Leicestershire Partnership NHS Trust

University Hospitals of Leicester NHS Trust

LLR alliance
Providing care around you together

Combined UHL / LPT / LLR Alliance

Cardiopulmonary Resuscitation Policy

Approved By:	UHL – Policy & Guideline Committee
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Trust Leads:	Resuscitation Lead – LPT Head of Nursing – LLR Alliance Resuscitation Lead - UHL
Board Director Lead	John Jameson, Deputy Medical Director
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Review dates and details of Changes made during the review

January 2019 Review and changes made to:

Section 1.3 Table "university Hospitals of Leicester – Glenfield Hospital - change of procedure for summoning help at The Firs & The Laurel outlying buildings.
Section 1.3 includes adult patient in PSAU
Section 5.5 – change to definition of resuscitation trainer
Section 5.7(d) – inserted responsibility of CMG Heads of Nursing to establish local policy within the CMG for the frequency of cardiac arrest trolley checking
Section 5.9(e) – refer to "role" rather than "area of employment"
Section 6.1 (c) – included activation of 999 protocol for "The firs and the Laurels"
Section 6.1(k) – frequency of Equipment checks
Section 6.1 (l) – TBC
Section 6.1(M) removal of detail –replaced by Service Level agreement in full Appendix ?8
Section 6.3(e) - frequency of Equipment checks – LLR TBC
Section 7.1(b) – TBC
Section 7.1(d) (e) – inclusion terms Assured registered professional
Section 7.3 – amendment to revalidation of cascade trainer process
Section 8 – amendment to the Monitoring compliance roles and responsibilities
Appendix 3 - amended to include Adult, Paediatric and Neonate training UHL education and training
Appendix 4 & 5 removed
Appendix 6,7,8 renumbered
Appendix 6 - LPT & UHL Service level agreement for provision of resuscitation services

June 2019 – Review and changes made to:
Section 1-Changes to spelling of LPT sites. Prison services removed, CAMHS added.
Section 2.1 b) Added ReSPECT
Section 6.2 A- Paragraph wording changed.
B- Information added for 2222 response.
C c)- Requirements for documentation added.
D b)- Changed from grab bag to emergency bag, paragraph wording changed.
c)- Wording changed from excluding to including.
g)- Changed to reflect terms used for LPT equipment bags.
h)- Additional paragraph about removal of essential ward equipment following an incident.
E b)- Change in policy regarding sealing of trolleys.
c)- Requirement to seal trolley.
d)- Paragraph added to reflect change in practices.
e)- Change to where resource information can be found.
f)- Paragraph added to reflect changes to checking procedures and documentation storage.
F- Updated information for LPT areas with emergency equipment bags.
Appendix Two- Updated copy of Terms of Reference for LPT Resuscitation Committee
Appendix Seven- LPT Resuscitation Audit form

This document replaces the following Policies:
UHL Cardiopulmonary Resuscitation Policy, Trust ref A14/2001
LPT Resuscitation Policy 2014 Trust ref A14/2001

Key Words

Advanced Directive to Refuse Treatment (ADRT), Cardiac Arrest, Cardiopulmonary Arrest, Cardiopulmonary Resuscitation (CPR), Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), Medical Emergency, Respiratory Arrest, Resuscitation

1 Introduction

1.1 This policy sets out LPT and UHL (including LLR Alliance) processes for the management and strategic oversight of the provision of resuscitation services, training and the effective management of Cardiac Arrests and Medical emergencies in accordance with Resuscitation Council UK guidelines.

1.2 For the purpose of this policy unless specified the term 'the Trust' will cover all the sites for UHL, LPT and the LLR Alliance. Where there is requirement to provide specific site related details this will be clearly explained

1.3 All the sites covered by this policy and the number to dial in a cardiac arrest or medical emergency situation are:

University Hospitals of Leicester	
Site	**Emergency Contact Number**
Leicester Royal Infirmary – all buildings	**2222**
Leicester General Hospital – all buildings run by UHL	**2222**
Glenfield Hospital –all buildings run by UHLsee exception below, the Bradgate Unit and Bennion Centre and mobile Screening Vans.	**2222**
Glenfield Hospital –outlying buildings the "Firs" and the "laurels",	**(9) 999**
Renal Satellite Units or Off Site Services Provided by UHL	
Left intentionally blank for local completion	
Leicestershire Partnership Trust	
Site	**Emergency Contact Number**
Coalville Community Hospital -Wd 1 2 and 3	**9999**
Feilding Palmer Hospital, Lutterworth ward area	**9999**
Hinckley Hospital North and East ward	**9999**
Loughborough Hospital – Swithland and Out Patient Units / clinics	**9999**
Evington Centre –Clarendon / Beechwood / Gwendolen / Coleman	**9999**
Melton Mowbray Hospital- Dalgleish ward	**9999**
St Lukes, Market Harborough – Wd 1 and 3	**9999**
Rutland Memorial Hospital – Ward area	**9999**
Grange Short breaks	**9999**
Gillivers Short breaks	**9999**
Agnes Unit	**9999**
Rubicon Close Short breaks– Mountsorrell	**9999**
Herschel Prins/ Stewart House/Mill Lodge	**9999**
The Willows	**9999**
CAMHS, Rothesay	**9999**
Glenfield Hospital site -including Bradgate Unit and Bennion Centre, including adults within PSAU (detailed in Appendix 6 SLA)	**2222 + 9999**
LLR Alliance sites	
Site	**Emergency Contact Number**
Coalville Community Hospital	**9999**
Feilding Palmer Hospital, Lutterworth	**9999**
Hinckley and District Hospital	**9999**
Loughborough Hospital	**9999**
Market Harborough and District Hospital	**9999**
LLR Alliance sites	
Site	**Emergency Contact Number**
Melton Mowbray Hospital	**9999**
St Lukes, Market Harborough	**9999**
Rutland Memorial Hospital	**9999**

2 Policy Aims

2.1 The aim of this policy is to provide an efficient and effective resuscitation service. by ensuring that:

a) All clinical interventions are based upon the latest guidelines produced by the Resuscitation Council (UK)

b) All patients are presumed to be for Cardiopulmonary Resuscitation (CPR) unless a valid Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision has been made and documented, a ReSPECT document states Not for Resuscitation or an Advanced Directive to Refuse Treatment (ADRT) prohibits CPR, In which case a DNACPR should also be completed.

c) All patients without a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, who suffer a cardio-pulmonary arrest, whilst under the care of the Trust, receive basic life support at point of recognition of cardiac arrest and defibrillation at the earliest opportunity if appropriate.

d) A Resuscitation/Medical Emergency team (where relevant) which is appropriately trained in resuscitation techniques and is used to support the management of actual or potential cardiopulmonary arrests.

e) Appropriate information, resuscitation skills training and regular updates / supervision for maintaining a level of competence are appropriate to each individual's job role.

3 Policy Scope

3.1 This policy applies to all employees (including medical staff) who work for LPT and UHL (Including LLR Alliance, Renal Satellite Units and Off Site Services provided by UHL), including those on the Staff Bank, Agency or honorary contracts.

3.2 This policy applies to all adult and paediatric patients

3.3 This policy does not provide details on Do Not Attempt Cardiopulmonary Resuscitation information. UHL and LLR Alliance Staff – please refer to the UHL Do Not Attempt Cardiopulmonary Resuscitation policy (Trust ref . B25/2014) LPT staff – refer to DNA-CPR V3.

3.4 UHL, LPT and LLR Alliance are learning environments and provide placements for pre-registration training for students such as Medicine, Nursing, Midwifery, Paramedic, Radiography and Pharmacy. This policy applies to these students whilst on placement and directed by a mentor / supervisor.

4 Definitions

4.1 **Cardiac Arrest (CA):** is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness, apnoea or agonal respirations. In simple terms, cardiac arrest is the point of death.

4.2 **Cardiopulmonary Resuscitation (CPR):** interventions delivered with the intention of restarting the heart and breathing. These will include: chest compressions and ventilations; and may include defibrillation and the administration of drugs.

4.3 **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR):** refers to not making efforts to restart breathing and/or the heart in cases of respiratory/cardiac arrest. It does not refer to any other interventions/treatment/care such as analgesia, fluid replacement, feeding, antibiotics and essential care.

4.4 **Medical Emergency:** an injury or illness that is acute and poses an immediate risk to an individual's life or health. These emergencies may require assistance from another person who should be suitably qualified to do so.

4.5 **Resuscitation/Medical Emergency Team Leader:** a suitably qualified and identified member of staff designated as the responsible individual to lead the management of a cardiac arrest / medical emergency

4.6 **The Trust**: is used to define all sites and organisations this policy applies to

5 Roles and Responsibilities

5.1 Chief Executive

Responsible for Trust compliance with Trust Policy and Procedures.

