## RESUSCITATION POLICY

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<tr>
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<td>September 2007</td>
</tr>
<tr>
<td>Ratification</td>
<td>Resuscitation Committee</td>
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<td>September 2007</td>
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</table>
| Reviewing responsibility | Trust Resuscitation Committee  
CARE committee |
| Lead Author/s Sponsor | Linda Holdway -  
Senior Resuscitation Officer  
Michelle Davies – Resuscitation Officer |
| Contributors | See acknowledgements page |
ACKNOWLEDGEMENTS

We gratefully acknowledge the contribution of the following members of staff.

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<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Dr R. Davies</td>
<td>Chairman Resuscitation Committee</td>
<td>Cardiology</td>
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<tr>
<td>Dr N. Macarthy</td>
<td>ITU Consultant Intensivist</td>
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<td>CNST Trust Lead</td>
<td>Clinical Governance &amp; Risk</td>
</tr>
</tbody>
</table>
COMMENTS AND REVIEW BY:

Resuscitation Committee       Barnet and Chase Farm Hospitals NHS Trust
CARE Committee               Barnet and Chase Farm Hospitals NHS Trust
EXECUTIVE SUMMARY


All clinical practitioners and staff should ensure that they have understood their responsibilities in relation to the key areas outlined below:

This policy is applicable to all clinical staff who supervise or provide direct care of patients within Barnet and Chase Farm Hospitals NHS Trust.
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1. INTRODUCTION

“Healthcare institutions have an obligation to provide an effective resuscitation service to their patients and to ensure that their staff receive training and regular updates maintaining a level of competence appropriate to each individual’s employed role. This requires appropriate equipment for resuscitation, training in resuscitation, managerial and secretarial support, financial planning, and continual reappraisal of standards and results.

Failure to provide an effective service is a failure in duty of care that is a clinical risk, contravenes the principles of clinical governance, and has implications for clinical negligence premiums”. (1)

Service Objectives

The purpose of this policy is to provide direction and guidance for the planning and implementation of a sustainable high-quality resuscitation within the Trust. It is the joint responsibility of the Clinical Risk Committee / Senior Resuscitation Officer and the Resuscitation Committee to ensure policy distribution, implementation and compliance throughout the Trust.

A suitable infrastructure is required to establish and continue support for these activities. (2)

2. SYNTHESIS OF EVIDENCE

In 2000 the first evidence based guidelines were published from ILCOR (International Liaison Committee on Resuscitation) & from which the ERC (European Resuscitation Council) based its own resuscitation guidelines. Resuscitation science continues to advance & these clinical guidelines were again updated in 2005(4)

2.1 PREDICTING AND PREVENTING CARDIAC ARRESTS

This section should be understood by all clinical staff and is a direct extract from
- BCH. CLINICAL GUIDELINES FOR THE REFERRAL OF PATIENTS USING THE PAR-SCORING TOOL TO THE CRITICAL CARE OUTREACH TEAM (CCOT) (5)

The Critical Care Outreach team within Barnet and Chase Farm hospitals NHS Trust have adopted an adapted physiological early warning-scoring tool, based on the version from Nottingham Foundation NHS Trust hospital.
Use of the PAR tool

All patients who have documented clinical observations including Temperature, Pulse, Respirations and Blood Pressure should have a PAR score recorded on every occasion. Observations should be documented on the Trust’s Clinical observations chart, which incorporates the PAR tool below.

In addition, patients who are a matter of concern for a health care professional should have a set of observations recorded and a PAR score calculated.

<table>
<thead>
<tr>
<th>Score</th>
<th>Neuro level</th>
<th>Resp. rate</th>
<th>Heart rate</th>
<th>BP systolic</th>
<th>Urine output</th>
<th>Total score</th>
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<tr>
<td>3</td>
<td>Confused or agitated</td>
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<td>71-80</td>
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<td>81-100</td>
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</table>

The PAR Tool flowchart outlines the actions to be taken if the patients PAR score is above 3 or if a member of staff is concerned about a particular patient. The Flow chart endorses the prompt recording of clinical observations, including heart rate, blood pressure, pulse, respirations and conscious level. If the score is 3 or more or the member of staff remains concerned, a call should be made to the SHO of the patient’s own team or on call equivalent plus the Critical Care Outreach Team. See Appendix 5.

The importance of thorough clinical observations and the use of the PAR tool has been incorporated into all BLS, ILS, ALS teaching sessions run by the Resuscitation Officers to promote the work of the Critical care Outreach and the early warning systems in place within the Trust.

2.2 TRAINING OF CLINICAL STAFF

All Medical, Nursing, Midwifery & Allied Health Professionals ( AHP ) staff working within the Trust should safely and ably assess a collapsed individual within the hospitals sites & initiate appropriate further action.
All non clinical staff should summon further assistance and phone the 2222 Emergency number.

All clinical staff should be given the availability to undertake annual BLS updates.

