Lincolnshire Community Health Services
NHS Trust

# Resuscitation Policy

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Chair: Elaine Baylis QPM
Chief Executive: Maz Fosh

# 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 Learning from Deaths Panel.

## COVID-19

**The coronavirus pandemic has created numerous difficulties for everyday healthcare practice as well as resuscitation actions.**
**It is not appropriate to revise all policies to reflect scientifically recommended and government mandated modifications to practice when these may alter frequently.**

**The latest requirements and any modifications to Resuscitation Guidelines will always be found on the Trust Staff Intranet and it must be understood these may supersede elements of this 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 | 06.01.11 | J. Anderson |

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|---|---|---|---|---|
| | | Resuscitation Guidelines (October 2010) | | |
| 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 |
| 8 | All | Full policy revision to incorporate Resuscitation Guidelines 2021 | | 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 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.

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.

**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-07 - ReSPECT Policy
P-CS-32 – Anaphylaxis Recognition & Treatment Policy
P-CS-16 – Physiological Observations Policy
P-CS-49 – Sepsis Recognition 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, 2020, 2021*) :

- 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 2021
- Ensure staff understand decisions specific to cpr and a 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 Learning from Deaths Panel and Clinical Safety Effectiveness Group.

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 and have easy access to personal protective equipment.

Resuscitation Committee

Resuscitation Committee functions will be undertaken as part of the Clinical Safety Effectiveness Group. 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 to include resuscitation matters to be standing agenda items.

## 3. Training and Competence

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 via **Appendix 4**

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 expired air ventilation can no longer be supported.

**Until** appropriate personal protective and airway management equipment (e.g. pocket mask, bag valve mask) 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 and this is the standard to which LCHS will be judged in the event of an incident.**

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/ReSPECT form or ADRT that specifically details resuscitation actions.

## 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)

**There are few unequivocal criteria when cpr may be withheld; -**

- **when the safety of the provider cannot be adequately assured**
- **when there is obvious mortal injury or irreversible death**
- **when a valid and relevant advance decision becomes available that recommends against the provision of CPR.**

It is therefore essential to identify patients for whom cardiopulmonary arrest represents an appropriate terminal event and for whom cardiopulmonary resuscitation is inappropriate so a determination for provision of cpr may be made.

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

***Where a 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 person's 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 (May 2021) Resuscitation Guidelines
2021 Resuscitation Guidelines | Resuscitation Council UK
Last accessed 5/5/21

Resuscitation Council (UK) (updated - 2020) Quality standards for cardiopulmonary resuscitation practice and training – Community Hospitals
Quality Standards: Community hospitals care | Resuscitation Council UK
Last accessed 10/5/21

Resuscitation Council (UK) (updated - 2020) 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 10/5/21

Resuscitation Council (May 2021) Advanced Life Support Manual 8th Edition

Resuscitation Council (May 2021) Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers
Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers | Resuscitation Council UK
Last accessed 10/5/21

Resuscitation Council Cardiopulmonary Resuscitation and Pandemic SARS-CoV-2
Statements and resources on COVID-19 (Coronavirus), CPR and Resuscitation | Resuscitation Council UK
Last accessed 10/5/21

Resuscitation Council (May 2021) Working Group: Guidance for Safer Handling during resuscitation in healthcare settings.
https://www.resus.org.uk/library/publications/publication-guidance-safer-handling
Last accessed 11/5/21

British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (2016) Decisions relating to Cardiopulmonary Resuscitation (3rd edition - 1st revision)
Publication: Decisions relating to cardiopulmonary resuscitation (3rd edition - 1st revision) | Resuscitation Council UK
Last accessed 10/5/21

ReSPECT Process
ReSPECT for healthcare professionals | Resuscitation Council UK
Last accessed 10/5/21

## 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 or algorithms imaged within this portfolio will be found either from direct source links within this document or as downloadable high-quality printable image files within the Deteriorating Patient/Resuscitation section of the LCHS staff intranet site.**

# Guide 1…..Adult Basic Life Support Procedures

Based on Resuscitation Guidelines 2021

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 and should in all locations commence with a call to the emergency services as soon as cardiac arrest is confirmed.

