Birmingham Children's Hospital
NHS Foundation Trust

Resuscitation Policy

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Ratified by:	Clinical Risk and Quality Assurance Committee
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Name of originator/author: Lead Officer Responsible:	Fiona Reynolds, Paul McVittie & Helen Cope Paul McVittie, Resuscitation Service Manager
Name of responsible committee	Resuscitation Committee
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Target audience:	All Trust Staff

Contents

Appendices

1 Introduction

This resuscitation policy fully supports the recommendations for clinical practice and training in cardiopulmonary resuscitation published by the Resuscitation Council (UK) (2005) and has been written to promote compliance with the NHSLA Risk Management Standards (NHSLA, 2007).

2 Purpose

The purpose of the policy is to provide direction and guidance for the planning and implementation of a high-quality and robust resuscitation service to the organisation. The strategy for resuscitation incorporates the current published guidelines for resuscitation (Resuscitation Council (UK), 2005).[1]

3 Duties

Birmingham Children's Hospital NHS Foundation Trust has an obligation to provide an effective resuscitation service to its patients and appropriate training to its staff. A suitable infrastructure is established and continues to support these activities.

3.1 Duties within the Organisation

It is the responsibility of the Clinical Risk and Quality Assurance Committee/ Resuscitation Service Manager / and the Trust's Resuscitation Committee to ensure policy distribution, implementation and compliance throughout the organisation.

The lead officer responsible for coordinating the development and subsequent review of the document will be the Resuscitation Services Lead.

3.2 Functions of Resuscitation Committee

3.2.1 Aim of the Committee

- To promote the standards and quality of resuscitation within Birmingham Children's NHS FoundationTrust
- To achieve a robust, multidisciplinary approach to service, training, education and development of resuscitation
- To report to the Clinical Risk and Quality Assurance Committee

3.2.2 Objectives of the Committee

- To advise and seek to implement current guidelines and protocols in accordance with the recommendations of the Resuscitation Council (UK), European Resuscitation Council, Royal Colleges (Royal College of Surgeons, RCN) and other international and national professional bodies (eg BMA, NMC)

- To achieve a broader approach to resuscitation training and education through development of specialised multidisciplinary courses (e.g. Advanced Paediatric Life Support, European Paediatric Life Support, Paediatric Life Support Course)
- To be able to inwardly invest in paediatric resuscitation courses to meet the needs of the Trust
- To seek to establish a resuscitation training profile that compliments our role as a centre of excellence.
- To regularly review the practice of resuscitation within the Trust, to advise and recommend changes to meet the standards of good practice
- To continue to develop resuscitation audit
- To promote opportunities for research, education, audit and development in the field of Resuscitation.
- To support early recognition of deterioration to prevent cardio respiratory arrests.
- To form the Medical Gases Committee twice an annum with additional members.

3.2.3 Committee Membership (including key stakeholders).

The Resuscitation Committee Chair is appointed by the Medical of Director.

The membership shall be:

• A Chair – appointed by the Medical Director	• The Resuscitation Services Manager
• The Resuscitation Officers	• A Medical Consultant
• A Surgical Consultant	• An A&E Consultant
• An Anaesthetic Consultant	• A PICU Consultant
• A Senior Nurse	• Pharmacist
• Representative from Education & Learning	• Junior Medical Representative.
• Medical Gases Authorised Person for the Medical Gases Committee	• Head of Portering – for the Medical Gases Committee

3.2.4 Approval of the Resuscitation Policy (Including Stakeholder involvement)

Contributions, comments and agreement regarding the content of the resuscitation policy has been sought from all disciplines and ratified by the Resuscitation Committee has been accepted as an organisation-wide policy by the Clinical Risk and Quality Assurance Committee. Due to the nature of the policy patient review has not been sought.

4 Training Strategy

The strategy for resuscitation training shall embody the statements and guidelines published by the Resuscitation Council (UK) and the European Resuscitation Council, incorporating the most recent updates to these guidelines.

The organisation will provide sufficient and appropriate resuscitation training for each of the main staff groups. Profession specific resuscitation training will be directed by their respective functional role and the guidelines and directives issued by their professional bodies (e.g. The Royal College of Anaesthetists). The profession specific guidelines for resuscitation training are detailed in the Training Needs Analysis at Appendix C and incorporate adult and paediatric resuscitation.

The approach to teaching is one of positive encouragement and proven educational efficacy which follows the recommendations for resuscitation teaching advocated by the Resuscitation Council (UK) (Mackway-Jones & Walker, 1998).

Basic Life Support Training

4.1.1 Clinical Staff

All doctors, nurses, allied health professionals and clinical support staff must be adequately and regularly trained in cardiopulmonary resuscitation to a level appropriate to their discipline, as determined by their respective professional bodies and the West Midland Peer Review Standards for Care of the Critically Ill and Injured Child (2005), which provides an evidenced based needs analysis for resuscitation training recommendations.

All doctors, nurses, allied health professionals and clinical support staff must complete a Basic Life Support session each year, unless an advanced life support course has been taken within that year at BCHFT. Monitoring of this training activity is included within the Education & Learning mandatory training reports.

Advance Life Support Instructors must either complete BLS training or have an assessed teaching session for BLS annually.

Please refer to Appendix D for clarification

4.1.2. Non-Clinical Staff

All hospital staff with frequent, regular contact with patients should be encouraged to receive training in basic life support (BLS).

5 The Resuscitation/Emergency Team Response

In the event of a cardiac arrest / respiratory arrest /medical emergency being identified and triggered the appropriate resuscitation team must be alerted immediately.