It is the responsibility of all senior staff / clinical managers to ensure that their staff can access resuscitation training - both on induction and as appropriate subsequently and it is also the responsibility of the individual staff member to seek such training.

Staff should undergo regular resuscitation training to a level appropriate for their expected clinical responsibilities & relevant specialties (1) See Appendix 9a-b – Mandatory Training Matrixes (Training Needs Analysis)

This will commence during their initial Trust Induction as CPR involves essentially practical skills (6) all training sessions will allocate sufficient time to teach and practice relevant skills.

Within this Trust the training for management of a cardiopulmonary arrest will follow the standard national and international guidelines.

Clinical staff will be instructed to implement the Resuscitation Council RC(UK) 2005 guidelines for Adult, Paediatric and Newborn resuscitation. This will be facilitated by the Trust Resuscitation Officers and Ward / Dept Link Trainers.

2.3 RESUSCITATION TEAM

Every hospital admitting acutely ill patients should have a Resuscitation Team responding to any Cardiopulmonary Arrest. Ideally the team should include at least two doctors with current training in advanced life support (1)

It is the responsibility of each manager / shift leader to ensure that all staff present know how to initiate the correct action, in addition laminated posters at each phone support the correct procedures including Obstetric Emergencies & Trauma calls.

To summon the appropriate Resuscitation Team member / members for all respiratory and cardiac arrests, the following action is undertaken:

**DIAL 2222 & clearly state:**

- Whether Adult or Paediatric Cardiac Arrest
- Name of Ward / Dept or
- exact location if elsewhere within Hospital perimeter
To summon the appropriate Doctor concerned for the patient who shows signs of life but requires immediate Emergency care, the following action is undertaken:

**DIAL 2222 & clearly state**

- **FAST BLEEP** the specific Registrar required to the relevant area (e.g. Medical, Anaesthetist, Paediatric Registrar)

All team members will respond to the relevant daily “Test Call” to ensure their Voice Pager is functioning correctly

**Record keeping**

All events to which the cardiac arrest team is called must be audited (8)

The team leader should ensure the **mandatory CPR Report form** is completed during / post arrest with x1 copy for patient notes & 2nd copy to the Resuscitation Officer. Appendix 11a-b.

**2nd Emergency call within primary response period**

Where another team cannot provide cover, the above team leader will designate a team member to respond or attend themselves

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### 2.4 RESUSCITATION COMMITTEE

Healthcare institutions should have a resuscitation committee that is responsible for all resuscitation issues(1) and lead on the monitoring of all the minimum (Level 1) requirements within the current NHSLA Risk Management Standards(2)

Barnet & Chase Farm Hospitals NHS Trust has an active committee who meet on a regular (bimonthly) basis with all members having an active interest in resuscitation.

See Appendix 14 Terms of Reference

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### 2.5 ROLE OF RESUSCITATION OFFICERS

To fulfil training requirements, emergency clinical support and additional responsibilities relating to resuscitation, one RO is required for every 750 members of clinical staff (1)

- to lead, manage and develop – as expert specialists in field, the effective provision of a comprehensive resuscitation service throughout the Trust.
• to lead the planning, organisation and implementation of resuscitation training to clinical staff to a level compatible within their designated role within CNST requirements.
• to be responsible for the ongoing review of all resuscitation practice within the Trust to ensure all patients receive the highest level of clinical practice within the framework of clinical governance.
• To participate/lead regularly, as an active, integral member of the cardiac arrest team to ensure that quality standards are being maintained and own clinical credibility.

Within Barnet and Chase Farm Hospitals NHS Trust there is a team of Resuscitation Officers with secretarial support based within the centralised Resuscitation Training Dept.

There should be a defined resuscitation budget made available for the Senior RO to maintain, upgrade & purchase new equipment for patient use and for training(1)

2.6 RESUSCITATION EQUIPMENT

Ideally the equipment used for cardiopulmonary resuscitation( including defibrillators ) & the layout of equipment & drugs on resuscitation trolleys should be standardised throughout an institution(1).

• All areas should have Pocket Masks strategically placed to enable expired air resuscitation without direct mouth to mouth contact and until Bag/Valve/Mask (BVM) ventilation available.
  Within the Trust all training incorporates use of a Pocket Mask and no staff member is expected to perform mouth to mouth ventilation without this safety device.
  NB. Chest compressions should be commenced whilst awaiting an airway device.
  ( This is known as compression–only CPR ) (7).

• All clinical areas will have a fully equipped resuscitation trolley maintained in a state of readiness at all times and standardised for specific needs of patients e.g. Adult / Paediatric / Newborn.
  Within some Maternity areas sharing between certain areas will occur.

• All Medical, Surgical & Paediatric in-patient clinical areas will have a fully functioning defibrillator – Manual / A.E.D.
  These must only be operated by staff specifically trained in their use.