5.2 Medical Director

Is the executive lead for this policy and responsible for ensuring that the Trust has policies and procedures in place for the provision of an effective and efficient resuscitation service and will feedback progress, concerns and issues to the Executive Team.

5.3 Resuscitation Committees

a) Act in accordance with Resuscitation Council UK Guidelines https://www.resus.org.uk/ as a decision making body for the development and implementation of operational policies governing cardiopulmonary resuscitation (management and prevention), practice and training.

b) Determine the composition of the Resuscitation/Medical Emergency Team, taking advice from specialist areas as appropriate

c) Meet as a minimum on a quarterly basis, however, may meet more frequently as required and agreed by the committee.

Full terms of reference for Resuscitation Committees can be found in Appendix One and Two.

5.4 Senior Resuscitation Officer for UHL and LLR Alliance / Resuscitation Officer for LPT

With the support of the Chair of the Resuscitation Committee will review, support and implement policies and procedures in place for the provision of an effective and efficient resuscitation service. They will feedback progress, concerns and issues to their Organisations Resuscitation Committee.

5.5 **UHL Resuscitation designated trainers, LPT Designated Trainer** have delegated authority and responsibility to:

a) Deliver Resuscitation training to all Trust staff employees

b) Train and support Cascade Trainers (where relevant)

c) Support the Resuscitation Training service

5.6 Chief Pharmacist

Has the responsibility to ensure that sufficient Cardiac Arrest Drug boxes are available to all areas requiring them within their Trust.

5.7 Clinical Directors/Leads and Heads of Nursing

Have responsibility to:

a) ensure that the they provide an appropriately staffed Resuscitation/Medical Emergency team as detailed in section 6.1E) (UHL Only)

b) Ensure that all their staff are aware of the policy

c) Ensure that staff groups and individuals are given appropriate training as detailed in Section 7

d) To establish the frequency of cardiac arrest trolley equipment checking within the CMG by individual clinical area and by senior nurse/ manager

e) Monitor compliance of emergency equipment readiness checks on a monthly basis

f) Ensure that appropriate support is given to staff involved in any resuscitation incident

g) Manage the effectiveness of this policy through an effective system of reporting, investigating and recording incidents and report any concerns/issues to the Resuscitation Committee.

h) Where auditing has identified deficiencies there must be evidence that recommendations and action plans have been developed and changes implemented as per existing escalation processes.

i) Clinical Director Leads have an obligation to ensure the purchase of replacement emergency medical equipment and this is given immediate financial authorisation.

5.8 Department/ Ward Managers/Team Leaders of all Services in UHL / LPT / LLR Alliance

Have responsibility to:

a) Ensure all staff, including temporary staff and students are made aware of the location, function, and use of emergency equipment, the location of the ward / department phone and the emergency number and how to summon help.

b) Ensure that the emergency number is clearly displayed near all phones within their clinical area

c) Ensure the resuscitation and emergency equipment is available and in working order

d) Ensure local processes are in place for the checking of emergency medical equipment, to include processes to ensure defective / missing equipment is reported and replaced expediently

e) Monitoring compliance with Trolley checks according to local policy :

- Compliance with daily checks of defibrillators, suction and equipment
- A full check of the trolley ascertaining whether:
  - there are any missing or out of date items of equipment
  - There are any unnecessary or added items

f) Maintain accurate records of staff deemed competent to undertake checking of resuscitation equipment.

g) Ensure that appropriate support is given to staff involved in any resuscitation incident

h) Develop and implement action plans in response to the findings of local audit and submit these to the nursing leads. Records should provide clear audit trails in terms of compliance.

i) Ensure Emergency equipment checks list are retained for 8 years.

5.9 All Employees

Have responsibility for:

a) Being aware of and complying with policy, guidelines, procedures and processes in relation to resuscitation.

b) Initiating the resuscitation attempt when finding a patient in a cardiac arrest situation and managing the situation until support arrives such as the Resuscitation/Medical Emergency Team (UHL) or Paramedics (LPT/LLR Alliance – also see 5.12)

c) Clinical areas must as much as practicably possible help direct and facilitate access to the Resuscitation/Medical Emergency team to their areas.

d) Support the Resuscitation/Medical Emergency team as required.

e) All Staff must undertake training in resuscitation skills appropriate to their role. See section 7 for further details.

5.10 Resuscitation/Medical Emergency Team Leader (for UHL only)

Have responsibility for:

a) Managing the arrest situation in line with resuscitation council guidelines and as detailed in section 6.1

b) Ensuring that they are suitably qualified to lead the management of a cardiac arrest / medical emergency by completing either Advanced Life Support course in within the last 4 years or equivalent as agreed with the Senior Resuscitation Officer or evidence of annual update at resuscitation training

5.11 The Resuscitation/Medical Emergency Team Members (for UHL only)

Have responsibility for:

a) Responding to the 2222 emergency bleep and twice daily 2222 emergency bleep test

b) Maintaining professional responsibility to ensure that their knowledge and skills in relation to resuscitation training is in date and valid

c) Supporting the Resuscitation/Medical Emergency Team Leader

d) Making themselves aware of the layout of the hospital site(s) in which they work

5.12 Nurse / Medic / Allied Healthcare Professional in Charge (for LPT/LLR Alliance)

Have responsibility for:

a) Initiating the resuscitation attempt and managing the situation until the paramedics arrive on scene

b) Providing a handover to the Paramedic crew

6 Policy Statements

6.1 UHL Resuscitation / Medical Emergency Response Processes and Procedures

University Hospitals of Leicester (UHL)		
A)	**Cardiopulmonary Arrest Prevention** **Identifying the deteriorating patient** Early recognition of the deteriorating hospital patient allows prompt and effective treatment. The use of an Early Warning Score (NEWS2) system of clinical triggers is used to identify patients who deteriorating or acutely unwell and at an increased risk of cardiopulmonary arrest. **EWS Escalation pathway** The referral pathway attached to the scoring system directs nursing and medical response. The use of structured communication tool SBAR (Situation/ Background/ Assessment/ Recommendation) should be used to assist in the communication of the patient's condition.	
B)	**If you have significant concerns regarding the patient's condition and require support and assistance to manage that patient you should not hesitate to summon the Resuscitation / Medical Emergency team for UHL on 2222.** The 2222 system **MUST** be used to summon urgent assistance in these circumstances. Staff required in addition to the emergency team can be contacted urgently through switchboard.	
C)	**Activating the UHL Resuscitation/Medical Emergency Team** **All 2222 calls will now be considered as Cardiac Arrest calls by Switchboard.** This means that Switchboard will automatically refer to **2222** medical emergency calls as Cardiac Arrests when putting out a message over the Emergency Bleep. You should state: • Nature of emergency (e.g. Cardiac Arrest or Medical Emergency) • Ward / Department • The level the ward/ department is on • The Building the ward/ department is in • The Hospital site the ward/ department is on For Example:- "Adult Cardiac Arrest, Ward 15, level 5, Balmoral Building, Leicester Royal Infirmary" "Paediatric Cardiac Arrest, Ward 12, level 4, Balmoral Building, Leicester Royal Infirmary" UHL has many sites and buildings with many departments' especially non-clinical areas less well known to many members of staff or have restricted access. If the team have not arrived within five minutes then the person activating the call must ring 2222 again.	

Activating Emergency Response with "The Firs or The Laurels" building Glenfield site

Summon assistance via 9999 and state:

- Nature of emergency (e.g. Cardiac Arrest or Medical Emergency)
- Name of building, and location

For Example:-
"Adult Cardiac Arrest, The Fir's, Glenfield Hospital site,

The Caller must Ensure that the person on the end of the line knows that the hospital is not place of safety and that this is an emergency.

D)

Actions of the Resuscitation/Medical Emergency Team Leader

a) Actively direct and coordinate the resuscitation attempt, according to Resuscitation Council (UK) Advanced Life Support guidelines.

b) Ensure the precise and detailed documentation of all aspects of this should be on both the cardiac arrest / medical emergency section of the relevant incident reporting system and in the patient's medical notes.

c) Consult for advice and information, where appropriate and feasible, with:
   i. Fellow members of the Resuscitation/Medical Emergency team (where applicable)
   ii. The patient's own Consultant led team
   iii. The most senior clinician in charge of the patient's care

d) Cease the resuscitation attempt after consultation with members of the resuscitation team as appropriate.

e) Ensure that post-resuscitation care and safe transfer to other care facility e.g. ITU, CCU, Theatres etc. is organised or appropriately delegated.

f) If a patient is to be transferred to another center for ongoing treatment, it is the Team Leaders responsibility to ensure that a 999 call has been placed for a paramedic crew and an effective handover has been given, either by themselves or an appropriately delegated resuscitation team member, to the team transferring the patient e.g. the Paramedic crew and the receiving centre.

g) Instigate and allow time for 'debriefing' after resuscitation attempt.

