary, adjust the hand under the cheek to keep the head tilted and facing downwards to allow liquid material to drain from the mouth
	• Check breathing regularly
	Be prepared to restart CPR immediately if the victim deteriorates or stops breathing normally

Healthcare Premises

Even within healthcare premises the ability of providers to undertake more than Basic Life Support Actions may be severely limited.

In areas of the Trust undertaking interventional procedures and treatment additional provision of resuscitation services may include RC(UK) Immediate Life Support Providers, who have been trained with additional resuscitation skills and equipment commensurate with those skills.

In the event of an incident the person raising the alarm should ask for help and any resuscitation equipment that is available on-site, basic life support actions should commence until staff with additional skills or equipment arrives.

AED Use

AEDs are safe and effective when used by laypeople, including if they have had minimal or no training.
Life support providers should continue CPR with minimal interruption to chest compressions both while attaching an AED and during its use. CPR providers should concentrate on following the voice prompts, particularly when instructed to resume CPR, and minimising interruptions in chest compression. ILS providers MAY instruct rescuers in modified techniques to ensure minimisation of interruptions.

Many manufacturers supply purpose-made paediatric pads or programmes, which typically attenuate the output of the machine to 50–75 J. These devices are recommended for children between 1 and 8 years. If no such system or manually adjustable machine is available, an unmodified adult AED may be used.

All staff using a defibrillator will receive update training on an annual basis. However, the use of Automated External Defibrillators (AED) is not restricted to trained personnel, as 'such restrictions are against the interests of the cardiac arrest victim' (Resuscitation Council, 2009).

Refer to Guide 4 for specific information regarding defibrillator and AED provision and use in LCHS.

High quality printable copies of the algorithms suitable for use as posters are available within the Deteriorating Patient/Resuscitation section of the Trust Intranet site.

Guide 2…..Paediatric Basic Life Support

Based on Resuscitation Guidelines 2015.

<u>Recognition of cardiorespiratory arrest – healthcare provider and lay person</u>

If a layperson or healthcare provider considers that there are no 'signs of life', CPR should be started immediately.

Feeling for a pulse is not a reliable way to determine if there is an effective or inadequate circulation. Absence of 'signs of life', such as response to stimuli, normal breathing (rather than abnormal gasps) or spontaneous movement must be looked for as part of the child's circulatory status.
The decision to start CPR should take less than 10 seconds from starting the initial assessment of the child's circulatory status and if there is still doubt after that time, start CPR.

All providers should be encouraged to initiate CPR in children even if they haven't been taught specific paediatric techniques. CPR should be started with the C:V ratio that is familiar and for most, this will be 30:2.
Rescuers who have been taught adult BLS, and have no specific knowledge of paediatric resuscitation, should continue to use the adult 30:2 sequence.

The following modifications to the adult sequence will make it more suitable for use in children where staff have a requirement to treat children as an element of their role:

- ➤ Give 5 initial rescue breaths before starting chest compression.

- ➤ If you are on your own, perform CPR for 1 min before going for help.

- ➤ Compress the chest by at least one-third of its depth, approximately 4 cm for an infant and approximately 5 cm for an older child. Use two fingers for an infant under 1 year; use one or two hands for a child over 1 year to achieve an adequate depth of compression.
- ➤ The compression rate should remain 100–120 min-1.

The specific paediatric sequence incorporating the 15:2 compression ventilation ratio is primarily intended for those who have the potential to resuscitate children as part of their role.

<u>AED Use</u>

AEDs are safe and effective when used by laypeople, including if they have had minimal or no training.
Life support providers should continue CPR with minimal interruption to chest compressions both while attaching an AED and during its use. CPR providers should concentrate on following the voice prompts, particularly when instructed to resume CPR, and minimising interruptions in chest compression. <u>ILS providers MAY instruct rescuers in modified techniques to ensure minimisation of interruptions.</u>

All staff using a defibrillator will receive update training on an annual basis. However, the use of Automated External Defibrillators (AED) is not restricted to trained personnel, as 'such restrictions are against the interests of the cardiac arrest victim' (Resuscitation Council, 2009).

Refer to Guide's 4 & 5 for specific information regarding defibrillator and AED provision and use in LCHS.

High quality printable copies of the Resuscitation Council (UK) Guidelines 2015 algorithms suitable for use as posters are available within the Deteriorating Patient/Resuscitation section of the Trust Intranet site.