• Portable equipment will be available within the Trust for availability outside a clinical area.
- Portable oxygen and suction should be on / adjacent to all resuscitation trolleys. Where piped or wall oxygen and suction is available, **these facilities should always be immediately ready for use** (subject to Infection Control guidelines) and always used in preference to portable equipment.

- It is the responsibility of the Ward/Dept manager or shift lead to ensure that all resuscitation equipment in their area is kept clean & fully functional. **All** portable & bedside emergency equipment should be checked and recorded daily and **following each emergency use** by a qualified member of staff. N.B. the frequency of checking will depend on some local circumstances (1).

- All resuscitation equipment should be cleaned / disposed of (single use items) as directed within Trust Infection Control Manual.

- All staff should know the procedures for locating spare equipment for restocking their resuscitation equipment, both on - each ward / dept and the correct use of the Emergency Cupboards.

## 2.7 MANUAL HANDLING

In situations where the collapsed patient is on the floor, in a chair or in a restricted / confined space, the Trust guidelines for the movement of the patient must be followed to minimise the risks of manual handling and related injuries to both staff and patient. Please also refer to the RC (UK) statement which can be found at [http://www.resus.org.uk/pages/safehand.htm](http://www.resus.org.uk/pages/safehand.htm) (2).

## 2.8 POST RESUSCITATION CARE

The importance of Post-resuscitation Care has been recognised by its inclusion into the revised Chain of Survival. Post-resuscitation care commences at the return of spontaneous circulation (ROSC). Once stabilised, the monitored patient needs to be safely transferred to the most appropriate care area (e.g ITU, HDU, CCU) for continued monitored care.

**Prior to / during transfer**

The decision to transfer a patient should be made by a senior member of the admitting team.
- A full assessment of the patient must be carried out and documented immediately prior to the patients transfer.
- Oxygen, suction, a defibrillator/monitor and emergency drugs must accompany the patient in the event their condition deteriorates or changes en route.
- The relatives should be updated and informed of the transfer.
- The transfer team should comprise of individuals capable of responding appropriately to any deterioration in the patient's condition, including a further cardiac arrest. (1)

It also may be necessary to transfer the patient to another hospital or organisation using the most suitable Ambulance service depending on the patients’ condition.

2.9 **DO NOT ATTEMPT RESUSCITATION (DNAR)**

It is essential to identify
(a) patients for whom cardiopulmonary arrest is an anticipated terminal event and in whom cardiopulmonary resuscitation (CPR) is inappropriate; and
(b) patients who do not wish to be treated with CPR (1)

All staff should refer further to the separate Trust DNAR policy that is available to all staff and patients.

Adherence to the Mental Capacity Act (2005) which came into force on 1st April 2007 is a legal requirement and should always be referred to when considering DNAR orders and Advanced Decisions (2)

3.0 **PERFORMANCE EVALUATION**

3.1 **Evaluation of effectiveness**

Clinical effectiveness and outcomes are measured against national objectives formulated by the Resuscitation Council (UK) (2004) and NHSLA Risk Management Standards for Acute Trusts (April 2007)
- Early warning systems in place for the recognition of patients at risk of cardiopulmonary arrest;
- Post resuscitation care;
- Do not attempt resuscitation orders (DNAR);
- Process for ensuring the continual availability of resuscitation equipment;
- Training requirements for all clinical staff, as identified in the training needs analysis;
- Audit and evaluation of all the services provided

► Early warning system – PAR is audited twice yearly through snapshot audits of usage on wards. This data is collected by the critical care outreach team. Results are disseminated to the Nurse and Midwifery Executive Committee
The CPR report forms should be completed for all cardiac arrest calls including false calls to enable correlation of outcomes & immediate action on any issues that may arise. Appendix 11a & b
This will also enable the Resuscitation officers to produce an annual report of resuscitation practice and outcome.

Yearly & “spot check” audits on Equipment & DNAR policy are undertaken by the Resuscitation Officers and presented to the Resuscitation Committee & sent to Clinical Governance for any further dissemination within the Trust.

Performance monitoring of all training includes recording of all attendance and non attendance and 6 monthly reports to all Dept managers.

4. FEEDBACK, CORRESPONDENCE AND REVIEW

4.1 Review dates
This document will be reviewed by the Resuscitation Committee in 2011 or before if prompted by scientific developments, new guidance from the Resuscitation Council or by other issues generated within the Trust.

4.2 Process for feedback
The names of staff listed on page 2 have been sent an electronic copy of this document and invited to add comments. This process will be repeated 6 months before the review date in 2011.
LITERATURE SEARCH

The Databases used in this literature search included CINHAL and Medline. Search terms included
- Prevention of cardiac arrests
- Resuscitation
- Witnessed Resuscitation

The time span of the search predominantly ranged from 2000-2007
Articles have only been included in the reference list prior to 1999 if they are internationally recognised papers that lay the foundations for the development of witnessed resuscitation.
APPENDIX 2

CRITICAL APPRAISAL

The references cited in this document have been appraised using the Trust-wide model of critical appraisal – SIGN- Appendix 3
APPENDIX 3

REFERENCE LIST
The reference list will be in a table with SIGN grading.