E)	**Actions of the Resuscitation/Medical Emergency Team** The Team should consist of a minimum of 5 core members, who must be identifiable on a published daily Rota. The Resuscitation/Medical Emergency Team membership at all three UHL sites should as far as possible include as a minimum: • Resuscitation Team Leader: • Anesthetic cover (minimum Core Trainee) • 2 junior Doctors (minimum of one FY2 /SHO) • Senior Nurse support Other members of staff can request to receive 2222 Emergency Bleeps; however, they are considered additions to the team and should not replace core team members.	
F)	**Escalation pathway (Appendix Five)** Sets out an Escalation Pathway to assist team leaders, members and switchboard to resolve issues that arise from Medical Emergency/ Resuscitation Team under establishment, non-response to a 2222 call or Bleep tests within UHL.	
G)	**Manual Defibrillation** Available for those members of staff that work in an acute clinical area only such as ITU's, HDU's, CCU's, Admission Units and the Emergency Department. This training is provided by attending one of the following courses. • Immediate Life Support or UHL equivalent (Having specifically been assessed and signed as competent at Manual Defibrillation). • Advanced Life Support. • Advanced Paediatric Life support. • Paediatric Life Support. • Doctors on the cardiac arrest team training or equivalent. • Bespoke training approved by the Clinical Skills Unit.	
H)	**Automated External Defibrillation (AED's)** The Resuscitation Council (UK) has recommended that the use of AED's should become a standard training requirement for all clinically qualified staff not listed above. This training is provided by attending one of the following courses. • Basic Life Support and AED • ILS where an AED certificate only is deemed appropriate	
I)	**Defibrillation and Children** Defibrillation of children may only be undertaken by staff who have completed an appropriate Paediatric Life Support Course or who have a documented competency on eUHL. AED's can only be used on children over 8 years old.	
J)	**Resuscitation / Emergency Medical Equipment** a) These procedures outline the processes the Trust must have in place to ensure	

emergency medical equipment is available in the right place, at the right time, and in optimal operational order.

b) The term emergency medical equipment refers to all oxygen delivery methods, portable suction, wall Suction, defibrillator, drug box and resuscitation equipment usually held within a suitably approved resuscitation trolley or a grab bag. This is not an exhaustive list and clinical areas should include any other items deemed to be essential based on the unique clinical needs of the area.

c) Maintenance of emergency medical equipment applies to all clinical areas, both outpatients and inpatients, and any other patient treatment areas requiring the presence of emergency medical equipment.

d) Those persons checking the resuscitation/emergency equipment must be deemed competent by the senior ward / clinical area manager, to do so prior to carrying out equipment checks and should be undertaken by a professionally registered member of staff.

e) In any clinical areas that do not have registered professional members of staff or if they are unavailable a non-registered member of staff may carry out equipment checks providing that they have been deemed competent to do so.

f) Equipment checks must include, where appropriate, the availability of Emergency medical equipment at every inpatient bed space, operational status and readiness of equipment.

g) A record of all checks must be made using the Emergency Medical Equipment Checking Book listing:

- The individual who made the check.
- Any deficiencies/ omissions and the action put into place to rectify the situation.
- A record of the date and time.

K)

<u>Frequency and level of equipment checks</u>

a) Heads of Nursing have the delegated authority to propose the frequency of checking of the resuscitation equipment within their CMG subject to the minimum requirement of :

I. The Cardiac Arrest Trolley **MUST** be opened a **<u>MINIMUM</u>** of once per week. The weekly check **MUST** be a full check of all of the equipment in the trolley including the checking of all expiry dates ensuring no item of equipment will expire prior to the next check.

II. The once weekly Cardiac Arrest Trolley check **it is recommended** this check should take place on a Wednesday between the hours 08:00- 16:00 to ensure you have access the Cardiac Arrest Equipment Central stores to replace equipment.

III. The Cardiac Arrest Trolley **MUST** be sealed at all times with a Numbered Snappable security tag. This security tag **MUST** be checked and documented daily that it remains intact.

IV. The Cardiac Arrest Trolley **MUST** be fully checked if the seal is broken and / or after each use.

V. The Defibrillator, Portable Suction, Oxygen Cylinder, Wall suction, Wall Oxygen **MUST** be checked daily and after every use.

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b) A cardiac arrest equipment check lists (Adult, Adult / Paediatric combined) and equipment picture books can be accessed via INSITE

c) CMG's may develop cardiac arrest check list forms locally to meet the unique needs of the area on the proviso that they adhere to the guiding principles of this procedure and provide clear audit trails. Any amended sheet must be submitted to the Resuscitation Committee for consideration and approval prior to use.

L)

Out of Clinical Area Emergency

UHL Adult 'Grab bags' are located

- GGH main reception only.

The Adult grab bag contains

- 1x Lifepak 1000 (AED)
- 1X BVM Adult
- 1X BVM Child
- 1X portable Suction Unit
- 1X Oxygen (CD) cylinder

This Adult grab bag is intended to provide basic equipment in an emergency only.

UHL Paediatric 'Grab Bags' are located

- Glenfield Hospital Paediatric Intensive Care Unit,
- Leicester Royal Infirmary Children's Intensive Care Unit,

The Paediatric grab bags contain equipment that compliments the Combined Adult & Paediatric trolley and MUST be taken to all Paediatric 2222 calls by a member of the Paediatric cardiac arrest team from either CICU or PICU.

M)

Cardiopulmonary Arrest / Medical Emergency call to Leicester Partnership Trust Buildings – Bradgate Unit or Bennion Centre

a) The provision of resuscitation services between UHL and LPT are specified in the "Resuscitation services" (Adult) service level agreement is reviewed annually

b) Full Operational details are to be found in Appendix SIX of this policy.

N)

Renal Satellite Units or Off Site Services Provided by UHL

In the event of a Cardiac arrest or Medical emergency at a renal satellite unit or any off site service provided by UHL staff they should follow their locally agreed protocol.

6.2 LPT Resuscitation / Medical Emergency Response Processes and Procedures

Leicester Partnership Trust (LPT)		
A)	**<u>Activating Emergency Response within LPT</u>** Summon assistance via (9) 999 along with 2222 where appropriate (Bradgate & Bennion Centre excluding HPC) and state: •Nature of emergency (e.g. Cardiac Arrest or Medical Emergency) •Hospital Name, Location and Ward **For example**:- " Adult cardiac arrest, Hinckley and Bosworth Community Hospital East ward". Ensure that the person on the end of the line knows that the hospital is not a place of safety and that this is a medical emergency **<u>Activating Emergency Response from UHL 2222 team within LPT</u>** UHL will respond to 2222 call made by LPT as specified in Appendix 6 (Service Level agreement between UHL & LPT) **All 2222 calls received by UHL Switchboard will be considered as <u>Cardiac Arrest calls.</u>** This means that Switchboard will automatically refer to **2222** medical emergency calls as a Cardiac Arrest, when putting out a message over the Emergency Bleep system. Callers should state: • Nature of emergency (e.g. Cardiac Arrest or Medical Emergency) • Ward / Department • The level the ward/ department is on • The Building the ward/ department is in • The Hospital site the ward/ department is on **For Example**:- "Adult Cardiac Arrest, Belvoir Ward, Bradgate Unit, LPT buildings, Glenfield hospital Site"	
B)	**All staff MUST know the telephone number to summon help in their clinical environment. Dialing 9 will get an outside line and then 999 will get the emergency services. Bradgate & Bennion Centre (excluding HPC) must also call 2222.**	
C)	**<u>Actions of the Nurse / Medic / Allied Healthcare Professional in Charge</u>** a) Activate the emergency response and commence resuscitation attempt according to Resuscitation Council (UK) Advanced Life Support guidelines. b) On arrival of paramedic crew handover the incident. c) Ensure the incident is documented using the incident reporting system system e-irf in addition complete cardiac arrest audit form and document in the patient's notes. d) Provide support to the Paramedic crew as requested e) Instigate and allow time for 'debriefing' after resuscitation attempt.	