The resuscitation/Emergency team is summoned by using the universal number **2222**. The precise location of the patient must be communicated promptly and clearly to the switchboard operator:

- For paediatric patients state ***cardiac arrest /respiratory arrest/medical emergency***
- For adult patients state ***adult cardiac arrest***
- For trauma patients state ***trauma emergency***
- For ECLS (Extra corporeal life support) patients state ***ECLS emergency***

All emergency bleeps will be alerted simultaneously by the switchboard operator via a speech channel. Each member of the appropriate emergency team must respond at their earliest opportunity. The speech channel will be tested at 10am each day, to ensure that the system and individual bleeps are in working order, **all** bleep holders **must** respond to this test call.

5.1 Composition of the Resuscitation Team

The composition of the respective emergency teams (Paediatric + Adult / Trauma / ECLS) is detailed within Appendix E1,2,&3.

5.2 Call for Monitor/ Defibrillator

The portering staff will ensure that a monitor/defibrillator is brought to each emergency call. Security staff will ensure the grab bag and defibrillator from the Welcome Desk is taken to a non clinical area event. Appendix F for locations

5.3 Induction agent location

Ketamine 10mg in 1ml (20ml)10mg/mlmg vial is to be kept on each ward/department for emergency use only. This is to be stored in the CD cupboard but not mixed with department's stock items.

5.4 Content of Thomas bag

The PICU representative for each event will bring the Thomas bag. For contents of the Thomas bag. see the Thomas Bag Check List

6 Post Resuscitation Care

The Trust must make provisions for safe continuity of care and safe transfer following resuscitation of the patient. This may involve the following steps:

- Full and complete hand-over of care to a specialist;
- Selection of appropriate equipment, oxygen, drugs and monitoring systems. Observation & Monitoring Policy
- Intra-hospital transfer;
- Staff experienced in patient transfer Patient Transfer Policy.
- Informing relatives.

Should resuscitation be unsuccessful and the child dies please refer to the Bereavement Policy the care of the child and family after death. Staff debriefing will be held by the Resuscitation Service Department if required.

7 Resuscitation Equipment, Replenishment and Cleaning

All **resuscitation trolleys and defibrillators must** be maintained in a state of readiness at all times.

Each part of the equipment should be checked on a weekly basis to ensure it is in good working order, expiry dates have not been reached and that there are no items missing. The trolley should then be closed and sealed. Each day the items not in the trolley are to be visually checked and any deficiencies rectified. These should all be documented on the appropriate sheet.

The resuscitation trolleys should be stocked in accordance with the standardised list issued by the Resuscitation Department Resuscitation Trolley & Grab Bag Checklist. Items should be replenished at the earliest opportunity from the area identified on the check list. Non-disposable items should be de-contaminated / cleaned in accordance with both the manufacturers' policy and the organisation-wide Infection Control Policy and re-instated to the trolley as soon as is practical.

To replenish contents of the emergency boxes a new box should be obtained from Pharmacy within normal working hours. Outside of these hours the clinical coordinator is to be contacted immediately. Spare boxes are kept in the emergency drug cupboard. If seal of box is broken, obtain a new box.

8 Moving & Handling

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

9 Cross Infection

Whilst the risk of infection transmission from patient to rescuer during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. It is therefore advisable that direct mouth-to-mouth resuscitation be avoided wherever possible and especially in the following circumstances:

- All patients who are known to have or suspected of having an infectious disease;
- All undiagnosed patients entering the Emergency Department, Outpatients or other admission source;
- Other persons where the medical history is unknown.

All clinical areas should have immediate access to airway devices (e.g. Bag Valve Mask or a pocket mask) to minimise the need for mouth-to-mouth ventilation. However, in situations where airway protective devices are not immediately available, start chest compressions whilst awaiting an airway device. If there are no contraindications consider giving mouth-to-mouth ventilations.

10 Anaphylaxis

The management of suspected anaphylactic reactions should be conducted in accordance with the Resuscitation Council (UK) Guidelines for the management of anaphylaxis. http://www.resus.org.uk/pages/reaction.pdf

11 Defibrillation

Defibrillators must only be operated by persons specifically trained in their use who hold a current APLS/EPLS/ALS/PLS provider qualification. Those without APLS/EPLS/ALS/PLS

provider qualifications will be individually assessed by the Resuscitation Services Department. All assessments will be carried out on an annual basis.

12 Procurement

All resuscitation equipment purchasing is subject to the organisation's standardisation strategy. Ordering information for specialist products is available on the Trust's intranet. Therefore all resuscitation equipment purchased must be sanctioned by the Resuscitation Service prior to ordering.

13 Do Not Attempt Resuscitation (DNAR) Guidelines

The organisation has developed DNAR Guidelines which fully comply with the guidance issued by the BMA / RCN / Resuscitation Council (UK) (2002) and the recommended standards issued in the Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians, the Intensive Care Society and the Resuscitation Council (UK) standards for clinical practice and training.

The overall responsibility for decision about DNAR orders rests with the consultant in charge of the patient's care. DNAR Policy

The DNAR policy will be replaced with the Paediatric Advanced Care Pathway for End of Life Care when it is launched in May 2011 by the West Midlands Regional Palliative Care Network

14 Process for Monitoring Compliance with, and the Effectiveness of this Policy

All ward based 2222 events to which a resuscitation/emergency team is summoned will be audited. The Resuscitation Service Manager in conjunction with the Resuscitation Chair/Committee will report on these events to Clinical Risk and Quality Assurance Committee (CRAQAC) on a monthly basis. Statistical data on ward based 2222 events are also reported the Board of Directors on a monthly basis.