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<td>5. BCH. 2006 Clinical Guidelines for the referral of patients using the PAR scoring tool to the Critical Care Outreach Team (CCOT)</td>
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### APPENDIX 4

#### BIBLIOGRAPHY

   
   *Resuscitation* 67, S1, 53-189

   
   Safer care for the acutely ill patient: learning from serious incidents.
   
   *NHS. National Patient Safety Agency*


   
   *Resuscitation* 67, S1, 175 -176
Barnet & Chase Farm Hospitals NHS Trust
Patient At Risk (PAR) FLOW CHART

Perform Clinical observations
T,P, R, BP

Pulse absent?
Yes

No
perform PAR score

PAR >3

No

Yes

Still worried?
Call critical care outreach team for advice and support.
Document time of call.

Bleep SHO of team responsible for patient and critical care outreach team

Medical emergency?
Yes

Call SpR

No

Assess patient
MOVE = Monitor, Oxygen, IV, ECG

Begin appropriate treatment and investigations

Improvement?
Yes

No

Continue to monitor patient with less frequent observations, and recheck score

Score increasing >3
More experienced medical assistance and advice of ITU must be sought
Call ITU medical staff
Patient might benefit from transfer to critical care area
APPENDIX 6a

COLLAPSE OF PATIENT, STAFF OR VISITOR IN NON CLINICAL AREA

A non clinical area is defined as any area within the parameters of the hospital grounds that has no clinical staff working in the area and has no clinical equipment.

RESPONSIBILITIES

It is the responsibility of all members of Trust and Contract Staff to assist any Individual (patient, visitor or staff) that is found collapsed or in distress in any non-clinical area of the site.

Actions of –

- **Non Clinical Personnel if individual unconscious / unresponsive:**
  Summon help by calling the Medical / Paediatric Registrar Ext 2222 and stay with the individual.

- **Actions of Clinical Personnel if individual shows no signs of life:**
  Call Cardiac Arrest team Ext 2222 and commence basic life support until the Cardiac Arrest Team arrives.

- **Actions of all staff if individual is conscious / responsive**
  Emergency Bleep the Site Manager via Ext 2222 who will assess and arrange transport to a clinical area*.
  Stay with the individual until the Site Manager arrives.

*Transfer to a clinical area may necessitate a 999 Ambulance call.

The Site Manager will complete the IR1 and Site Log and inform the Senior Manager on call.

**Barnet Car Park**

If the above individual is located in the **Barnet car park** – use the yellow emergency phones – on automatic 2222 dial to Switchboard.

If you are in any doubt call the Hospital Switchboard - 2222 immediately.
EMERGENCY CALLS FROM A NON CLINICAL AREA

Casualty found collapsed or has called for help

Casualty collapsed and responsive

Dial 2222

Ask to Fast Bleep the Site Manager

State exact location

Await switchboard staff to repeat back the message

Replace phone

Always return to the casualty and stay until senior assistance arrives

Casualty unresponsive

Ask to Fast bleep a Medical Registrar

State exact location

Await switchboard staff to repeat back the message

Replace phone

Resuscitation Department September 2007
IN THE CASE OF A PATIENT EMERGENCY

Patient Assessment

Patient BREATHING

FAST BLEEP / SPECIFIC TEAM

Patient NOT BREATHING

CARDIAC ARREST

Dial 2222

State “FAST BLEEP” for which Registrar/team you require e.g. Medical, Anaesthetic, Paediatric, Surgical.

OBSTETRIC EMERGENCY TRAUMA TEAM

State exact location

Await switchboard staff to repeat back the message

Replace phone

State “CARDIAC ARREST” Adult or Paediatric

State exact location

Await switchboard staff to repeat back the message

Replace phone

Resuscitation Department September 2007
CARDIAC ARREST IN PREGNANCY.

Staff in A+E receive relevant patient details from Ambulance crew and ask for an ETA time.

Staff in A+E then call 2222 stating “Cardiac Arrest and Obstetric Emergency Teams to A+E Resus” and Supervisor of Midwives also to be informed.

Senior midwife on Delivery Suite attends A+E bringing a Resusci-taire.

Staff member in charge from SCBU attends/designates a staff member to attend A+E with neonatal pack.

Senior staff in A+E prepare bed area, check equipment (inc. Obstetric pack) and allocate roles for the resuscitation attempt.

Staff in A+E then call 2222 stating “Cardiac Arrest and Obstetric Emergency Teams to A+E Resus” and Supervisor of Midwives also to be informed.

Senior midwife on Delivery Suite attends A+E bringing a Resusci-taire.

Staff member in charge from SCBU attends/designates a staff member to attend A+E with neonatal pack.

Resuscitation of the mother continues until ROSC or decision made to cease Resuscitation attempt by the Cardiac Arrest Team.