Outside of healthcare premises

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.

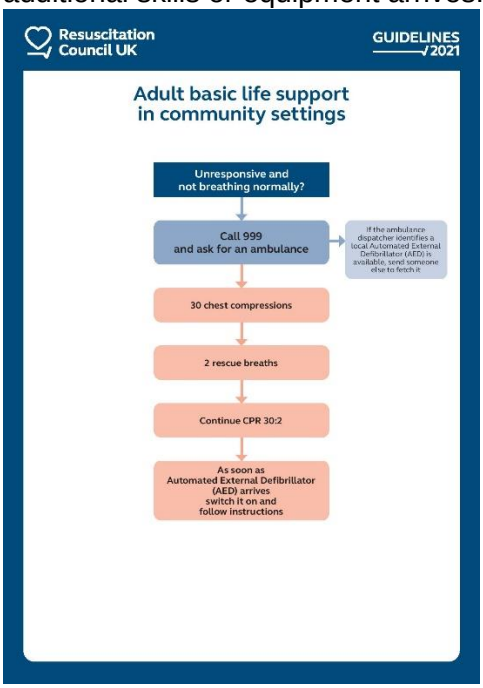
This BLS/AED sequence of steps is appropriate for incidents outside healthcare premises where access to additional healthcare staff may be limited.

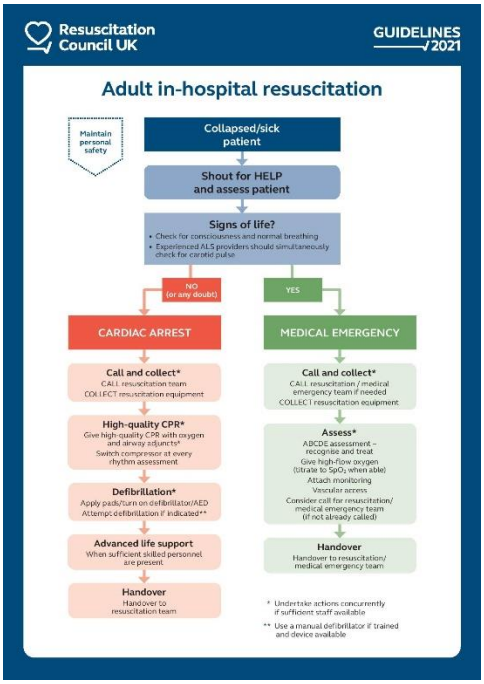
Healthcare Premises

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.




**Clicking on the images will open printable copies of each algorithm directly from the Resuscitation Council (UK) website.**

Basic Life Support Includes 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.

**ILS providers MAY instruct rescuers in modified techniques to ensure minimisation of interruptions and maximise chest compressions when using AED's.**

# Guide 2…..Paediatric Basic Life Support

Based on Resuscitation Guidelines 2021.

Recognition of cardiorespiratory arrest – healthcare provider and lay person

**Unless the LCHS premises are situated on the same site as an acute hospital with direct access to the Emergency Department, an 999 ambulance should be called immediately to each child who collapses or deteriorates**

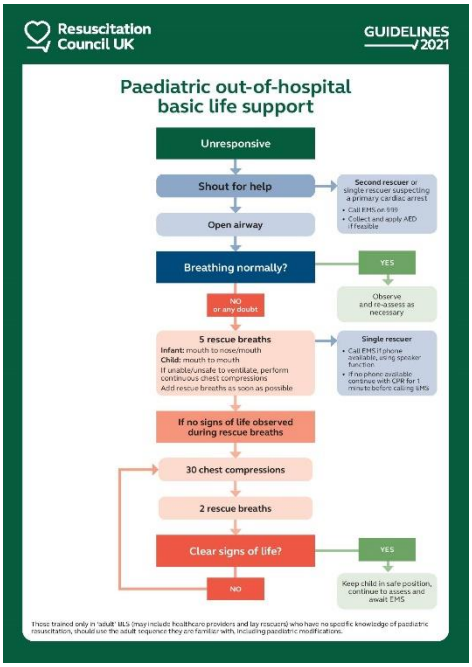
If a member of the general public or healthcare provider considers that there are no 'signs of life', and the child or infant exhibits abnormal or absent breathing, CPR should be started immediately.