Leicester Partnership Trust (LPT)		
D)	**<u>Resuscitation / Emergency Medical Equipment</u>** a) These procedures outline the processes the Trust must have in place to ensure emergency medical equipment is available in the right place, at the right time, and in optimal operational order. b) The term emergency medical equipment refers to oxygen, suction, defibrillator, drug box and resuscitation equipment usually held within a suitably approved resuscitation trolley or an emergency bag. The contents are standardised and must not be altered witout the approval of the Resuscitation service/ Committee. c) Maintenance of emergency medical equipment applies to all clinical areas including outpatient facilities, and any other patient treatment areas requiring the presence of emergency medical equipment. d) Those persons checking the resuscitation/emergency equipment must be deemed competent to do so prior to carrying out equipment checks and should be undertaken by a professionally registered member of staff. e) In any clinical areas that do not have registered professional members of staff or if they are unavailable a non-registered member of staff may carry out equipment checks providing that they have been deemed competent to do so. f) Equipment checks must include, where appropriate, the availability of Emergency medical equipment at every inpatient bed space, operational status and readiness of equipment. g) A record of all checks must be made using the Daily Emergency Equipment Trolley/Bag Daily Check Record: • The individual who made the check. • Any deficiencies/ omissions and the action put into place to rectify the situation. • A record of the date and time. h) Emergency equipment must not be removed following a medical emergency from the clinical area for investigative purposes, for example by police officers this includes defibrillator, oxygen and suction machine. Clinical staff should contact the on call manager in the event of any requests to remove emergency equipment.	

E)	**Frequency and level of equipment checks** a) All suction, oxygen and defibrillator, must be checked a minimum of every 24 hours or after each time the equipment is used. This includes portable and wall mounted equipment. b) Within LPT community in-patient ward areas the resuscitation trolley must be sealed. c) Within LPT acute Mental health, Mental Health Services for Older People (MHSOP) and Children and Adolescent Mental Health Services (CAMHS) wards the resuscitation trolley must be sealed and kept within a locked room. d) In all areas the cardiac arrest equipment must be checked on a daily basis in accordance with the Locally Agreed Emergency Trolley/Bag checklist and this must be rotated between both day and night staff to ensure that staff are familiar with the Trolley/bag opening and closing mechanisms and equipment familiarisation. e) The daily trolley checklist for non-acute/acute areas for wards, pictures of the trolley contents and other trolley related checklists can be accessed through LPT E-Source. Please refer to Knowledge and development Resuscitation resource folder. f) Resuscitation equipment must be checked daily and recorded on the appropriate checklist found in the resuscitation checklist file. These records should be archived for 8 years in line with information storage guidelines.	
F)	**Out of Clinical Area Emergency** LPT Emergency Bags are located at Gillivers, The Grange, Rubicon Close short break homes and CAMHS Rothesay.	

6.3 LLR Alliance Resuscitation / Medical Emergency Response Processes and Procedures

LLR Alliance		
A)	**<u>Activating Emergency Response within the LLR Alliance</u>** Summon assistance via 9999 and state: • Nature of emergency (e.g. Cardiac Arrest or Medical Emergency) • Hospital Name, Location and Ward For Example:- "Adult Cardiac Arrest, Hinckley" Ensure that the person on the end of the line knows that the hospital is not place of safety and that this is an emergency	
B)	**All staff MUST know the telephone number to summon help in their clinical environment. Dialing 9 will get an outside line and then 999 will get the emergency services**	
C)	**<u>Actions of the Nurse / Medic / Allied Healthcare Professional in Charge</u>** a) Activate the emergency response and commence resuscitation attempt according to Resuscitation Council (UK) Advanced Life Support guidelines. b) On arrival of paramedic crew handover the incident c) Ensure the incident is documented using the incident reporting system and in the patient's medical notes. d) Provide support to the Paramedic crew as requested e) Instigate and allow time for 'debriefing' after resuscitation attempt.	
D)	**<u>Resuscitation / Emergency Medical Equipment</u>** a) These procedures outline the processes the Trust must have in place to ensure emergency medical equipment is available in the right place, at the right time, and in optimal operational order. b) The term emergency medical equipment refers to oxygen, suction, defibrillator, drug box and resuscitation equipment usually held within a suitably approved resuscitation trolley or a grab bag. This is not an exhaustive list and clinical areas should include any other items deemed to be essential based on the unique clinical needs of the area. c) Maintenance of emergency medical equipment applies to all clinical areas, both outpatients and inpatients, and any other patient treatment areas requiring the presence of emergency medical equipment. d) Those persons checking the resuscitation/emergency equipment must be deemed competent to do so by the senior ward / clinical area manager, prior to carrying out equipment checks and should be undertaken by a professionally registered member of staff. e) In any clinical areas that do not have registered professional members of staff or if	

they are unavailable a non-registered member of staff may carry out equipment checks providing that they have been deemed competent to do so.

f) Equipment checks must include, where appropriate, the availability of Emergency medical equipment at every inpatient bed space, operational status and readiness of equipment.

g) A record of all checks must be made using the Emergency Medical Equipment Checking Book listing:

- The individual who made the check.
- Any deficiencies/ omissions and the action put into place to rectify the situation.
- A record of the date and time.

E) **<u>Frequency and level of equipment checks</u>**

d) Heads of Nursing have the delegated authority to propose the frequency of checking of the resuscitation equipment within their CMG subject to the minimum requirement of :

VI. The Cardiac Arrest Trolley **MUST** be opened a **<u>MINIMUM</u>** of once per week. The weekly check **MUST** be a full check of all of the equipment in the trolley including the checking of all expiry dates ensuring no item of equipment will expire prior to the next check.

VII. The once weekly Cardiac Arrest Trolley check it is recommended this check should take place on a Wednesday between the hours 08:00- 16:00 to ensure you have access the Cardiac Arrest Equipment Central stores to replace equipment.

VIII. The Cardiac Arrest Trolley **MUST** be sealed at all times with a Numbered Snappable security tag. This security tag **MUST** be checked and documented daily that it remains intact.

IX. The Cardiac Arrest Trolley **MUST** be fully checked if the seal is broken and / or after each use.

X. The Defibrillator, Portable Suction, Oxygen Cylinder, Wall suction, Wall Oxygen **<u>MUST</u>** be checked daily and after every use.

e) A cardiac arrest equipment check lists (Adult, Adult / Paediatric combined) and equipment picture books can be accessed via INSITE

CMG's / LLR Alliance may develop cardiac arrest check list forms locally to meet the unique needs of the area on the proviso that they adhere to the guiding principles of this procedure and provide clear audit trails. Any amended sheet must be submitted to the Resuscitation Committee for consideration and approval prior to use.

F) **<u>Out of Clinical Area Emergency</u>**

LLR Alliance Grab Bags are located at Market Harborough District Hospital, Melton and Oakham Outpatient Departments.

7 Education and Training

7.1 General Requirements:

a) Staff must undertake the Resuscitation training relevant to the patient group(s) in their workplace, i.e. Adult, Paediatric and/or Neonate. This may involve all three. This initial training should ideally take place during the staff member's induction period

b) Non-Clinical staff should be trained as a minimum to recognise a cardiopulmonary arrest, summon help and initiate chest compressions.

c) Non-Registered Clinical Staff who are 'patient facing' should be trained as a minimum to recognise patients at risk of cardiopulmonary arrest and to use a systematic approach to assess and recognise the need to summon appropriate help early and make appropriate interventions

d) Registered Clinical Staff (Statutory or assured including Medical Staff) who are 'NON patient facing' should be trained as a minimum to recognise patients at risk of cardiopulmonary arrest and to use a systematic approach to assess and recognise the need to summon appropriate help early and make appropriate interventions

e) Registered Clinical Staff (Statutory or assured including Medical Staff) who are 'patient facing' should be trained as a minimum to recognise patients at risk of cardiopulmonary arrest and to use a systematic approach to assess and recognise the need to summon appropriate help early and use the defibrillator in manual or automated mode if appropriate

f) Medical Staff should be trained as a minimum as above. However trainees will have specific requirements as specified by the Foundation Programme, General Medical Council or Royal College. I.e. Foundation Year One – Immediate Life Support; Foundation Year Two – Advanced Life Support.

g) Access to Resuscitation Education and Training for Adult, Paediatric, and Neonatal is via www.uhlhelm.com, The Academy, through Educational Leads or Departmental Resuscitation Cascade Instructors.

h) LPT and UHL (including LLR Alliance) will recognise the Basic Life Support and Automated External Defibrillator Resuscitation training provided by the resuscitation trainers with assurance that:

    a) The training complies with Resuscitation Council (UK) Guidelines

    b) Includes a theoretical component

    c) Includes an appropriate assessment of ability

    d) The above does not negate the requirement to attend Trust specific additional training or an annual update

7.2 For staff who are accredited instructors, facilitation on one of the courses listed below is deemed your annual update in that component. Evidence of training delivery must be provided to the relevant training department within their Organisation before the training record is updated

a) Basic Life Support

b) Immediate Life Support (ILS) - Full day or Update

c) Advanced Life Support (ALS)

d) Managing Obstetric Emergencies and Trauma (MOET)

e) Advanced Paediatric Life Support (APLS) / European Paediatric Life Support (EPLS)

f) Paediatric Life Support (PLS) / Paediatric Immediate Life Support (PILS)

g) Newborn Life Support (NLS)

7.3 Resuscitation Cascade Instructor Training (UHL ONLY)

a) Resuscitation Cascade Instructors have a delegated role from the Clinical Skills Unit, to teach Basic Life Support and Automated Defibrillation to members of staff.

b) Members of CMG Educational Teams and other staff approved by the Resuscitation Committee can become Cascade Instructors to maintain knowledge and skills they can:

- Attend the Cascade Instructors Course

  or

- Be observed by a member of the Clinical skills unit at one of their cascade sessions on an annual basis as a competence check

c) Cascade Instructors will be able to incorporate the assessment of Basic Life Support and Automated Defibrillation into their Job Role or ward training days

d) Instructors will have autonomy to manage their own training in liaison with the Clinical Skills Unit administration team. All electronic training data will be kept centrally via the www.uhlhelm.com for training quality and audit purposes.

e) All Resuscitation training registers must be entered onto www.uhlhelm.com within 5 days from the date of the course.

f) It is the Cascade Instructor's responsibility to ensure that training is accurately entered onto www.uhlhelm.com

g) Cascade Instructors must provide a minimum of six sessions a year, any less than this will invalidate their instructor status.