Guide 3…..Choking

Based on Resuscitation Guidelines 2015.

Choking is an uncommon but potentially treatable cause of accidental death. As most choking events are associated with eating, they are commonly witnessed. As victims are initially conscious and responsive, early interventions can be life-saving.

Recognition of airway obstruction is the key to successful outcome. Choking usually occurs while the victim is eating or drinking. People at increased risk of choking include those with reduced consciousness, drug and/or alcohol intoxication, neurological impairment with reduced swallowing and cough reflexes (e.g. stroke, Parkinson's disease), respiratory disease, mental impairment, dementia, poor dentition and older age.

Table 2: Sequence of steps for managing the adult victim who is choking	
SEQUENCE	**Technical description**
SUSPECT CHOKING	**Be alert to choking particularly if victim is eating**
ENCOURAGE TO COUGH	**Instruct victim to cough**
GIVE BACK BLOWS	**If cough becomes ineffective give up to 5 back blows** • Stand to the side and slightly behind the victim • Support the chest with one hand and lean the victim well forwards so that when the obstructing object is dislodged it comes out of the mouth rather than goes further down the airway • Give five sharp blows between the shoulder blades with the heel of your other hand
GIVE ABDOMINAL THRUSTS	**If back blows are ineffective give up to 5 abdominal thrusts** • Stand behind the victim and put both arms round the upper part of the abdomen • Lean the victim forwards • Clench your fist and place it between the umbilicus (navel) and the ribcage • Grasp this hand with your other hand and pull sharply inwards and upwards • Repeat up to five times • If the obstruction is still not relieved, continue alternating five back blows with five abdominal thrusts
START CPR	**Start CPR if the victim becomes unresponsive** • Support the victim carefully to the ground

	• Immediately activate the ambulance service
	Begin CPR with chest compressions

<u>Aftercare and referral for medical review</u>

Following successful treatment of choking, foreign material may nevertheless remain in the upper or lower airways and cause complications later.

Victims with a persistent cough, difficulty swallowing or the sensation of an object being still stuck in the throat should, therefore, be referred for medical review.

Abdominal thrusts and chest compressions can potentially cause serious internal injuries and all victims successfully treated with these measures should be comprehensively examined afterwards for injury.

Guide 4…..Defibrillators

Defibrillation within 3–5 min of collapse can produce survival rates as high as 50–70%. Each minute of delay to defibrillation reduces the probability of survival to hospital discharge by 10%.

Automated External Defibrillators (AEDs) are safe and effective when used by laypeople, including if they have had minimal or no training. AEDs may make it possible to defibrillate many minutes before help arrives with the skills to interpret ecg rhythms during a cardiac arrest.

All defibrillators within LCHS are AED's or manual defibrillators with advisory (AED) mode.

CPR providers should concentrate on following the voice prompts, particularly when instructed to resume CPR, and minimising interruptions in chest compression.

ILS providers MAY instruct rescuers in modified techniques to ensure minimisation of interruptions and maximise chest compressions.

Manual defibrillators within LCHS must <u>ALWAYS</u> initially be used in advisory mode.

In the event that a senior clinician with Resuscitation Council (UK) Advanced Life Support Provider or Instructor status is present and they specifically require a defibrillator returned to manual mode this is possible.
This is only indicated when the presenting ecg is clearly suitable for defibrillation but the defibrillator is suggesting otherwise, therefore this is only possible when clinicians of relevant experience are present.

Suitable clinical notes detailing the rationale are required and a print-out from the defibrillator showing the presenting ecg rhythm is essential as potential errors of diagnosis in advisory mode will need to be reported to the MHRA.

Guide 5…..Resuscitation Equipment

The Trust has an obligation to provide an effective resuscitation service to our service users. Our obligations extend to the requirement to show we have a process to ensure the continued availability of resuscitation equipment and that it is checked, stocked and fit for use.

Compliance with this standard rests with the Patient Safety Committee and demonstrating monitoring activity is a requirement of CQC standards.

The provision of equipment as stipulated within the LCHS Standard Resuscitation Equipment List document Fig 1. is to be considered the minimum requirement appropriate for the level of clinical activity at the location. Additional equipment may be required to satisfy locally accepted increased levels of clinical response. Completion of checking documentation is mandatory to ensure evidence of compliance.

Processes

All non-personal resuscitation equipment must be checked, as a minimum, daily and signed as check complete. Weekly the responsible manager will sign to confirm checks are complete, with records of these checks remaining with the equipment for a minimum of three years.