Ensure family are supported and communicated to as necessary.

The baby is assessed and treated on the Resusci-taire as per Newborn Resuscitation (UK) guidelines.

In the event of a response to resuscitation Baby is transferred safely to SCBU.

In the event of ROSC - Mother transferred safely to ITU.

Ensure family are supported and communicated to as necessary.

The baby is assessed and treated on the Resusci-taire as per Newborn Resuscitation (UK) guidelines.

In the event of a response to resuscitation Baby is transferred safely to SCBU.

Resuscitation of the mother continues until ROSC or decision made to cease Resuscitation attempt by the Cardiac Arrest Team.

In the event of ROSC - Mother transferred safely to ITU.

Resuscitation Department September 2007
EMERGENCY CAESAREAN SECTION

Direct extract from:-

When initial resuscitation attempts fail, delivery of the fetus may improve the chances of successful resuscitation of the mother and fetus. The best survival rate for infants over 24-25 weeks gestation occurs when delivery of the infant is achieved within 5 min after the mother’s cardiac arrest. Delivery relieves caval compression and may improve the likelihood of resuscitation the mother. Delivery also enables access to the infant so that resuscitation of the newborn child can begin.

In the supine position, the gravid uterus begins to compromise blood flow in the inferior vena cava and abdominal aorta at approximately 20 weeks gestation; however, fetal viability begins at approximately 24-25 weeks.

- **Gestational age under 20 weeks.**
  Urgent Caesarean delivery need not be considered, because a gravid uterus of this size is unlikely to compromise maternal cardiac output.

- **Gestational age approximately 20-23 weeks.**
  Initiate emergency delivery to enable successful resuscitation of the mother, not survival of the delivered infant, which is unlikely at this gestational age.

- **Gestational age approximately over 23 weeks.**
  Initiate emergency delivery to help save the life of both the mother and the infant.

**Planning**

Advanced life support in pregnancy requires co-ordination of maternal resuscitation, Caesarean delivery of the fetus, and newborn resuscitation within 5 min. To achieve this, units likely to deal with cardiac arrest in pregnancy should:

- have in place plans and equipment for resuscitation of both the pregnant patient and the newborn child;
- ensure early involvement of obstetric and neonatal teams
- ensure regular training of staff in obstetric emergencies(7)

Within Barnet and Chase Farm Hospitals NHS Trust all relevant staff will follow Appendix 8a.
### Mandatory Training Induction Matrix for Resuscitation

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<th>PAR &amp; Basic Life Support</th>
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<th>Newborn Life Support</th>
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<td>Nurses and HCA's (Children's Areas)</td>
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### Mandatory Training Update Matrix for Resuscitation

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<td></td>
</tr>
<tr>
<td><strong>Nurses and HCA’s (Children’s Areas)</strong></td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td><strong>Midwives</strong></td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td><strong>Nurses and HCA’s (SCBU)</strong></td>
<td>√</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td><strong>Doctors (Adult Areas)</strong></td>
<td>√ inc ALS update</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctors Children’s Areas and SCBU</strong></td>
<td>√ inc ALS update</td>
<td>√ inc PALS update</td>
<td>√</td>
</tr>
<tr>
<td><strong>Doctors Obstetric areas</strong></td>
<td>√</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td><strong>PAMS (Physio, OT, Dietician, Pharmacists etc)</strong></td>
<td>√ If clinical</td>
<td>√ If clinical in paeds</td>
<td></td>
</tr>
<tr>
<td>ADULT CARDIAC ARREST TEAM:--</td>
<td>PAEDIATRIC TEAM:--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Registrar</td>
<td>Pediatric Registrar &amp; SHO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical SHO</td>
<td>Anaesthetic Registrar / S.H.O.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical HO</td>
<td>Resuscitation Officer *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthetic Consultant/Registrar/SHO</td>
<td>Porter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuscitation Officer* (when not teaching)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care Outreach Nurse * (if on duty)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Porter</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OBSTETRIC EMERGENCY TEAM:--</th>
<th>TRAUMA TEAM:--</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric Consultant</td>
<td>Orthopaedic Registrar &amp; SHO</td>
</tr>
<tr>
<td>Obstetric Registrar &amp; SHO</td>
<td>Surgical Registrar &amp; SHO</td>
</tr>
<tr>
<td>Paediatric &amp; Neonatal Registrar &amp; SHO</td>
<td>Anaesthetic Consultant</td>
</tr>
<tr>
<td>Anaesthetic Registrar / SHO</td>
<td>Anaesthetic Registrar / S.H.O.</td>
</tr>
<tr>
<td>Senior Midwife</td>
<td>Resuscitation Officer *</td>
</tr>
<tr>
<td>Senior Nurse – SCBU</td>
<td>Critical Care Outreach Nurse *</td>
</tr>
<tr>
<td>Resuscitation Officer*</td>
<td>Radiographer</td>
</tr>
<tr>
<td>Critical Care Outreach Nurse *</td>
<td>Porter</td>
</tr>
</tbody>
</table>
## Barnet and Chase Farm Hospitals NHS Trust – A&E CPR Report

N.B. This is the sole record of this CPR attempt. Use 24 hour clock to record all times.