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 ratio that is familiar and for most, this will be 30 compressions followed by 2 breaths.

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.




**Clicking on the image will open a printable copy directly from the Resuscitation Council (UK) website.**

**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 normal healthcare role and have received pILS training.**

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.

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.

## **Rescue Breaths in Children

- Although rescue breaths are described here, it is common in healthcare environments to have access to bag-mask devices and providers trained in their use should use them as soon as they are available. In larger children when BMV is not available, competent providers can also use a pocket mask for rescue breaths.

- While performing the rescue breaths, note any gag or cough response to your action. These responses, or their absence, will form part of your ongoing assessment of 'signs of life'

Rescue breaths for an infant (<12m):

- Ensure a neutral position of the head (as an infant's head is usually flexed when supine, this may require some gentle extension) and apply chin lift.
- Take a breath and cover the mouth and nose of the infant with the mask, making sure you have a good seal.
- Blow steadily into the mask over 1 second sufficient to make the chest rise visibly. This is the same time period as in adult practice.
- Maintain head position and chin lift, take your mouth away, and watch for their chest to fall as air comes out.
- Take another breath and repeat this sequence four more times.

Rescue breaths for a child over 1 year:

- Ensure head tilt and chin lift; extending the head into 'sniffing' position.
- Pinch the soft part of the nose closed with the index finger and thumb of your hand on their forehead.
- Open the mouth a little but maintain the chin lift.
- Place mask around the mouth/nose, making sure that you have a good seal.
- Blow steadily into the mask over 1 second sufficient to make the chest rise visibly.
- Maintaining head tilt and chin lift, take your mouth away from the mask and watch for the chest to fall as air comes out.
- Take another breath and repeat this sequence four more times.
- Identify effectiveness by seeing that the child's chest has risen and fallen in a similar fashion to the movement produced by a normal breath.

**For both infants and children, if you have difficulty achieving an effective breath, the airway may be obstructed:**

- Open the child's mouth and remove any visible obstruction. Do not perform a blind finger sweep.
- Ensure that there is adequate head tilt and chin lift but also that the neck is not over extended; try repositioning the head to open the airway.
- If head tilt and chin lift has not opened the airway, try the jaw thrust method.
- Make up to 5 attempts to achieve effective breaths. If still unsuccessful, move on to chest compressions.

**High quality printable copies of the Resuscitation Council (UK) Guidelines 2021 algorithms suitable for use as posters are available within the Deteriorating Patient/Resuscitation section of the Trust Intranet site.**

# Guide 3…..Foreign Body Airway Obstruction - Choking

Based on Resuscitation Guidelines 2021.

Recognition of airway obstruction is the key to successful outcome. Suspect choking if someone is suddenly unable to speak or talk, particularly if eating.

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.

If an **adult** is suddenly unable to speak or talk; -

- Encourage the person to cough.

- If the cough becomes ineffective, give up to 5 back blows:
  - Lean the person forward.
  - Apply blows between the shoulder blades using the heel of one hand.

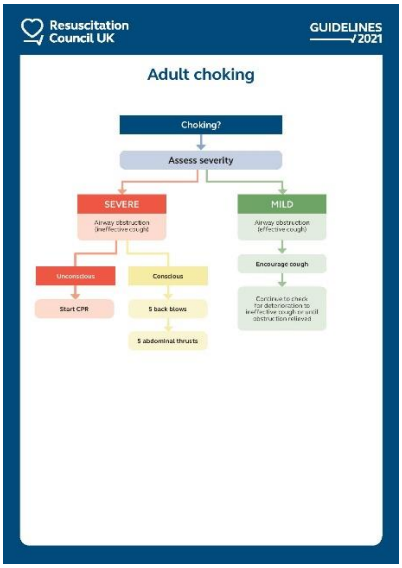
- If back blows are ineffective, give up to 5 abdominal thrusts:
  - Stand behind the person and put both your arms around the upper part of their abdomen.
  - Lean the person forwards.
  - Clench your fist and place it between the umbilicus (navel) and the ribcage.
  - Grasp your fist with the other hand and pull sharply inwards and upwards.