The standardised checking sheet Fig 2. is to used together with the follow on sheet to detail shortfalls or faulty items and provide an audit trail for fault rectification.
It is expected that following incident use another check should be performed, the follow on sheet becoming a record of items used and therefore requiring replacement.

Lincolnshire Community **NHS**
Health Services
NHS Trust

Equipment List

Equipment	Location
Pocket Mask	For All building locations/ peripatetic staff
AED Adult Pads x2 Paediatric Pads x1	For All Face to Face Patient locations
Oxygen cylinder with regulator	All Patient Intervention Locations
SpO2 Monitor	All Patient Intervention Locations
Oxygen mask with reservoir bag Adult x 2 Paediatric x1	All Patient Intervention locations
Bag Valve Mask Adult x 1 Paediatric x 1	All Patient Intervention Locations
Oropharyngeal (Guedel) airways Size 8 Size 9 Size 10	All Patient Intervention locations
Nasopharangeal airways Size 6id Size 7id Size 8id	All Patient Intervention locations
iGel Supraglottic Airway Size 4	All Patient Intervention locations
Magills Forceps Adult	All Patient Intervention locations
Suction - Portable mains/battery Manual	All Patient Intervention locations * *

*All intervention areas must have suction equipment available. If portable powered equipment is provided a hand powered back-up device is also required.

Fig 1. Standard Equipment List

EMERGENCY EQUIPMENT CHECKLIST

Unit...Week Commencing						
1x Pocketmask						
1x Defibrillator/AED – Check ready for use indicator						
2x Adult pads – Check undamaged and Expiry Date						
1x Spare AED Battery						
Airway management Equipment (Check packaging intact and expiry date)						
☐ Non re-breathing oxygen mask (2)						
☐ Adult Bag Valve Mask Single Use (2)						
☐ Oral Airway size ISO 8,9,10						
☐ Nasal Airway size 6,7,8 id.						
☐ iGel Size 4						
☐ Magill's Forceps						
☐ Hand Held Suction Equipment						
1x portable Suction Unit (Check tubing, canister and unit charged)						
Oxygen Cylinder – check regulator undamaged and fill level						
1x Pulse Oximeter – check operation						
Detail any additional equipment;-						
Tick for items present and correct, indicate by a cross deficient items and complete follow-up form and sign to indicate checks complete. Any items not stocked at your location indicate with N/A Signature						

Completion of this checklist to be audited and confirmed weekly by the responsible manager.

Fig 2. Check Sheet

Responsible Managers Signature---Date-------------------------------------

A standard notation shall be used, a tick to represent present and correct item, a cross for incorrect or missing item and N/A for an item not stocked at that location.

Any faulty/broken equipment is to be noted and reported to the relevant department or service agent as a matter of urgency and the responsible manager contacted regarding suitable contingency measures whilst repair/replacement is undertaken.

Responsibility

The responsible manager will ensure staff are aware of the daily checking requirement and monitor compliance with weekly sign-off. The manager shall ensure any follow-on actions are completed in a timely manner.

The Resuscitation Lead will instruct Matrons to request an a random basis copies of weekly checking sheets to confirm compliance and this will be reported as an occasional element of the Deteriorating Patient Monthly Report
The Resuscitation Lead will report monitoring activity as part of the ongoing work strategy plan within the annual report.

High quality printable copies of the equipment list and check sheet are available in the Deteriorating Patient/Resuscitation section of the Trust Intranet site

Guide 6 ….. Cessation of CPR

Most resuscitation attempts are unsuccessful — we need to know when to stop and this is a difficult decision.

The decision to stop a resuscitation attempt for anything other than a return of spontaneous circulation and the observation of signs of life however brings a certainty of the victim's death and that brings issues that require clarification.

For all but the situation where the continuance of the attempt would bring danger to the rescuer/s or a valid order is discovered that indicates CPR is not appropriate the decision to stop CPR has to be tailored according to the specifics of the individual case and is based on clinical judgement, the difficulty is that the level of clinical judgement required is significant.

A general approach for healthcare providers in healthcare environments is to stop CPR after 20 minutes if there is no return of spontaneous circulation (ROSC) or viable (shockable) cardiac rhythm re-established, and no reversible factors present that would potentially alter outcome.

Identification and exclusion of the potentially reversible cause factors does however require significant clinical and diagnostic expertise together with diagnostic equipment generally unavailable within LCHS.