### Pre-hospital care (from ambulance form)

| Time of 999 call | hrs | Cannulated | y | n |
| Time crew reached patient | hrs | Drugs given | y | n |
| Time of arrival at A&E | hrs | Intubated | y | n |
| Was arrest witnessed? | y | n | Defibrillated | y | n |
| Bystander CPR? | y | n | CPR | y | n |

### On arrival at A&E

- Airway maintained: yes | no |
- Adequate ventilation: yes | no |
- Cardiac massage: yes | no |
- Relatives present: yes | no |
- Cycles timed: yes | no |
- Supported by: yes

### Crash team

<table>
<thead>
<tr>
<th>Name</th>
<th>Arrival time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casualty Officer</td>
<td>hrs</td>
</tr>
<tr>
<td>Medical Registrar</td>
<td>hrs</td>
</tr>
<tr>
<td>Medical SHO</td>
<td>hrs</td>
</tr>
<tr>
<td>Medical HO</td>
<td>hrs</td>
</tr>
<tr>
<td>Anaesthetics SHO</td>
<td>hrs</td>
</tr>
<tr>
<td>Porter</td>
<td>hrs</td>
</tr>
<tr>
<td>Other - specify</td>
<td>hrs</td>
</tr>
</tbody>
</table>

### Resuscitation details - please give full information on all interventions (with times)

<table>
<thead>
<tr>
<th>Time</th>
<th>Rhythm</th>
<th>nurse</th>
<th>DC shock (J)</th>
<th>Injection site</th>
<th>Atropine</th>
<th>Atropine-dose</th>
<th>CPR - manuels</th>
<th>Interventions / drugs</th>
</tr>
</thead>
</table>

- Defibrillation delivered by Doctor: yes | no |
- Manual: AED | ICD |
- Time CPR stopped: |
- Reason - patient died: survived |
- Team leader - name: |
- Grade: |
- Form completed by: Use additional form if necessary

Additional problems / interventions? | yes | no |
- Documented in Nursing: yes | no |
- Medical notes: |
- Resuscitation Officer informed? | yes | no |
- Top copy to be retained in confidential notes: |
- Yellow copy to be returned to the Resuscitation Officer: |
## APPENDIX 11b

### Barnet and Chase Farm Hospitals NHS Trust — In-Hospital CPR Report

N.B. This is the sole record of this CPR attempt.

Use 24 hour clock to record all times

| Hospital: | Barnet | Chase Farm |

### Crash team

<table>
<thead>
<tr>
<th>Name</th>
<th>Arrival time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Registrar</td>
<td>hrs</td>
</tr>
<tr>
<td>Medical SHO</td>
<td>hrs</td>
</tr>
<tr>
<td>Medical HO</td>
<td>hrs</td>
</tr>
<tr>
<td>Anaesthetics SHO</td>
<td>hrs</td>
</tr>
<tr>
<td>Porter</td>
<td>hrs</td>
</tr>
<tr>
<td>Other - specify</td>
<td>hrs</td>
</tr>
</tbody>
</table>

### Patient’s name: ____________________________

### Hospital number: ____________________________

### Date of birth: __/__/____

### Date of admission: __/__/____

### Diagnosis: ____________________________

### Date of arrest: __/__/____

### Time crash call made: __________ hrs

### Location: ____________________________

### Was arrest witnessed? yes [ ] no [ ]

### Basic life support initiated by: ____________________________

### Mechanism of arrest

| Cardiac [ ] | Respiratory only [ ] | False alarm [ ] |

### Presenting rhythm

| Asystole [ ] | VF / VT [ ] | PEA [ ] |

### Resuscitation details - please give full information on all interventions (with times)

<table>
<thead>
<tr>
<th>Time</th>
<th>Rhythm</th>
<th>Thump?</th>
<th>DC shock [J]</th>
<th>Amiodarone dose</th>
<th>CPR - minutes</th>
<th>Interventions / drugs</th>
</tr>
</thead>
</table>

### Defibrillation delivered by Doctor [ ] Nurse [ ] Implantable [ ]

### Manual [ ] AED [ ] ICD [ ]

### Time CPR stopped __________

### Reason - patient died [ ] survived [ ]

### Documentation in Nursing [ ] Medical [ ] notes

### Resuscitation Officer informed? yes [ ] no [ ]

### Additional problems / interventions? yes [ ] no [ ]

### Top copy to be retained in medical notes

### Pink copy to be returned to the Resuscitation Officer.

---

**Use additional form if necessary**
IN – HOSPITAL RESUSCITATION

Collapsed/sick patient

Shout for HELP and assess patient

NO

Call Resuscitation Team

CPR 30:2
With oxygen and airway adjuncts

Apply pads/monitor
Attempt defibrillation if appropriate

Advanced Life Support when Resuscitation Team arrives

YES

Signs of life?