Emergency events which happen in other areas e.g PICU are reported through departmental structures. If issues are raised or evident; these are then reported to CRAQAC.

Regular equipment audits and 'checking' documentation will be carried out by the Resuscitation Service. Any deficiencies identified will be reported to the Resuscitation committee.

The Trust Board, Strategic Education Forum and Directorate leads to receive performance reports stating activity and compliance against mandatory training KPIs on a quarterly basis.

Heads of Departments and Ward Managers will receive performance reports stating activity and compliance against mandatory training KPIs on a quarterly basis.

Process to Deal with Non Compliance

The Education and Learning Team request action plans from Heads of Departments and Ward Managers with planned activity to ensure compliance against mandatory training KPIs.

Non return and achievement of action plans will be reported by the Education and Learning Team to Directorate Performance leads, Heads of Departments and Ward Managers.

References

- Induction Policy
- Study Leave Policy

15 Process for reviewing, approving and archiving this document

This document will be reviewed bi-annually or whenever national policy or guideline changes are required to be considered (whichever occurs first), primarily by the Trust-wide Resuscitation Committee following which it will be subject to re-ratification. The current policy will be available on the Trust Intranet system; older versions will be archived in the Resuscitation Services Department.

16 Dissemination, Implementation and Access to this Document

This policy should be implemented and disseminated throughout the organisation immediately following ratification and will be published on the Trust's P drive. Access to this document is open to all and is available to patients, and the public on request.

17 Preparation for Resuscitation

17.1 All clinical / patient areas (Exception of PICU, Theatres & Emergency Department) within the Trust must have:

- A standard resuscitation trolley or bag, including emergency drug boxes, with the recommended equipment. Resuscitation Trolley & Grab Bag Checklist
- Portable oxygen and suction equipment with appropriate attachments
- A defibrillator located within a 3 minute walking distance
- Areas that are adjacent to a larger patient area may share the equipment with that area
- Open access for the resuscitation team

17.2 PICU, Theatres & Emergency Department must have:

Standard resuscitation equipment, including emergency drug boxes, with the recommended equipment.

Portable oxygen and suction equipment with appropriate attachments

A defibrillator located within a 3 minute walking distance

Open access for the resuscitation team

17.3 Non patient & non-clinical areas that are covered by the resuscitation team will:

Use the Thomas bag from PICU, grab bag & defibrillator from the front desk

17.4 It is the responsibility of the Directorates to

Ensure ALL new staff receive guidance and information on the Resuscitation Policy, appropriate to their role, as per local induction checklist.

17.5 It is the responsibility of the Directorates to ensure that all medical, nursing and allied health professions (AHP) staff:

- Attend appropriate resuscitation training including use of resuscitation equipment
- Are able to locate the nearest resuscitation equipment, including defibrillator and ensure that it is available at the incident
- Know how to summon the resuscitation team

17.6 It is the responsibility of the ward / department manager to:

Ensure that all new staff are made aware of the Resuscitation Policy and procedures

Facilitate basic life support training provided by resuscitation trainers.

Ensure clinical areas have sufficient resuscitation trainers to ensure all staff have annual resuscitation training updates.

Ensure all non-clinical areas have at least one designated resuscitation trainer. Basic life support training will be guided by local need e.g. adult basic life support training for estates department

Ensure that the recommended equipment is available and operational and that stocks are replenished after use

Ensure that all resuscitation equipment which is not kept securely sealed in the emergency trolley is checked daily, any deficiencies to be remedied immediately.
Ensure that all resuscitation equipment is fully checked each week. Ensuring that products and equipment are within date and packaging is appropriately sealed.,

Liaise with medical engineering to ensure that planned preventative maintenance is carried out on resuscitation equipment and records made.

Ensure that all equipment faults / problems are acted upon immediately and reported to the appropriate departments, including completion of an incident form.

Ensure that all staff within the ward / department receive appropriate resuscitation training and records of training are maintained

Ensure that if their area has limited / restricted / secured access that provision is made for the resuscitation team to enter

17.7 It is the responsibility of each Clinical Service Lead to:

- Ensure that all new medical staff in their speciality are made aware of and receive guidance and information on the Resuscitation Policy and procedures.
- Take a lead role in implementing the Trust ‘Do Not Attempt Resuscitation’ Policy
- Ensure that all grades of medical staff in their speciality have attended appropriate resuscitation training
- Support and advise the resuscitation team as appropriate

17.8 It is the responsibility of each resuscitation team member to:
Attend specified resuscitation training and updates

Ensure that they are up to date with current Resuscitation Council (UK) Guidelines and competencies required

Carry the arrest bleep during their period of duty with the resuscitation team and hand it over to their replacement

Ensure appropriate cover and inform switchboard if they are unable to carry the cardiac arrest bleep during their allocated duty time

Answer all test calls, made by switchboard, within 5 minutes of the call being made, when on duty for the resuscitation team

Liaise with switchboard relating to any cardiac arrest bleep concerns
Attend simulation training where available.

17.9 It is the responsibility of the switchboard supervisor to:

- Ensure that all switchboard staff are aware of the procedure for dealing with emergency calls
- Ensure test calls are made to all resuscitation team members at the pre arranged times
- Ensure that all resuscitation team members that do not respond within 5 minutes of the test call being made are bleeped a second time
- Ensure switchboard staff contact the Consultant and/or Manager on call if a member of the resuscitation team does not respond following a second test call
- Ensure that the operator making the test call completes appropriate documentation for audit purposes.