In the <u>prehospital</u> setting a validated rule was described by Morrison et al (2006):
"Stop CPR if:
— no return of spontaneous circulation
— no shocks are administered, ***and***
— the arrest is not witnessed by emergency medical-services personnel"
Otherwise, the rule recommends transportation to the hospital, in accordance with routine practice.
The difficulty with this is that no indicative timescale for the failure to restore spontaneous circulation was given.

The overriding consideration is that the decision to stop any resuscitation attempt has to be made with full examination and understanding of the circumstances of the cardiac arrest. Prolonged resuscitation is indicated in several situations and those are potentially the most difficult to exclude as potentially reversible cause factors.

Within LCHS resuscitation attempts should continue until a clinician is present who can undertake the process of establishing that life is extinct, there is absolutely no chance of survival and that continuing resuscitation attempts would be futile. It goes without saying that a fully documented rationalisation of any such decision to stop <u>is an absolute requirement</u> of any clinician in this circumstance.

References
Morrison LJ, Visentin LM, Kiss A, Theriault R, Eby D, Vermeulen M, Sherbino J, Verbeek PR; TOR Investigators. Validation of a rule for termination of resuscitation in out-of-hospital cardiac arrest. N Engl J Med. 2006 Aug 3;355(5):478-87. PubMed PMID: 16885551.

Stub D, Bernard S, Pellegrino V, et al. Refractory cardiac arrest treated with mechanical CPR, hypothermia, ECMO and early reperfusion (the CHEER trial). Resuscitation. 86:88-94. 2015.

Larkin GL. Termination of resuscitation: the art of clinical decision making. Curr Opin Crit Care. 2002 Jun;8(3):224-9. Review. PubMed PMID: 12386501

Appendix 1 ……Anaphylaxis

The current **P_CS_32 Anaphylactic Reaction Policy** is available from the Trust public website.

Accessing the policy directly from the website ensures the latest version is viewed.
https://www.lincolnshirecommunityhealthservices.nhs.uk/policies

Appendix 2….. ReSPECT Policy

The current **P_CS_54 ReSPECT Policy** is available from the Trust public website.

Accessing the policy directly from the website ensures the latest version is viewed.
https://www.lincolnshirecommunityhealthservices.nhs.uk/policies

Appendix 3 ….. Physiological Observations

The current **P_CS_16 Physiological Observations Policy** is available from the Trust public website.

Accessing the policy directly from the website ensures the latest version is viewed.
https://www.lincolnshirecommunityhealthservices.nhs.uk/policies

Appendix 4 ….. Resuscitation training Matrix

The current **Resuscitation Training Matrix** is available to staff from the Trust intranet site, Resuscitation Resources page.

Accessing the policy directly from the intranet site ensures the latest version is viewed.

Equality Analysis

Name of Policy/Procedure/Function* Resuscitation Policy **Equality Analysis Carried out by: Tim Balderstone** **Date: 5:11:2018** **Equality & Human rights Lead: Rachel Higgins** **Director\General Manager: Susan Ombler**		

*In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.				
A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	Is to provide clear and consistent guidance to LCHS staff which is evidence based to ensure an effective response to, and the management of a cardiac arrest or medical emergency, with procedures in place to respect the individual rights of patients during emergency situations, which are understood by any staff involved in delivering care to patients.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	Applicable to all		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	
	Religion or Belief		X	
	Carers		x	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – lease go to section 2			

The above named policy has been considered and does not require a full equality analysis	
Equality Analysis Carried out by:	Tim Balderstone
Date:	5:11:2018

Monitoring Template

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/audit	Responsible individuals/ group/ committee (multidisciplinary) for review of results	Responsible individuals/ group/ committee for development of action plan	Responsible individuals/ group/ committee for monitoring of action plan
Number and Types of Resuscitation events	Resuscitation Audit Forms completed	Safeguarding & Patient Safety Group	Annual	Safeguarding & Patient Safety Group	Safeguarding & Patient Safety Group	Safeguarding & Patient Safety Group
National Early Warning Score completion Audit	Monthly Report	Safeguarding & Patient Safety Group	Monthly, annual report.	Safeguarding & Patient Safety Group	Safeguarding & Patient Safety Group	Safeguarding & Patient Safety Group
Equipment Checking Audit	Audit	Safeguarding & Patient Safety Group	Yearly	Safeguarding & Patient Safety Group	Safeguarding & Patient Safety Group	Safeguarding & Patient Safety Group