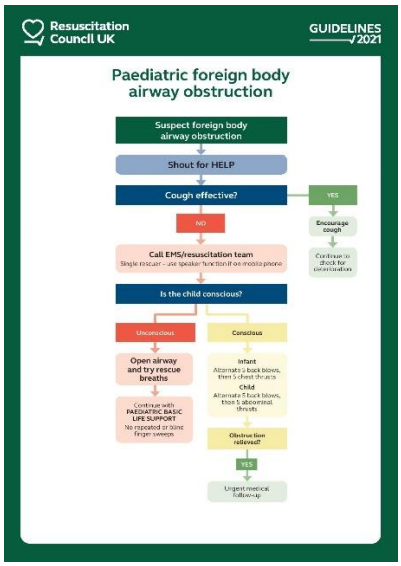
- If choking has not been relieved after 5 abdominal thrusts, continue alternating 5 back blows with 5 abdominal thrusts until it is relieved, or the person becomes unresponsive.

- If the person becomes unresponsive, start CPR.

- 

**For children abdominal thrusts may be used, for infants (<12months) use chest rather than abdominal thrusts.**




**Clicking on the images will open printable copies of each algorithm directly from the Resuscitation Council (UK) website.**

**Aftercare and referral for medical review**

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.

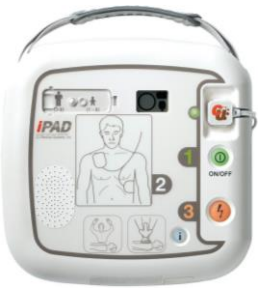
## Guide 4…..Defibrillators - AED & Manual

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 Lifepak 20e defibrillators with advisory (AED) mode.

Several manufacturers AED's are deployed within LCHS, but all have similar working processes therefore 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 when using AED's.**

**Lifepak 20e manual defibrillators within LCHS must <u>ALWAYS</u> initially be used in advisory mode.**

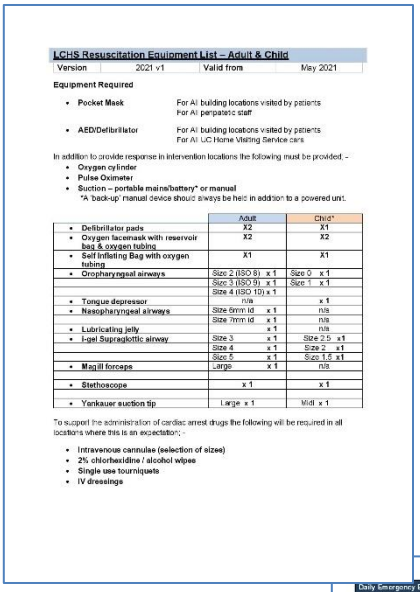
**Should a senior clinician with Resuscitation Council (UK) Advanced Life Support Provider or Instructor status be present and they specifically require a defibrillator returned to manual mode this is possible.**

**<u>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.</u>**

**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.



LCHS Resuscitation Equipment List – Adult & Child

| Version | 2021 v1 | Valid from | May 2021 |
|---|---|---|---|

**Equipment Required**

- **Pocket Mask** — For All building locations visited by patients; For All peripatetic staff
- **AED/Defibrillator** — For All building locations visited by patients; For All LC Home Visiting Service cars

In addition to provide response in intervention locations the following must be provided: -

- Oxygen cylinder
- Pulse Oximeter
- Suction – portable mains/battery* or manual
  *A 'back-up' manual device should always be held in addition to a powered unit.