8.Process for Monitoring Compliance

This list is not exhaustive and may be added to as other audits are identified.

Element to be monitored	Lead	Method	Frequency	Reporting arrangements
Uptake of training compliance	Trust Resuscitation Lead	HELM or LPT ULEARN System	Monthly at the Resuscitation Committee	A report will be reviewed at each meeting of training compliance across the Services and staff group
Cardiac Arrests - National Cardiac Arrest Audit (NCAA)	Trust Resuscitation Lead	Datix National Cardiac Arrest Audit	Monthly Quarterly (Nationally)	Reported quarterly to Resuscitation Committee Meeting
Do Not Attempt Cardiopulmonary Resuscitation	Trust Resuscitation Lead	Random review of completeness	Quarterly	Reported at quarterly Resuscitation Committee Meeting
Resuscitation Equipment spot audits	Trust Resuscitation Lead	spot audit 20% of each CMG trollies	Monthly	Reported at each Resuscitation Committee Meeting
Resuscitation Equipment	CMG Nursing Leads	Nursing Metrics or local processes	Monthly	reported to the monthly CMG Performance Review Meetings

9 Equality Impact Assessment

a. The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

b. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

10 Legal Liability

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their CBU to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes.

It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies. For further advice contact:

UHL Head of Legal Services on 0116 258 8960 or LPT Head of Legal Services

11. Supporting References, Evidence Base and Related Policies

British Medical Association (2016, 3rd Edition 1st revision) Decisions relating to cardiopulmonary resuscitation. Joint Statement from the British Medical Association, the Resuscitation Council UK and the Royal College of Nursing
https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Resuscitation Council (UK). (2015) Resuscitation Guidelines. RC (UK), London
https://www.resus.org.uk/resuscitation-guidelines/adult-advanced-life-support/

Resuscitation Council (UK). (May 2017) Quality standards for cardiopulmonary resuscitation practice and training. Introduction and Overview. RC (UK), London
https://www.resus.org.uk/quality-standards/acute-care-quality-standards-for-cpr/

Resuscitation Council (UK). (May 2017) Quality standards for cardiopulmonary resuscitation practice and training Acute Care. RC (UK), London
http://www.resus.org.uk/pages/QSCPR_Acute.pdf

Resuscitation Council (UK). (March 2018) Minimum equipment and drug lists for cardiopulmonary resuscitation Acute Care. RC (UK), London
http://www.resus.org.uk/pages/QSCPR_Acute_EquipList.pdf

Skills for Health. (2013) UK Core Skills Training Framework Subject Guide. Skills for Health, Bristol.
http://www.skillsforhealth.org.uk/developing-your-organisations-talent/uk-wide-core-skills-training--framework/

12. Process for Version Control, Document Archiving and Review

12.1 This document will be uploaded onto SharePoint and available for access by Staff through INsite/e-source. It will be stored and archived through the Organisations local systems.

12.2 This document will be reviewed every three years or in response to changes in national guidance or issues identified through incidents.

Appendix One: UHL Resuscitation Committee Terms of Reference

Title :	Resuscitation Committee
Membership :	Chair, appointed by the Medical Director Nominee of the Chief Nurse Senior Clinical Skills Facilitator (Resuscitation Lead) Nominee from the UHL DART team Clinical Member with expertise in Adult resuscitation. Clinical Member with expertise in Paediatric resuscitation. Member with expertise in Palliative Care. Director of Clinical Quality Nominee of Outcome and Effectiveness
	Other members of staff may be co-opted to the Resuscitation Committee or task and finish groups as required
	Administrative support will be provided from the Administration Manager, Clinical Skills Unit, or the Resuscitation Data Officer, Clinical Skills Unit.
Purpose:	To act as an Decision making body for development and implementation and advise on operational policies governing cardio-pulmonary resuscitation and Anaphylaxis (monitoring, management and prevention), and the practice and training of cardiopulmonary resuscitation within the University Hospitals of Leicester NHS Trust (UHL), NCESM and Alliance.
	To make recommendations to the Executive Quality Board regarding all areas of cardiopulmonary resuscitation;
	To monitor the implementation and adherence to national resuscitation guidelines and standards and make recommendations for action where necessary.
	To define the role and composition of the resuscitation team.
	To monitor resuscitation equipment for clinical use is available and ready for use. To advise on standardisation and suitability of such equipment.
	To monitor that appropriate resuscitation drugs (including those for peri-arrest situations) are available and ready for use. To advise on standardisation of such drugs, and to monitor usage.
	To advise on the level of resuscitation training required by staff members with reference to national guidance. To plan adequate provision of training in resuscitation and monitor resuscitation training delivery and uptake.
	To prepare and implement policies relating to resuscitation and treatment

	To review and revise the overseeing, preparation and implement a policy on resuscitation decisions and outcomes, (e.g. DNACPR decisions), and advanced care planning (in collaboration with palliative care).
	Quality improvement – to review plans based on audits, e.g. review of audit data using National Cardiac Arrest Audit data for benchmarking and to make recommendations/propose actions where necessary.;
	To review resuscitation incident data relating to patient safety, identifying trends and themes and to make recommendations where necessary.
	To prepare an annual report for presentation to the Executive Quality Board.
	To review UHL position at four monthly intervals in relation to cardiac arrest incident, type of arrests and hospital outcome through audit data to inform future policy and practice development.
	To keep informed of trends and developments in Resuscitation matters from relevant national bodies e.g. CQC, NCEPOD, and to ensure UHL is responding appropriately to such developments.
	To act as an advisory body for all other issues relating to resuscitation practice.
Attendance :	The members of the committee listed above are required to attend at least three quarters of the meetings held annually.
	It shall be permissible for deputies to attend by exception.
Quorum :	A quorum shall be 4 members, including the Chair and Senior Clinical Skills Facilitator/Resuscitation Lead (or, in their absence, their deputies), and at least one clinical member with expertise in resuscitation.
Frequency of meetings:	The committee will meet monthly or more often if required
Minutes and Reporting:	The minutes of all meetings shall be formally recorded
	The committee will report to the Executive Quality Board via a quarterly report.
Sub-Committees:	The committee has no formal subcommittees
	'Task and finish' groups may be established by the committee as required. Such groups will report to the Resuscitation Committee. Membership, Aims and timelines for such groups will be defined by the Committee.
Review:	The terms of reference of the committee shall be reviewed at regular intervals, but at least every year.

Appendix Two: LPT Resuscitation Committee Terms of Reference

References to "the Committee" shall mean the Resuscitation Committee

1.0 Purpose of Committee

1.1 The purpose of the Group is to lead on the development, delivery, and assurance on all matters relating to resuscitation and recognising the deteriorating patient standards and risk. The committee reports to the Patient Safety Improvement Group.

2.0 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

3.0 Authority

3.1 The Committee is authorised by Patient Safety Improvement Group to conduct its activities in accordance with its terms of reference.

3.2 The Committee is authorised by Patient Safety Improvement Group to seek any information it requires from any employee of the Trust in order to perform its duties.

4.0 Membership

4.1 The membership of the Committee is listed in below.

4.2 Only members of the Committee have the right to attend Committee meetings. However, other individuals and officers of the Trust may be invited to attend for all or part of any meeting as deemed appropriate.

4.3 Membership of the Committee will be reviewed and agreed annually with the Patient Safety Group.

4.4 Chairmanship of this Committee will be jointly by Dr Reza Kian, Consultant in Learning Disabilities, Learning Disabilities and Kate Fitzpatrick, Senior Resuscitation Officer. In the absence of both, the remaining members present shall elect one of themselves to chair the meeting.