Assess ABCDE
Recognise and treat
Oxygen, monitoring, IV access

Call Resuscitation Team if appropriate

Handover to Resuscitation Team
Unresponsive?

Open airway
Look for signs of life

CPR 30:2
Until defibrillator/monitor attached

Call Resuscitation Team

ASSESS RHYTHM

Shockable (VF/pulseless VT)

1 Shock
150j-360j biphasic or 360j monophasic

Immediately resume CPR 30:2 for 2 min

DURING CPR
Correct reversible causes *
Check electrode position and contact

Attempt/verify:
IV access
airway and oxygen

Give uninterrupted compressions when airway secured

Give adrenaline every 3-5 min

Consider: amiodarone, atropine

Non-shockable (PEA/Asystole)

Immediately resume CPR 30:2 for 2 min

*REVERSIBLE CAUSES
HYPOXIA
HYPOVOLAEMIA
HYPER/HYPOKALAEMIA & METABOLIC
HYPOTHERMIA

TENSION PNEUMOTHORAX
TAMPOANE / CARDIAC
TOXINS
THROMBOSIS (CORONARY OR PULMONARY)
PAEDIATRIC BASIC LIFE SUPPORT

(Health Care Professionals with a duty to respond)

UNRESPONSIVE?

Shout for HELP

Open airway

NOT BREATHING NORMALLY?

5 rescue breaths

STILL UNRESPONSIVE? (no signs of circulation)

15 chest compressions  2 rescue breaths

After 1 minute call resuscitation team then continue CPR
**PAEDIATRIC ADVANCED LIFE SUPPORT**

Unresponsive?

- Commence BLS
  - Oxygenate/ventilate

CPR 15:2
- Until defibrillator/monitor attached

Call Resuscitation Team

ASSESS RHYTHM

**Shockable (VF/pulseless VT)**

- **1 Shock**
  - 4k/kg or AED
  - (attenuated as appropriate)

- Immediately resume CPR 15:2 for 2 min

**DURING CPR**
- Correct reversible causes *
- Check electrode position and contact
- Attempt/verify:
  - IV/IO access
  - airway and oxygen
- Give uninterrupted compressions when trachea intubated
- Give adrenaline every 3-5 min
- Consider: amiodarone, atropine

**Non-shockable (PEA/Asystole)**

- Immediately resume CPR 15:2 for 2 min

*REVERSIBLE CAUSES*

- HYPOXIA
- HYPOVOLOAEMIA
- HYPER/HYPOKALAEMIA & METABOLIC
- HYPOTHERMIA
- TENSION PNEUMOTHORAX
- TAMPONADE,CARDIAC
- TOXINS
- THROMBOEMBOLISM
NEWBORN LIFE SUPPORT

Birth

Term gestation? Amniotic fluid clear? Breathing or crying? Good muscle tone?

YES

Routine care
Provide Warmth
Dry
Clear airway if necessary
Assess colour+

NO

Provide warmth
Position; clear airway if necessary*
Dry, stimulate, reposition

Evaluate breathing, heart rate, colour+ and tone

Apnoeic or HR <100 min

Give positive pressure ventilation+*

HR <60 min

Ensure effective lung inflation +*
then add chest compression

HR <60 min

Consider adrenaline etc.

A

B

C

D

*Tracheal intubation may be considered at several steps
+Consider supplemental oxygen at any stage if cyanosis persists
APPENDIX 13  WITNESSED RESUSCITATION

Background:-
The recommendations from both the Royal College of Nursing & British Association for Accident and Emergency (1995) was that witnessed resuscitation by a close family member should be fully supported (14)

This was further supported by the RC(UK) Project team in 1996 (9)
- offer the relatives the opportunity to be present during resuscitation
- allocate someone specifically to be with them at all times
- explain that if they interfere they may be asked to leave
- explain what is happening in terms they can understand
- allow them to make physical contact with the patient when it is safe to do so

In 2002 the RCN issued further guidance. It is the view of the RCN that, wherever possible, witnessed resuscitation should be supported if that is the wish of the relatives and family members (13)

Guidelines for Staff

- Where possible relatives should be prepared by staff for what they may observe.

- Staff should be able to provide relatives with sufficient information to enable them to make an informed choice. They should be offered the choice of being present at the resuscitation or nearby with all staff present made aware of their location.

- An experienced and trained member of staff should remain present with relatives throughout and after the resuscitation, explaining procedures in terms they can understand and answering any questions. However there may not be adequately trained staff available to implement a supportive role to the family.

- Ensure family are kept fully informed of the resuscitation process where ever they choose to be during the process(10).

- Staff should be aware of relatives presence at the resuscitation and be aware that observed actions or remarks may be misinterpreted.