| | Adult | Child* |
|---|---|---|
| • Defibrillator pads | X2 | X1 |
| • Oxygen facemask with reservoir bag & oxygen tubing | X2 | X2 |
| • Self Inflating Bag with oxygen tubing | X1 | X1 |
| • Oropharyngeal airways | Size 2 (ISO 8) x 1 | Size 0 x 1 |
| | Size 3 (ISO 9) x 1 | Size 1 x 1 |
| | Size 4 (ISO 10) x 1 | |
| • Tongue depressor | n/a | x 1 |
| • Nasopharyngeal airways | Size 6mm id x 1 | n/a |
| | Size 7mm id x 1 | n/a |
| • Lubricating jelly | x 1 | n/a |
| • I-gel Supraglottic airway | Size 3 x 1 | Size 2.5 x1 |
| | Size 4 x 1 | Size 2 x1 |
| | Size 5 x 1 | Size 1.5 x1 |
| • Magill forceps | Large x 1 | n/a |
| | | |
| • Stethoscope | x 1 | x 1 |
| | | |
| • Yankauer suction tip | Large x 1 | Midi x 1 |

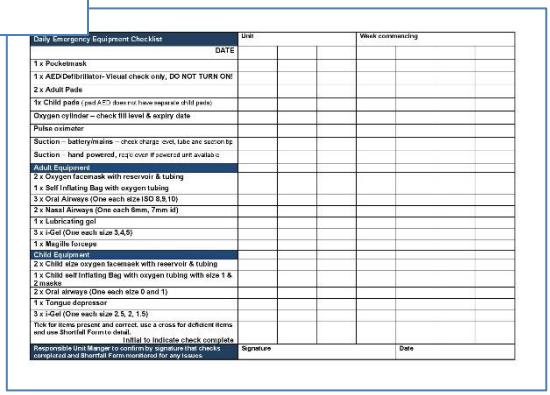
To support the administration of cardiac arrest drugs the following will be required in all locations where this is an expectation: -

- Intravenous cannulae (selection of sizes)
- 2% chlorhexidine / alcohol wipes
- Single use tourniquets
- IV dressings

The provision of equipment s stipulated within the LCHS Standard Resuscitation Equipment Lists – Adult & Child document 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 and archived for a minimum of ten years.



| Daily Emergency Equipment Checklist | Unit | | | Week commencing | | |
|---|---|---|---|---|---|---|
| DATE | | | | | | |
| 1 x Pocketmask | | | | | | |
| 1 x AED/Defibrillator- Visual check only, DO NOT TURN ON! | | | | | | |
| 2 x Adult Pads | | | | | | |
| 1x Child pads (pad AED does not have separate child pads) | | | | | | |
| Oxygen cylinder – check fill level & expiry date | | | | | | |
| Pulse oximeter | | | | | | |
| Suction – battery/mains – check charge ever, tube are suction tip | | | | | | |
| Suction – hand powered, ready ever if powered unit available | | | | | | |
| **Adult Equipment** | | | | | | |
| 2 x Oxygen facemask with reservoir & tubing | | | | | | |
| 1 x Self Inflating Bag with oxygen tubing | | | | | | |
| 3 x Oral Airways (One each size ISO 8,9,10) | | | | | | |
| 2 x Nasal Airways (One each 6mm, 7mm id) | | | | | | |
| 1 x Lubricating gel | | | | | | |
| 3 x i-Gel (One each size 3,4,5) | | | | | | |
| 1 x Magills forceps | | | | | | |
| **Child Equipment** | | | | | | |
| 2 x Child size oxygen facemask with reservoir & tubing | | | | | | |
| 1 x Child self inflating Bag with oxygen tubing with size 1 & 2 masks | | | | | | |
| 2 x Oral airways (One each size 0 and 1) | | | | | | |
| 1 x Tongue depressor | | | | | | |
| 3 x i-Gel (One each size 2.5, 2, 1.5) | | | | | | |
| Tick for items present and correct, use a cross for deficient items and use Shortfall Form to detail. Initial to indicate check complete | | | | | | |
| Responsible Unit Manger to confirm by signature that checks completed and Shortfall Form monitored for any issues | Signature | | | | Date | |

Sheet is to be used detail shortfalls or trail for fault
It is expected that check should be becoming a record of items requiring

The standardised Daily Checking together with the Shortfall Sheet to faulty items and provide an audit rectification.
following incident use another performed, the shortfall sheet items used and therefore indicating replacement.