4.5 The group will be made up of members who must attend regularly and meet the 75% attendance criteria and attendees who will need to attend when they have papers to present when required to do so for specific agenda items. Members will be:

- Senior Resuscitation Officer
- Consultant in Learning Disabilities, Learning Disabilities
- Learning and Development Representative
- Advanced Nurse Practitioner, ANP
- Patient Safety Representative
- Clinical Audit Lead
- Service Representation for each Directorate / Service
- Trainee Doctor

5.0 Secretary

5.1 An administrator will act as secretary of the Committee.

6.0 Quorum

6.1 The quorum necessary for the transaction of business shall be 5. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7.0 Frequency of Meetings

7.1 The Committee shall normally meet bi monthly but not less than 5 times a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

7.2 Members will be expected to attend at least three-quarters (75%) of all meetings.

8.0 Agenda/Notice of Meetings

8.1 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

9.0 Minutes of Meetings

9.1 The secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.

9.2 Minutes of Committee meetings shall be circulated within 7 working days to all members of the Committee. The Committee's minutes will be open to scrutiny by the Trust's auditors.

10.0 Duties

The Committee shall:

10.1 Devise, approve, agree implement and monitor policies within the remit of the Group, overseeing the guideline from Resuscitation Council.

10.2 Provide assurance to the Patient Safety Improvement Group of the Trust compliance with and implementation of all policies identified as the responsibility of the Group.

10.3 Communicate exceptions and risks to the Patient Safety Improvement Group in a bi-monthly highlight report.

10.4 Consider new and revised legislation and best practice guidance and how it may impact the Trust providing recommendations and guidance to the Trust regarding resuscitation and related subjects, including the recognition of the deteriorating patient.

10.5 Act as early warning mechanism to alert the organisation to resuscitation related emerging risks.

10.6 Disseminate information and provide feedback to appropriate groups, committees, staff and other stakeholders on resuscitation risk issues.

10.7 Ensuring that actions identified from clinical and quality improvement audits are communicated effectively.

10.8 Ensuring there is effective recording and reporting of incidents related to resuscitation where patient safety is a risk

11.0 Reporting Responsibilities:

11.1 The Committee shall make whatever recommendations to the Patient Safety Improvement Group it deems appropriate on any area within its remit where action or improvement is needed.

11.2 The Committee shall produce for the Patient Safety Improvement Group an annual report on the work it has undertaken during the course of the year.

12.0 Annual Review

12.1 The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Patient safety group for approval.

13.0 Risk Responsibility

13.1 The Group has special responsibility for management of all aspects of resuscitation activities including training, medical devices, liaising with UHL and across the full scope for the Trust's business undertakings.

Appendix Three: UHL Education and Training –

All UHL Staff and patient groups.

1) All clinical staff who have patient contact as part of their clinical duties must have access to an Annual assessment of their resuscitation skills appropriate to their role
2) All non clinical Staff will complete approved elearning package and online assessment
3) All staff will undergo a taught session and assessment in BLS and AED at their induction to the trust.
4) All subsequent annual resuscitation training updates can be obtained utilising the eLearning learning resources supported by face to face assessment of practical skills.
5) Those staff requiring Immediate / advanced Life support or UHL accredited equivalent can should book on to a taught session or arrange a 1-2-1 assessment with the clinical skills unit.
6) All Assessors must hold an appropriate nationally recognised or locally accredited qualification in resuscitation to be able to undertake staff training.
7) CMG's should make an assessment of the skill required for their staff in consultation with the resuscitation committee .

All training can be accessed through the Clinical Skills Unit website:
www.uhlhelm.com

Appendix Four : LPT Education and Training – Adult and Child

Resuscitation training is provided in accordance with the Leicestershire Partnership NHS Trust Mandatory Training Register as follows;

- Clinical staff in Adult Mental Health, Learning Disabilities and Community Health Services (except those who require Adult Immediate Life Support) will attend Adult Basic Life Support Level 2 and will repeat this training annually.
- Clinical staff in the Families, Young People and Children's services will attend Adult and Paediatric Life Support level 2 and will complete this training annually.
- Qualified nursing staff (where defibrillators available) will attend Adult Immediate Life Support level 3 and will complete this training annually.

Access to Adult Resuscitation Training

1) All clinical staff who have patient contact as part of their clinical duties must have access to training in resuscitation skills appropriate to their area of employment.

2) Training is available from the Resuscitation Service and Trainers. Competency must be demonstrated as per statutory and mandatory training policy and observed for competency. The level of skill which should be assessed will be dependent on the area in which the individual is employed and the scope of their employment. Individual managers where necessary can make an assessment of the skill required in consultation with the Learning and Development.

3) All qualified medical staff with patient contact must demonstrate competency in the management of a compromised, critically ill, and arrested patient. All qualified medical staff with patient contact should be familiar with the location, and use, of emergency equipment. They should demonstrate competency in the use of the defibrillator deployed in their area.

4) After the initial induction period no staff member should be allowed to act as part of the resuscitation team until competency has been demonstrated.

Delivery of adult training

Certificates of competency will be issued centrally for all staff and will be recognized across the Trust.

All training can be accessed through ULEARN

Appendix Five: UHL Escalation pathway

Escalation pathway to resolve Medical Emergency/Resuscitation Team under establishment and non response to a 2222 call or Bleep tests within UHL.

TEAM LEADER
If any allocated member of the Cardiac Arrest Team fails to attend a 2222 call

ALL STAFF
If at Hand Over the next person allocated to carry the Cardiac Arrest Bleep is absent from shift.

SWITCH BOARD
Following Failure to respond to **TWO** Cardiac Arrest Bleep Tests Switch Board

INFORM DUTY MANAGER

DUTY MANAGER
attempt to resolve issue locally.

DUTY MANAGER
If not resolved locally refer to
SILVER COMMAND.

GOLD COMMAND

Appendix Six

9.0 Emergency Response – SLA LPT – UHL

Service/ care pathway	**Resuscitation Services (Adults)**
Commissioner Lead	**Service Lead – Helen Perfect** **Contract Lead – Tony Scotcher**
Provider Lead	**Service Lead – Lee Rowley** **Contract Lead – Paresh Ruparel**
Period	**April 2018 – March 2019**
Date of Review	**November 2018 (updated January 2019)**

Key Service Outcomes

To provide the agreed level of clinical staff to the standards set out in this specification to ensure that a professional, high quality service is provided to patients, meeting national clinical and access requirements.

1. Purpose

1.1 Aims and objectives

Provide emergency resuscitation services for specific LPT sites for adult patients (Adult patients defined as age 18 years and over):

- Respond to 2222 calls with the agreed staffing levels

(For paediatric patients (aged under 18 years) LPT will contact 999)

2. Service Scope

2.1 Service Description

Events requiring adult resuscitation attempts are time critical; high risk episodes of care. These events are low in frequency but are obviously high risk.

Evidence suggests that patients that are treated with specific Resuscitation teams have improved chances of survival than ones where treatment is commenced/continued by ambulance staff.

University Hospitals of Leicester (UHL) operates an Adult Resuscitation service for the patients within its wards/hospitals. LPT operate services at Leicester Glenfield hospital that in the event of an emergency would benefit from access to the adult resuscitation services based at the same site. It makes sense to utilise these expert adult resuscitation resources to the limited occasions that LPT patients require them on these shared sites approximately, 25 incidents per year.

2.2 Any exclusion criteria

Wards and sites specified in 3.3 identify the scope of this service. This specification excludes the provision of:

- General medical or emergency response advice
- Specialist medical interventions that it would be unreasonable or impracticable to perform within the LPT ward / clinical environment.
- Paediatric patients (aged under 18 years)
- Sites not included in the service specification are as follows:
    - LPT Community clinics and services

2.4 Whole System Relationships

UHL will ensure that staff supplied to deliver this service cooperate fully with LPT staff, other staff and other Providers engaged by LPT in the delivery of its services.

2.5 Interdependencies with other services

LPT Resuscitation Training provider
LPT Resuscitation Committee
Emergency Ambulance Services
UHL Emergency Departments

2.6 Relevant networks and screening programmes
N/A

2.7 Training/ education/ research activities

Training is undertaken as part of LPT's own training protocols.

3. Service Delivery

3.1 Service model

NOTE: This specification covers Adult patients only and currently there is no provision for Paediatric patients within this specification.

Once the request (via 2222 call to UHL switchboard) has been made, the UHL Adult Resuscitation team will attend the LPT site at the internal door way between Glenfield hospital and Leicester Partnership Trust Building.

It is appreciated that access to LPT buildings is restricted for patient safety reasons. It is the sole responsibility of the LPT management to ensure that all LPT staff are aware of the procedure to facilitate access to UHL staff to their buildings and to the relevant area. (Specified in Section 3.2)

UHL's adult resuscitation service will work with LPT staff to attempt to resuscitate/stabilise the patient so that the next stage of the patient's pathway can be determined.