18 Resuscitation Procedures

18.1 On confirmation of an Acute Life Threatening Event (ALTE), respiratory or cardio-respiratory arrest ,all clinical staff will:
Begin basic life support using current Resuscitation Council (UK) guidelines according to the needs of the patient and continue until directed by the resuscitation team.

Summon the resuscitation team by dialling 2222, giving the exact location of the incident and indicating if appropriate any special circumstances

In areas where patients requiring resuscitation may be treated without alerting the resuscitation team (PICU, ED, the advanced life support (ALS) protocol will be followed according to the patient's needs and the individual staff's abilities

Ensure appropriate equipment is available for the incident

Co-operate and assist the resuscitation team with ALS as directed by the resuscitation team leader using the Resuscitation Council (UK) guidelines

Take account of 'DNAR' orders and End of Life Care Plans.

Support relatives, other patients and staff who are involved / witness a resuscitation attempt.

Ensure appropriate documentation is completed (i.e. Patient records, audit form and IR1)

18.2 Non clinical staff who suspect resuscitation may be required will:

- Respond to all such situations by dialling 2222 and stating the exact location of the incident
- If an incident occurs in a clinical area, immediately call a member of clinical staff and render assistance at the guidance of the clinical staff
- If the incident occurs away from a clinical area, also call a trained 'first aider', if available, and / or render assistance to the casualty according to their ability until clinical staff attend

18.3 On receiving a 2222 call switchboard will:

Repeat back the incident and exact location to the caller

Activate the resuscitation arrest team bleeps and send the resuscitation team in all cases

State location and incident including any special circumstances through the bleep system

Call 999 for all emergencies outside the main hospital buildings

Call 999 if instructed to do so by a BCH member of staff in attendance at the incident.

Contact other appropriate personnel as requested

Complete appropriate documentation

18.4 On hearing the cardiac arrest bleep, it is the responsibility of each resuscitation team member to:

- Respond with best speed to the site of the incident
- Contact switchboard immediately (using 2222) if they are unable to attend personally or have any queries relating to the call
- Carry out the duties assigned to them and at the direction of the team leader, using current Resuscitation Council (UK) guidelines
- Report immediately any deficiencies or problems that may affect the efficiency or effectiveness of resuscitation to the team leader, Resuscitation Services Manager and/or Risk Management Advisor
- Take into account the guidelines for relatives witnessing resuscitation
- The team leader will report the incident in the medical notes using the appropriate audit documentation for ALL emergency calls, even if the call is made in error or for a medical emergency.
- The resuscitation team members must understand that the team leader is responsible for the final decision to abandon the resuscitation attempt
- Other clinical/paramedical staff from within or from outside of the Trust must have agreement of the team leader of the resuscitation team to participate in and continue resuscitation attempts.

18.5 Debrief

Debriefing where necessary will be performed following the event. This will be facilitated by the resuscitation service.

19 Special circumstances in Resuscitation

The Resuscitation Policy must be adhered to at all times but consideration should be given in the following exceptional circumstances

19.1 Cardiac Surgery

Following cardiac surgery it is appropriate for the emergency team to include the cardiac surgeons

If a patient, following cardiac surgery, requires resuscitation then the cardiac surgery SpR can be requested when dialling 2222

Clinical areas that manage cardiac surgery patients must ensure that appropriate specific equipment is available and ready for use

19.2 Trauma

The trauma team leader would lead this emergency unless he delegates the responsibility to another member of staff. See Appendix E2 for whole team composition.

In areas that accept trauma patients, appropriate specific equipment must be available and ready for use. The most current advanced life support guidelines for trauma patients must be adhered to.

19.3 2222 Call during a Fire Alarm.

Should there be a 2222 call during a fire alarm the following must be adhered too.
Essential Resuscitation Team members to attend to the call.
Where available Site Practitioner to attend instead of the Clinical Co-ordinator and assume the role of nursing team leader, if Resuscitation Officer is present they will assume the nursing team leader role.

If the fire alarm is in activation and the patient's condition dictates a rapid transfer to either PICU, Theatres or Radiology following ascertain that the way to that area is 'safe to travel across' this may be carried out.
Refer to fire policy for further details.

19.4 Major Incident

During a major Incident the resuscitation will continue to be mobilised in the same way.

19.5 Theatres

- During daylight hours most respiratory and cardiac arrest calls in theatres will be managed by the theatre team.
- Out of hours the hospital team may be needed to respond. A call will be cascaded through the usual way.

19.6 Other specialities

The Birmingham Children's Hospital NHS Foundation Trust has many specialties and the resuscitation team may require their support in dealing with resuscitation attempts throughout the Trust

On arrival at the incident the resuscitation team leader will be responsible for leading the resuscitation procedure until the role is delegated from that leader to another.

The resuscitation team must ensure that they adhere to any specific protocols for specialised areas to ensure safety (e.g. patients in isolation)

If a senior doctor from the patient's own team is present, trained and willing, the resuscitation team leader may hand the leadership responsibility to them and then stand down.

If a patient's condition is of urgent concern to the staff present 2222 may be used to fast bleep the patient's own doctors. However, if the staff are concerned about a patients condition, then the team can still be summoned in the usual manner.

Non clinical staff, including the switchboard staff are NOT expected to diagnose respiratory / cardio- respiratory arrest and therefore emergency calls that are made with an undefined diagnosis will be put out as a cardiac arrest call and the resuscitation team would be expected to respond.