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 Shortfall actions are completed in a timely manner.

The Resuscitation Lead will instruct Matrons to request on 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 consider the criteria; -

- persistent asystole despite 20 minutes of advanced life support (ALS) in the absence of any reversible cause
- unwitnessed cardiac arrest with an initial non-shockable rhythm where the risk of harm to the patient from ongoing CPR likely outweighs any benefit e.g. absence of return of spontaneous circulation (ROSC), severe chronic co-morbidities
- other strong evidence that further CPR would not be consistent with the patient's values and preferences, or in their best interests.

As LCHS does not support Advance Life Support (ALS) provider status, its defibrillators are almost exclusively AED's without rhythm display and identification and exclusion of the potentially reversible cause factors does require significant clinical and diagnostic expertise together with diagnostic equipment generally unavailable within LCHS it is not envisaged the decision to cease cpr will normally be required by clinicians working within the Trust.

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 <u>absolutely no</u> 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 with <u>particular reference</u> to how potentially reversible causes were addressed and excluded <u>is an absolute requirement</u> of any clinician in this circumstance.**

## Appendix 1….Anaphylaxis

The current **P_CS_32 Anaphylaxis Recognition & Treatment 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_07 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 Staff Intranet site, Resuscitation Resources page.

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

# Appendix 5…..Equality Analysis

## Equality Impact Analysis Screening Form

| Title of activity | **Resuscitation Policy** | | |
|---|---|---|---|
| Date form completed | **10/5/2021** | Name of lead for this activity | **Tim Balderstone** |

| Analysis undertaken by: | | |
|---|---|---|
| Name(s) | Job role | Department |
| **Tim Balderstone** | **Resuscitation Lead** | **Effective Practice** |
| | | |

| What is the aim or objective of this activity? | **The main aim is to improve survival from cardiac arrest by revising evidence-based practice within the UK for those who sustain a cardiac arrest.** |
|---|---|
| Who will this activity impact on? *E.g. staff, patients, carers, visitors etc.* | **The policy covers all ages, all settings and are relevant to all professionals and all members of the public.** |

| **Equality Group** | Potential for **positive** impact | **Neutral** Impact | Potential for **negative** impact | Please provide details of how you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered) |
|---|---|---|---|---|
| **Age** | ☒ | ☐ | ☐ | **Causes and treatment of cardiac arrest varies with age. The policy has sections covering paediatric and adult patients to address this.** |
| **Disability** | ☐ | ☒ | ☐ | |
| **Gender reassignment** | ☐ | ☒ | ☐ | |
| **Marriage & civil partnerships** | ☐ | ☒ | ☐ | |
| **Pregnancy & maternity** | ☐ | ☒ | ☐ | |
| **Race** | ☐ | ☒ | ☐ | |
| **Religion or belief** | ☐ | ☒ | ☐ | |
| **Sex** | ☐ | ☒ | ☐ | |
| **Sexual Orientation** | ☐ | ☒ | ☐ | |
| **Additional Impacts** ***(what other groups might this activity impact on? Carers, homeless, travelling communities etc.)*** | ☐ | ☒ | ☐ | |

Level of impact

| | Yes | No |
|---|---|---|
| Could this impact be considered direct or indirect discrimination? | ☐ | ☐ |
| If yes, how will you address this? | | |
| | | |

| | High | Medium | Low |
|---|---|---|---|
| What level do you consider the potential negative impact would be? | ☐ | ☐ | ☐ |

Action plan

| How could you minimise or remove any negative impacts identified, even if this is rated low? |
|---|
| |
| How will you monitor this impact or planned actions? |
| |
| Future review date: **May 2023** |

## 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 | Learning from Deaths Panel | Annual | Learning from Deaths Panel | Learning from Deaths Panel | Learning from Deaths Panel |
| Equipment Checking Audit | Audit | Clinical Safety Effectiveness Group | Yearly | Clinical Safety Effectiveness Group | Clinical Safety Effectiveness Group | Clinical Safety Effectiveness Group |