- If they are not present and wish to see the patient, the staff member should go and assess the situation and update them prior to taking them into the resuscitation area.

- They must understand that if they interfere they may be asked to leave(9)
If a relative is extremely distressed and their actions put the patient at risk they should be escorted from the area by a member of staff. It must be the patient’s welfare that remains the prime consideration (9).

Summary:-

- Offer the relatives the opportunity to be present during the resuscitation
- Allocate someone specifically to be with them at all times
- Explain that if they interfere they may be asked to leave
- Explain what is happening in terms they can understand
- Allow them to make physical contact with the patient when it is safe to do so (9)

Recommended supportive mechanisms for staff members

- Nursing and Medical staff need to be provided with education and training to help equip them with the ability to provide both relevant responses and constant support to parents / carers and relatives.
- Discussion will take place at all level of Resuscitation training within the Trust. Also in order to prepare staff adequately for witnessed resuscitation, case scenarios should include the presence of relatives (11).
- All the staff involved must be given the opportunity to debrief after a resuscitation, particularly when relatives have been present (9)

WITNESSED RESUSCITATION IN RELATION TO RESUSCITATION OF A CHILD

Resuscitation of a child or infant is a rare event and recent research reveals both positive and negative family responses at being present to witness this event (9), (10).

Background:-

It is now widely accepted within children’s services that a parent, or other family member / carer can accompany the child at all times (11). Also current NSF health service standards (12) emphasise the importance of providing services centred on the needs of the child and family but make no specific mention of witnessed resuscitation.

The Resuscitation Council(UK) report (9) considered the presence of relatives in the resuscitation room and advocated giving them the opportunity to be present as long as professional support is provided.

The policy for Great Ormond Street states that relatives are considered to have more right to be present in the resuscitation room than nursing or medical staff (13).
Guidelines for staff

- Where at all possible parent or carer should be prepared by staff for what they may observe.

- Staff should be able to provide parent or carer with sufficient information to enable them to make an informed choice. They should be offered the choice of being present at the resuscitation or nearby with all staff present made aware of their location.

- An experienced and trained member of staff should remain present with parent or carer throughout and after the resuscitation, explaining procedures in terms they can understand and answering any questions. However there may not be adequately trained staff available to implement a supportive role to the family.

- Ensure family are kept fully informed of the resuscitation process where ever they choose to be during the process.

- Staff should be aware of parent or carer presence at the resuscitation and be aware that observed actions or remarks may be misinterpreted.

- If the parent/carer is not present and wishes to return to the child, a staff member should go and assess the situation and update them prior to taking them into the resuscitation area.

- They must understand that if they interfere they may be asked to leave. If a parent or carer is extremely distressed and their actions put the child at risk they should be escorted from the area by a member of staff. It must be the child’s welfare that remains the prime consideration.

- If siblings are present, consider contacting the paediatric ward for support

Paediatric Consultant

- He / She should also be available to explain procedures and answer questions prior to the transfer of the child e.g. awaiting CATS or following the death of the child.

Summary:-

- Offer the relatives the opportunity to be present during the resuscitation
- Allocate someone specifically to be with them at all times
- Explain that if they interfere they may be asked to leave
- Explain what is happening in terms they can understand
- Allow them to make physical contact with the child when it is safe to do so
Recommended supportive mechanisms for staff members

- Nursing and Medical staff need to be provided with education and training to help equip them with the ability to provide both relevant responses and constant support to parents / carers and relatives.

- Discussion will take place at all level of Resuscitation training within the Trust. Also in order to prepare staff adequately for witnessed resuscitation, case scenarios should include the presence of parents / carers.

- All the staff involved must be given the opportunity to debrief after a resuscitation, particularly when parent / carers have been present.
APPENDIX 14 RESUSCITATION COMMITTEE – TERMS OF REFERENCE

The Resuscitation Committee will:

- Maintain responsibility for implementing all operational policies governing Cardiopulmonary Resuscitation practice and training;

- Advise on the composition of the Resuscitation / Cardiac Arrest / Emergency Team & its role;

- Advise about the provision of adequate and appropriate equipment throughout the Trust both for resuscitation of patients and for training purposes;

- Be responsible for ensuring that ERC / RC(UK) guidelines for the resuscitation of victims of cardiopulmonary arrest are implemented effectively;

- Ensure that all members are familiar with research and development in the field of resuscitation;

- Advise on the financial implications of providing resuscitation services in the Trust;

- Support and promote the required numbers of Resuscitation Officers to enable them to fulfil the requirements of their Job Descriptions.

- Consider, approve & ratify any proposed changes with regard to Arrest Trolley layout. The Committee should also approve any changes / review of policies prior to ratification by Clinical Board / equivalent Trust group.

- Ensure essential Audit of both the process and outcome of resuscitation attempts in order to keep Trust management informed of any issues that cannot be resolved by Committee alone.

To these ends the Committee will seek/require the appropriate support from management and the clinical governance lead.