20 References

Advanced Life Support Group (ALSG) 2005 Advanced Paediatric Life Support (APLS) The Practical approach. 4th edition

National Health Service Litigation Authority (2007) NHSLA Risk Management Standards for Acute Trusts

Resuscitation Policy. Health Services Circular (HSC) 2000/028. London. Department of Health

Resuscitation Council (UK) (2001) Decisions Relating to Cardiopulmonary Resuscitation. A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. http://www.resus.org.uk/pages/dnar.htm [online]

Resuscitation Council (UK) (2004) Cardiopulmonary Resuscitation - Standards for Clinical Practice and Training. A Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians of London, the Intensive Care Society and the Resuscitation Council (UK). London. Resuscitation Council (UK)

Resuscitation Council (UK) (2010) Resuscitation Guidelines 2010. http://www.resus.org.uk/pages/guide.htm [online]

Resuscitation Council (UK) (2001) Guidance for Safer Handling during Resuscitation in Hospital

Appendix A

Emergency 2222 Calls

When a patient collapses within the hospital or its grounds a 2222 call should be made immediately stating Cardiac Arrest / Respiratory Arrest or other nature of incident and giving exact location. It should also be specified if the casualty is an adult.
The resuscitation team will attend all emergencies that occur on Birmingham Children's Hospital NHS Trust property or within its grounds.

Information given to / taken by switchboard in all cases should include:
The exact location and any relevant directions if known.
Any further relevant information

Switchboard will respond by:

- Sending the resuscitation team in all cases
- Calling 999 if instructed to do so by a BCH member of staff in attendance at the Incident

In non-clinical & non-patient areas the porter, on call for 2222 calls should collect a defibrillator and the emergency bag from the security desk for ALL calls. The PICU SpR (or nominated PICU Dr) should collect the Thomas bag from PICU.

The BCH resuscitation team leader is responsible for the management of ALL 2222 calls that occur within BCH or its grounds, once in attendance.

If a 999 call has been made and the ambulance crew is in attendance (or if they are present at an emergency within the Trust) they will work under the direction of the BCH resuscitation team leader.

If ambulance personnel are in the hospital or its grounds prior to the resuscitation team arrival they should initiate resuscitation according to the needs of the patient, summon the resuscitation team (if not already requested) and continue until directed by the BCH resuscitation team leader.

Guidelines for Witnessed Resuscitation

Introduction

Some parents have expressed strong feelings about wanting to be present during resuscitation to prevent feelings of 'failing their child' by not being with them during resuscitation. Others who have been present believe that it has helped with the bereavement process. Staff should ask if the parents wish to be present and facilitate this if possible.

Guidelines

These guidelines are generalised but can be adapted to most circumstances.

It is important to remember that every situation is unique and every person different.

A senior nurse must be present to support the parent or family. The nurse must be able to knowledge the difficulty of the situation, ensure that the relatives understand that they have a choice of whether or not to be present during resuscitation, avoid provoking feelings of guilt whatever their decision.

Relatives will be accompanied by the experienced nurse to care for them, whether or not they enter the resuscitation area. Make sure introductions are made and names are known

Give a clear and honest explanation of what has happened in terms of the illness or injury and warn them of what they can expect to see when they enter the area, particularly the procedures they may witness.

Ensure they will be able to leave and return at any time, and will always be accompanied

Ask the relatives not to interfere for the good of the patient and their own safety. They will be allowed the opportunity to touch the patient when it is safe to do so.

Explain the procedures as they occur in terms that the relative can understand
Ultimately this may mean being able to explain that their child has failed to respond and has died and that the resuscitation is to be abandoned

Advise that after the child has died, there may be a brief interval while equipment is moved after which they can return to be with the deceased in private. Under some circumstances, the Coroner may require certain tubes to be left in place

Offer the relatives' time to think about what has happened and give them the opportunity for further questions

Stopping Resuscitation

If a parent objects to the resuscitation being abandoned, it should be continued while the team leader reviews the situation, involving those participating and explaining the reasons for his/her decision to the relative. Alternatively, a parent may voice objections to continued resuscitation. The person leading the resuscitation team must make a decision in a similar manner. The final decision to stop resuscitation must always be made by the team leader. It is important to realize that despite their expressed opinions, the relative may later have guilt feelings if they feel the decision was theirs.

Finally, all staff involved must be given the opportunity to debrief after a resuscitation, particularly when relatives have been present. The resuscitation services department is able to facilitate debriefing.

References

Adams S, Whitlock M, Boomfield P, Baskett PJF, Should Relatives Witness Resuscitation? BMJ 1994, 308 : 1687 - 9

Awoonor - Rennor S, - I Desperately Need To See My Son. BMJ 1991 : 302 - 351

BAEM. RCN - Bereavement Care In A & E Departments - Reports Of The Working Group RCN 1995

Gregory CM, I Should Have Been With Lisa When She Died. Accident & Emergency Nursing 1991, 3 : 136 - 8

Resuscitation Council (UK) written by the Project Team, Should Relatives Witness Resuscitation (October 1996)