It will be the responsibility of UHL's cardiac arrest team to ensure appropriate contemporaneous documentation of their involvement in the 2222 event. This process will ensure effective documentation from UHL's cardiac arrest team to both LPT and the Emergency paramedics and ultimately the receiving medical team. LPT will document events up to the arrival of the cardiac arrest team.

LPT will either provide UHL cardiac arrest team access to the patient's electronic records system to document the 2222 event. A copy of the patients electronic records must be given by LPT to the emergency transferring paramedics to ensure effective handover of the event to the receiving medical team
or
LPT staff will make available to UHL's resuscitation team a specifically designed 2222 call proforma (appendix 1) that will ensure effective documentation of the 2222 event. A copy of the proforma must be given to the transferring emergency paramedics and be given to the receiving medical team.
The 2222 call proforma will be scanned into the patients LPT medical notes

If the patient is to be transferred outside of LPT It will be LPT's responsibility to ensure the documentation of the 2222 event is transferred with the patient to the receiving medical team, and when deemed appropriate verbal handover given.

An Incident report will be completed by the LPT staff for every 2222 call placed regardless of outcome and the information will be shared and reviewed with the UHL lead for Resuscitation to identify any issues or concerns by either Trust.

3.2 Care pathways

LPT clinical staff are trained in Resuscitation Training according to LPT standards and this is monitored by the LPT Resuscitation Committee.

Once the 2222 request / call has been made to UHL's Switchboard a member of the LPT staff will be available at the access door between UHL and LPT .They will remain at this point for a minimum of 20 minutes or until the UHL resuscitation service team leader states that they have adequate members of the resuscitation team present.

Following a 2222 call being placed to UHL, it is LPT staffs responsibility to immediately call 999 for a paramedic crew to attend the emergency. This will ensure a safe and timely transfer of the patient to an appropriate place of care.

It is the responsibility of LPT to ensure access for UHL resuscitation service team members. Delays in obtaining access will be identified and recorded on UHL incident reporting system and shared with the appropriate LPT team / representative.

Patients that are stabilised will continue to be cared by the LPT service without any further involvement with UHL services.

Patients that require further emergency treatment will be transferred to the appropriate Emergency Service.

If the patient requires transfer of care to another hospital outside of LPT:

- The UHL cardiac arrest team in conjunction with LPT staff must decide whether a medical or anaesthesia / critical care escort is to be considered.
- If anaesthesia / critical care escort is considered this must be discussed with on-call consultant for Glenfield AICU to elucidate what the transfer requirements are and whether anaesthesia / critical care accompaniment is required.
- If medical escort is needed then the cardiac arrest team leader is responsible in conjunction with the on-call medical consultant to decide how to proceed with the medical escort
- It is expected that some patients will be appropriate for transfer by paramedic escort alone

The emergency paramedic will together with LPT staff will be responsible for the safe transfer and handover of the patient to the receiving medical team.

Patients that do not survive the incident will follow LPT's normal Operating protocols.

3.3 Location(s) of service delivery for UHLs Adult Resuscitation team.
Services will be provided to:

- Bradgate Unit (Glenfield Site)
- Bennion Centre (Glenfield Site)

A full schedule of the Specific Wards, Divisions and main points of contacts are given below

Site	Venue	Contact Number	Meeting Point	Beds	Division	Main contact
Bradgate	Belvoir	225 2293		10	AMH	Rachel Dawson
Bradgate	Aston	225 2293		19	AMH	Rachel Dawson
Bradgate	Ashby	225 2293		21	AMH	Rachel Dawson

Bradgate	Bosworth	225 2293		20	AMH	Rachel Dawson
Bradgate	Heather	225 2293		18	AMH	Rachel Dawson
Bradgate	Thornton	225 2293		24	AMH	Rachel Dawson
Bradgate	Beaumont	225 2293		22	AMH	Rachel Dawson
Bradgate	Watermead	225 2293		20	AMH	Rachel Dawson
Bennion	Kirby			24	MHSOP	Zayad Saumtally
Bennion	Welford			24	MHSOP	Zayad Saumtally
Bennion	Langley			15	Eating Disorder	Maureen Williams Williams
Bradgate	PSAU (for Adult patients only)	225 2293		2 rooms	AMH	Rachel Dawson

3.4 Days/ hours of operation

The service is provided 24 hours a day seven days a week. UHL have in place appropriate systems that guarantees the handover of bleeps from one bleep holder to another and this is routinely tested and audited. Any operational issues with these processes are escalated to the on site duty manager for resolution.

3.5 Referral Criteria and sources

- The UHL Resus service will respond to adult cardiac arrests from all LPT Staff subject to any agreed exclusion criteria in 2.2.

3.6 Referral processes

- Referrals by dialling 2222 via the internal phone systems
- To ensure clarity all calls will be treated as the highest emergency (Cardiac Arrest)

3.7 Discharge processes

- Patients will be under the care of LPT and they will be responsible for the ongoing treatment of patients that stay within their units.
- Where clinically appropriate, patients may get referred on to UHL for continuing treatment.

3.8 Response times and prioritisation

- Response time is crucial
- UHL team/staff will aim to respond within 5 minutes of receiving the 2222 call from LPT. However, LPT will recognise that there is considerable distance between clinical areas within UHL and the LPT access doorway and times in excess of 5 minutes may be unavoidable.
- Given the above it essential that access to LPT buildings for UHL's resuscitation team is not delayed.
- LPT must have reliable procedures in place to facilitate access and this information must form part of the resuscitation training curriculum for LPT.
- UHL Adult Resuscitation team will treat LPT calls in the same priority as other UHL cases.

4. Other

4.1 Compliance with Trust Policies and Procedures

- A UHL representative will attend the LPT Resuscitation committee and feedback issues about quality and data/activity levels.

- There will be a minimum bi-annual operational meetings between the two services to aid good communication channels and share relevant changes to various Trusts policies and operational procedures. This should include Head of Service; Service Manager and Clinical Director from both organisations.
- LPT will identify an individual within their organisation that will act as a link for all LPT services; this must be an individual with knowledge and experience in dealing with resuscitation policy and procedures to deal with day to day issues and concerns.

- An Incident Report will be completed by the LPT staff for every 2222 call placed regardless of outcome and the information will be shared and reviewed with the UHL lead for resuscitation to identify any issues or concerns by either Trust.

- Either party will raise any problems identified with the service immediately, rather than waiting for the operational meetings. For example if UHL have problems accessing the site on any instances.

4.2 Compliance with National & Local Guidelines

- All staff supplied by the Provider must work with LPT to ensure that services are delivered in accordance with all mandatory national guidance and local commissioning guidelines and policies.

4.3 Professional Conduct

The Provider is to ensure that clinical staff who are supplied to LPT:

- Deliver the service with dignity and respect, with due regard to the needs and wishes of patients
- Act on all reasonable requests made by LPT staff and contractors when delivering services on behalf of LPT
- Treat all LPT staff, contractors and members of the public (patients and visitors) with dignity and respect and work to create an environment free from harassment

4.4 Equipment

Resuscitation equipment will be provided and maintained by LPT. The particular types of machines and equipment that are to be used are listed below.

UHL will provide LPT with the cardiac arrest trolley equipment checklist which is used within UHL and the layout of equipment within UHL's standardised cardiac arrest trollies for information purposes only. UHL does not stipulate how LPT should organise its equipment.

LPT remains solely responsible for devising its own resuscitation equipment checklist for use within its cardiac arrest trollies. LPT must ensure that their cardiac arrest equipment checklist complies with the recommendation for resuscitation equipment published by the Resuscitation councils (RC (UK) November 2015).
LPT will ensure all cardiac arrest equipment is present, available and in full operational working order.

LPT make their records immediately available to UHL for inspection of their checking processes for cardiac arrest equipment if UHL should require them as a result of any investigation following a 2222 call.

UHL will not assume any responsibility for any cardiac arrest equipment provided by LPT.

Medtronic Lifepak 1000 series automated defibrillators are used within LPT.

Equipment available and present on the Resuscitation trolley as listed.

Notification should be given to UHL where LPT are planning on purchasing or using alternative equipment.

LPT will be responsible for the provision and maintenance of all cardiac arrest equipment on LPT sites.

Any deficits found with LPT cardiac arrest equipment will be documented on a UHL clinical incident form and investigated by the Trust Lead for resuscitation.

4.5 NHS Standard Services Contract

The Provider will be supporting LPT in the delivery of clinical services under the terms of the Standard NHS Hospital Services Contract therefore must be able to provide evidence to support the key requirements of this as requested by the Trust.

4.6 Performance Monitoring
The service will be monitored through regular review meetings in accordance with the requirements of the service specification.

4.7 Quality & Governance
The Provider must have a robust clinical governance framework in place with strong clinical leadership and clear lines of accountability which operates across organisational and/or professional boundaries. The Provider must have effective systems and processes in operation, which ensure that high standards of clinical care are maintained and the quality of the services provided are continually improved. The service will reflect the service standards and governance arrangements as described in the UHL Resuscitation Policy, which adheres to the National Standards supervised by the Resuscitation Council.