Appendix C

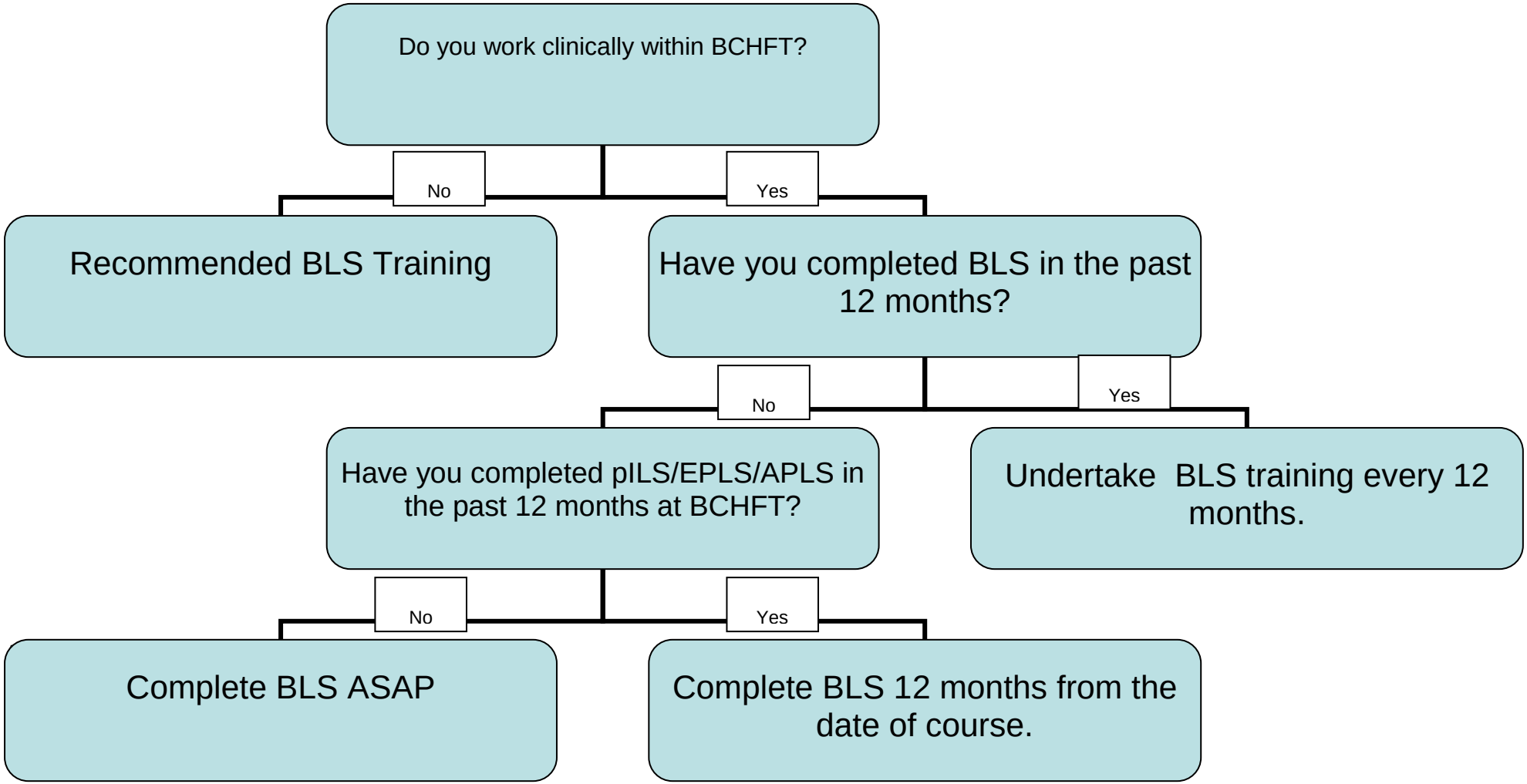
All mandatory training must be undertaken within 2 weeks of appointment..
1 – Mandatory 2 – Essential 3 - Desirable

Staff Group	BLS	PILS/ILS	APLS/ EPLS	ATLS
Refresher Period	Annually	Annually	4 yearly	4 yearly
Non Clinical Staff, with patient contact	3			
Clinical Support worker (All disciplines)	1			
Registered Allied Health Professionals	1	3		
Registered Nurses	1	3		
Nurses in charge of shift	1	2	3	
Nurses managing ward or nominated deputy	1		2	
Clinical Co-coordinator & Site Practitioners	1	2(ILS)	2	3
Clinical Resuscitation/Emergency team (RMO/PICU/ED team)	1		2	3
Clinical Resuscitation/Emergency team (others)	1	2	3	
Clinical Trauma Team Leader (ED)	1		2	2
Consultants	1	2	3	3
Trust Grade (or equivalent)	1	2	3	3
SPRs	1	2	3	3
Foundation year and SHOs	1	2	3	3