The key components of any effective clinical governance framework can be grouped under the following headings:

- Staffing & Staff Management
- Clinical Effectiveness & Clinical Audit
- Risk Management
- Research & Development
- Patient and Public Involvement
- Information Management

The Trust has clear expectations in respect of each of these components as they relate to the provision of this service.

4.7.1 Staffing & Staff Management

The staffing profile of the resuscitation team are as follows;

- Anaesthetist
- Registrar
- 2 junior doctors
- Outreach Nurse/Night Manager

- This provides a team which exceeds basic requirements for immediate care (Immediate/Advanced Life Support) and also permits decisions regarding further care if resuscitation restores a circulation after cardiac arrest.
- There are also some other colleagues who may be called to assist during a cardiac arrest resuscitation in different locations e.g. Surgical SpR for arrests in surgical wards, Perfusionist for arrest calls in critical care locations, it will be the decision of UHL cardiac arrest team leader to request these additional team members.

UHL must ensure that staff are employed in appropriate numbers and with the necessary skills and competence to deliver the entire service.

UHL is expected to demonstrate that employees' competencies and skill levels are in line with any national guidance and that these are clearly laid out in a locally agreed competency framework which are assessed on a regular basis.

The Provider will be required to demonstrate how they ensure the maintenance and development of the relevant clinical skills of their staff.

UHL is responsible for the appraisal of clinical staff

Where staff are required to be registered with professional bodies it is the responsibility of the provider to check compliance.

4.7.2 Clinical Effectiveness & Clinical Audit
It is required that the Provider delivers a service that is clinically effective, and that they regularly review their clinical practices in light of emerging evidence with regards to the effectiveness, efficiency and safety of individual interventions.

The Provider should provide the services in accordance with up-to-date evidence of clinical effectiveness and in particular, compliance with the following:

- Care Quality Commission Healthcare Regulations 2010
- Relevant national standards and guidelines

The Provider should perform regular clinical audit cycle, in which the clinical performance of the services are reviewed and measured against agreed standards, NICE etc, with the processes/practices refined and improved as required. The clinical audit cycle, report outcomes and evidence of learning need to be shared with LPT.

LPT will investigate the Incident Reports and when agreed and closed forward the final report to the Providers Resuscitation Officer/Data Officer to be collated with the Providers completed incident report.

4.7.3 Risk Management
Key components of any quality assurance programme are the minimisation of risk and effective management of those incidents that do occur. It is expected that the Provider will:

- Comply with appropriate statutory regulations (including, but not limited to Data Protection Act, Health & Safety at Work Act, COSHH Regulations)
- Implement the Trust's incident reporting policy in place and ensure that all incidents are reported in line with the Trust Policy and where any patient has been harmed, the Trust's 'Being Open' policy is applied. LPT service lead will provide copies of all policies where required.
- Have a robust system in place whereby families, other professionals and the public can raise concerns about the quality of care and have adequate arrangements in place for the investigation of such concerns in line with Trust policies, and ensure that any concerns raised are reported to the Trust complaints or PALS Service
- Have robust evidence based policies, procedures, guidelines, standard operating procedures in place for staff to follow in delivering the service. LPT service lead will provide copies of all policies and Guidelines to be provided.

4.7.4 Research and Development
In addition to compliance with up-to-date evidence and best practice, the Provider is encouraged to participate in research and development, provided that the necessary approval has been obtained from the Trust's Medical Research Ethics Committee and local protocols with regards to such activities are adhered to.

4.7.5 Patient and Public Involvement
As this is a direct clinical support service there is no specific patient or public involvement requirement.

4.7.6 Information Management
The Provider is required to comply with all IT and information governance standards and requirements. LPT service lead will provide copies of all policies and standards to be provided

5. Activity

5.1 Indicative Activity Plan

The baseline activity plan is approximately 25 attendances per year at the Glenfield site only. The service requirements fluctuate and are usually modest activity levels. Should the numbers increase significantly then this agreement must be reviewed.

If LPT resume admitting patients to their clinical areas at Leicester General Hospital a minimum of three months' notice must be given in writing to UHL's lead for Resuscitation outlining the proposed changes. This agreement will then require urgent review and will be renegotiated.

6. Prices & Costs

A recurring annual LEVEL 1 fee of £30,900 will be payable for the provision of the resuscitation service by UHL to LPT, this is to be reviewed every 12 months.

Level 2 & 3 payment will be invoiced per occurrence.

The Level 1 fee assumes that all 2222 events are not complex and will not result in any additional time (beyond the Resuscitation attempt) for the cardiac arrest team members

Level 1;
Attendance of the Resuscitation Team at an event
Completion of the Incident Form

Level One Cost:
Level One will be charged annually at £30,900.

Level 2:
Level 1 with an additional requirement to follow up including written reports by the Resuscitation Team

Level Two Cost:
Level Two will be charged per occurrence at £350 per occurrence via invoice. This sum is based on the salaries of the staff involved to review notes and prepare written reports.

Level 3:
Level 1 or 2 with an additional requirement to follow up including written reports by the Resuscitation Team resulting in any involvement in a critical incident review / coroner's investigation.

Level 3 Cost:
Level Three will be charged per occurrence at £600 per clinical staff member per day required to attend an investigation hearing via invoice. The time allocation to preparing and attending a serious investigation or coroner's court is significant. Therefore this sum is based on two working days of salary. One to prepare and one to attend.

Appendix Seven

LPT - Cardiac Arrest Audit Form

Affix Patient ID Label or record
Name:
NHS No:
Hosp. No.
D.O.B. / /
Male ☐ Female ☐ Consultant/Dr

Date……..…Time…….……..Ward/Department……
Initial Condition of the patient at the time of 1st healthcare professional

Conscious Yes ☐ No ☐ Collapse Witnessed Yes ☐ No ☐

Breathing Yes ☐ No ☐ Pulse Yes ☐ No ☐

Time of 999/2222 call …….. By whom……

BVM available Yes ☐ No ☐

i-Gel insertion Yes ☐ No ☐ By Whom ……..Time……..

AED available Yes ☐ No ☐

Time	Rhythm (Shockable/ non-shockable)	CPR (30:2)	Adrenaline	Other drugs

Time of paramedics/crash team at patient side……..

Time Resuscitation discontinued ..... (Please state reason)

Return of circulation ☐ No response to treatment ☐

Post arrest (please tick all that apply)

Breathing ☐ Pulse ☐ Blood Pressure……/ .....(please state)
Neuro status: Alert ☐ Verbal response ☐ Response to pain ☐
Unresponsive ☐

Transferred to GGH ☐ LRI ☐ Other ☐(please state)
Time of transfer to other hospital……

Relatives informed Yes ☐ No ☐ By Whom…….... Time……
Consultant informed Yes ☐ No ☐ By Whom……..…… Time……

EiRF entry completed Yes ☐ No ☐ By Whom

……Time……..…

Form completed by (please print) ..... Signature

……..……

Names of staff involved in incident

Name	Job title	Area of work

Please photocopy & place/scan in patient's notes
Additional Information

Appendix Eight

LPT DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**Joint Cardiopulmonary Resuscitation policy**		
Completed by:	**Terri Kilby**		
Job title	**Assistant resuscitation Officer**		**Date 22/07/2019**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		No	
8. Will the process require you to contact individuals in ways which they may find intrusive?		**No**	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**			
Data Privacy approval name:			
Date of approval			

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix Nine

LPT Due Regard Screening Template

Section 1	
Name of activity/proposal	Joint Cardiopulmonary policy
Date Screening commenced	18/07/2019
Directorate / Service carrying out the assessment	Enabling/Learning and Development. Resuscitation Service
Name and role of person undertaking this Due Regard (Equality Analysis)	Terri Kilby. Assistant Resuscitation Officer
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The aim of this policy is to provide an efficient and effective resuscitation service by ensuring that all clinical interventions are based upon the latest guidelines produced by the Resuscitation Council UK. This policy sets out LPT and UHL (including LLR Alliance) processes for the management and strategic oversight of the provision of resuscitation services, training and the effective management of Cardiac Arrests and Medical emergencies in accordance with Resuscitation Council UK guidelines.	
OBJECTIVES: The objective of this policy sets out LPT and UHL (including LLR Alliance) processes for the management and strategic oversight of the provision of Resuscitation services, training and the effective management of cardiac arrests and medical emergencies in accordance with Resuscitation Council UK Guidelines.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	There is no impact on any of the mentioned characteristics.
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	✓

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
The policy applies to all patients and does not impact on any protected characteristics.			
Signed by reviewer/assessor	Terri Kilby	**Date**	22/07/2019
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	