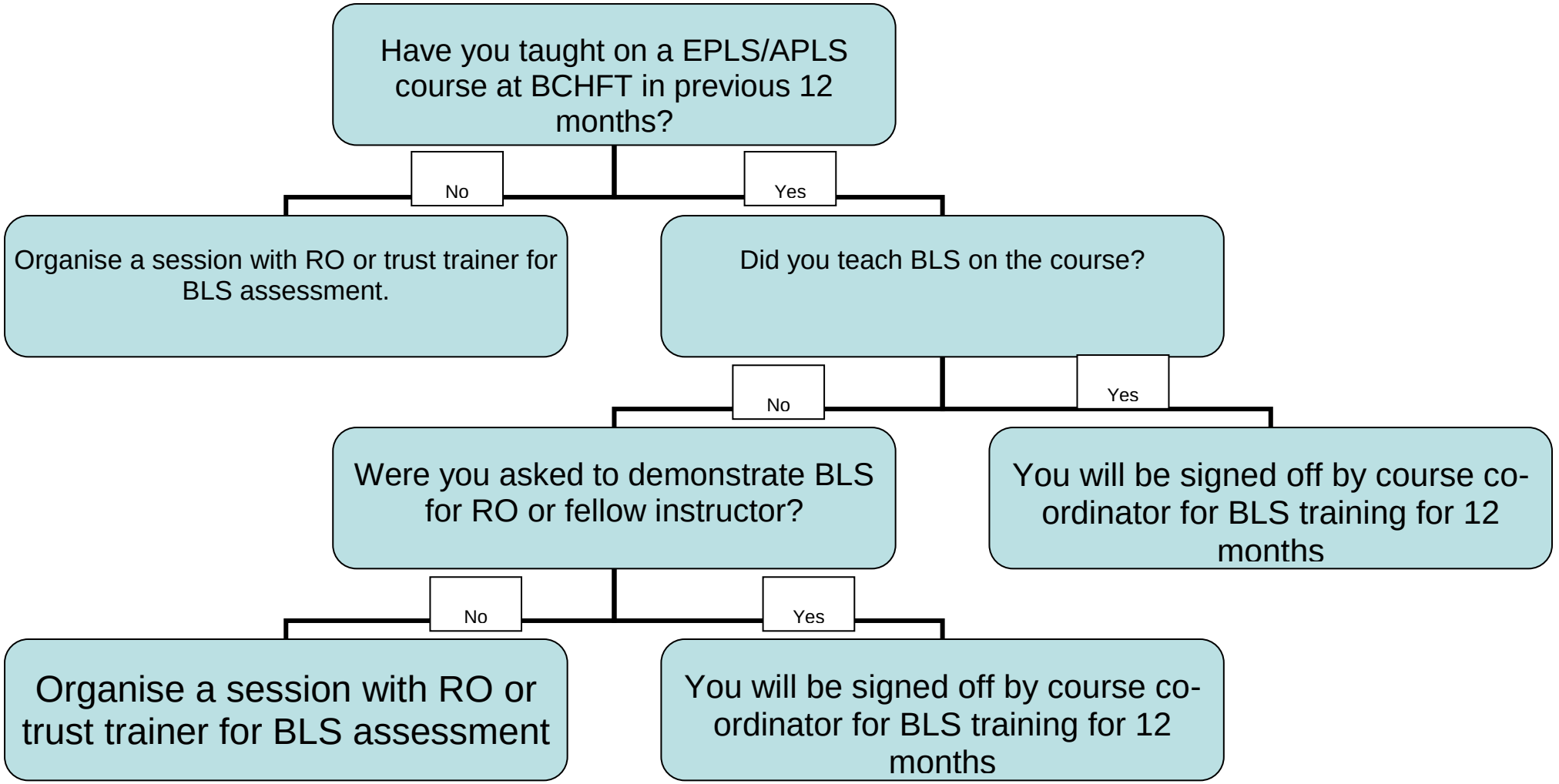
It is a pre-requisite of the West Midlands Anaesthetic SpR training that they hold a current a valid ALS certificate

Appendix D

BCH Staff. (non Life support instructors)



BCH Staff. (Life support instructors)



Appendix E1

RESUSCITATION/EMERGENCY TEAM COMPOSITION

It is essential when activating an emergency call that a standard competent team should arrive in less than 3 minutes and have appropriate equipment available to them.

This procedure should be uniform throughout the Trust thus ensuring a high quality resuscitation service to all patients.

Appropriate training should be received as per appendix b before becoming a resuscitation team member. Therefore new employees should be offered training on acceptance of their post if required.

The resuscitation team on **the Steelhouse Lane site should comprise**:

the duty anaesthetist

the duty PICU SpR as a back up airway skills if the anaesthetist is not able to attend

the duty SPR to lead the emergency (the duty RMO2)

the duty SHO

an experienced nurse who has demonstrated competence in resuscitation (clinical co-coordinator/site practitioner)

resuscitation services manager or resuscitation officer when available

PICU Consultant when available (they may take the lead when present)

a porter and a security officer

ODP if available from theatre

A minimum of 2 of this team must be Advanced Paediatric Life Support (APLS or EPLS) providers and at least 2 of team MUST be medically qualified.

This team will be managerially responsible to the clinical co-coordinator during the time that they are on the resuscitation team, but to remain clinically responsible to their own consultant or clinical lead / line manager.

Appendix E2

TRAUMA TEAM COMPOSITION

It is essential when activating a Trauma call that a standard competent team should arrive in less than 3 minutes and have appropriate equipment available to them.

This procedure should be uniform throughout the Trust thus ensuring a high quality service to all patients.

Appropriate training should be received as per appendix b before becoming a Trauma team member. Therefore new employees should be offered training on acceptance of their post if required.

The trauma team on **the main site should comprise**:

The duty anaesthetic SpR (or Consultant)

The ED Consultant or SpR Default Team Leader unless handed over to another member of the team

The duty PICU Consultant or SpR as a backup airway skills if the anaesthetist is not able to attend. If no ED Consultant or SpR available PICU will become team leader

The Duty RSO (or Consultant)

The duty SHO (ED & Surgery)

An experienced nurse who has demonstrated competence in resuscitation (clinical co-coordinator/site practitioner)

Resuscitation services manager or resuscitation officer when available

A porter and a security officer

ODP if available from theatre

Radiographer

A minimum of 2 of this team must be Advanced Paediatric Life Support (APLS or EPLS) providers and at least 2 of team MUST be medically qualified.

This team will be managerially responsible to the clinical co-coordinator (If ward based event) during the time that they are on the trauma team, but to remain clinically responsible to their own consultant or clinical lead / line manager.

Majority of trauma calls will be activated from ED. Due to this a variety of roles will be adopted by the ED team.

Appendix E3

ECLS EMERGENCY TEAM COMPOSITION

EMERGENCY COMMUNICATION GUIDELINE

Personnel: ECLS Specialist
Duty ECLS Consultant
Consultant Cardiothoracic Surgeon
PICU Intensivist
ECLS Lead Nurse
Perfusionist

ECLS Specialist Action (in the event of an ECLS emergency):

Call for assistance and

Pull the RED buzzer immediately.

- Each person should be aware of his / her responsibilities as directed by the Specialist.

- The Specialist should attempt to deal with the cause of the emergency immediately.

- Call 2222 and state **"ECLS EMERGENCY".**

At least three people are required:-
One Nurse to hand ventilate & monitor the patient
One person to telephone ECLS Consultant for support
One person to assist the Specialist – this will be another Specialist if on duty OR the PICU Nurse co-ordinator (Band 7) OR Team Leader (Band 6)

Lifted from Guidelines for the provision and management of patients on Extra Corporeal Life Support.

Appendix F

Placement of Defibrillators

Department	Site	No. of defibs	Also covers
Radiology	Main building Ground floor	One	
Ward 2	Main building Ground floor	One	Medical Day Unit Eye Department Haemoglobinopathy Wellcome Research Centre
Ward 5	Main building First floor	One	Burns centre
Burns Theatre	Main building First floor	One	Burns centre
PICU	Main building First floor	Three	Retrieval team
Ward 8	Main building First floor	One	Ward 6 Ward 7 Ocean Ward
Ward 9	Main building Second floor	One	Ward 10 Neonatal Surgical Unit
Main theatres	Main building Second floor	Four	
Ward 12	Main building Second floor	One	Ward 11
Heart Investigations	Main building Second floor	One	Heat Outpatients
Emergency Dept	Parsons House Ground floor	Two	Physiotherapy OT.
Ward 1	Main building Ground floor	One	Main Out Patients
Oncology Recovery	Parsons House Ground floor	One	Oncology Day Care
Ward 15	Parsons House First floor	One	Theatre 8
Theatres 5,6,7	Parsons House Second floor	One	Surgical Day Care
Security Desk	Main entrance	One	Front of house Non clinical areas
Ashfield Unit	Parkview	Two (only 1 in use, 1 as spare)	Rest of Parkview
EBME	Main building Lower Ground	One	Spare for hospital
Spare	Roving defib for ward moves. Will be located on ward 6 at end of ward moves	One	

Non-clinical areas are covered by resuscitation trolleys held in A&E and Ward 2. A portable defibrillator is held at the Security Desk.

Appendix G Parkview in – patient ward areas.

The following procedure should be followed by all staff should a Patient, Staff member or visitor require resuscitation within Parkview In-patient areas.

Staff 1	Staff 2	Staff 3	Staff 4	Staff 5
If a person requires resuscitation staff 1 should stay with them and begin resuscitation.	Staff 2 will telephone 9999 and request an ambulance giving the information asked for by the emergency services	Move other patients to a place of safety/containment	Obtain the resuscitation equipment from the clinic room on Ashfield unit. This includes: • Resuscitation Trolley • Suction Machine • Defibrillator	Either help staff 1 & 4 or staff 3 depending on need
Alert Staff (this will be done via personal alarms which each member of staff wears).	Ensure doors open for ambulance crew to use & direct them to patient once in the unit		Attach Defibrillator & use in AED Mode	
Continues basic life support as ambulance crew arrive until instructed to stop when crew are ready to take over. (Remember to swap roles with staff 4 to prevent tiredness)			Work with Staff 1 to ensure BLS is performed effectively until Ambulance crew arrive. (Remember to swap roles with staff 1 to prevent tiredness)	
Stay with Ambulance crew to assist if needed.				

Appendix H

Specialist Play Services Department

Procedure for 2222 incidents within the Play Centre

The following procedure should be followed by all staff should a child require resuscitation within the play centre. (In the event of an adult collapsing, follow the same procedure)

There must always be a minimum of two qualified members of staff within the play centre when there are children present – al least one of whom must be trained in basic life support.

Role of BLS trained staff (Staff 1)	Role of second staff member (staff 2)
1. If a child requires resuscitation staff 1 should stay with the child and begin resuscitation.	**1.** Staff 2 will telephone 2222 and request the resuscitation team stating "cardiac arrest, play centre ground floor"
2. Staff 1 continues basic life support as resuscitation team arrive until instructed to stop when resuscitation team are ready to take over.	**2.** Staff 2 will obtain the resuscitation equipment from the main staff office. This includes: • Oxygen cylinder • Suction machine and accessories • Resuscitation box containing bag valve masks etc. • Mouth shield
	3. Ensure that all coded access doors are open, including door to main hospital.
	4. Staff 2 supports staff 1 with resuscitation.

When cardiac team are resuscitating the child:	
3. Staff 1 stays with resuscitation team to assist if needed.	**5.** Staff 2 supports parent of patient and other parents if necessary. **6.** Staff 2 will direct other families back to the wards. 7. When able, staff 2 to contact the ward of the child being resuscitated to inform them of the situation.

It is the responsibility of the porter to organise a trolley for transporting the child out of the play centre following the resuscitation procedure.

Originated by: Specialist Play Services Health and Safety Team

Consulted: Resuscitation committee