# Medical Emergencies and Resuscitation Policy

**Version: 4**

## Summary:
The purpose of the policy is to provide direction and guidance for the planning and implementation of a high-quality and robust resuscitation service ensuring a consistent approach is applied in relation to the management of cardiopulmonary resuscitation and medical emergencies across the Trust.

## Keywords (minimum of 5): (To assist policy search engine)
- Asthma
- Anaphylaxis
- Cardio Pulmonary Resuscitation
- Cardiac Emergencies: Angina & Myocardial Infarction
- Choking and aspiration
- Hypoglycaemia
- Life support training
- Medical emergency
- Resuscitation equipment
- Seizures
- Syncope (fainting)
- The use of oxygen in an emergency

## Target Audience:
All staff involved with patient care

## Next Review Date:
April 2019

## Approved & Ratified by:
Resuscitation Group

## Date of meeting:
5 October 2017

## Date issued:
October 2017

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## Version Control

### Change Record

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1. **Introduction**

1.1 Southern Health NHS Foundation Trust (the Trust) recognises and accepts its responsibility to employees, patients, families and carers to ensure that the requirements for resuscitation (HSC 2000/028) are satisfied.

1.2 The Trust must provide a resuscitation service for patients, service users, visitors and staff on all of its sites. The aim is that all relevant staff defined within the TNA of this policy must be able to provide cardiopulmonary resuscitation (CPR) at a level appropriate to their role and healthcare environment in which they are working. As a minimum this is Basic Life Support (BLS). However, some staff (e.g. Doctors, Dentists, Registered Nurses & Allied Health Professionals) must provide elements of enhanced life support via Immediate Life Support (ILS). Please refer to TNA in Appendix 1 for requirements.

1.3 The Trust will take all reasonable steps to provide the initial first aid response for medical emergencies and in all instances refer for subsequent specialist treatment and care. It is important that emergency medical aid is sought immediately to improve the possibility of the patient’s outcome. It must be recognised that many resuscitation attempts will not be successful despite the best efforts.

1.4 Any persons suffering a cardiac or respiratory arrest on Trust premises, or while being attended to by a Trust employed health professional in other settings, should be considered for CPR unless an appropriate Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision or advanced directive is in force. The Trust has a unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) policy which should be read in conjunction with this policy to ensure that CPR is only initiated for patients when it is appropriate and in their best interests. It is the responsibility of each member of the multidisciplinary team to know whether a patient is for CPR or not. All teams within the Trust should establish a process to ensure this responsibility is recognised. **If there is any doubt about the CPR status of an individual, resuscitation should be commenced.**

1.5 This Medical Emergency and Resuscitation policy is based on the Quality Standards for Clinical Practice and Training in Cardiopulmonary Resuscitation published by the Resuscitation Council (UK) (November 2013, updated 2014, 2016) and has been developed to describe the process for managing and mitigating risks associated with resuscitation, as detailed in current NICE Guidance, The ECT Handbook (Royal College of Psychiatrists 2005), the Mental Health Act Revised Code of Practice (2015) and Resuscitation Council (UK) Decisions Relating to Cardiopulmonary Resuscitation (2014, updated 2015) for use within the Trust.

1.6 Resuscitation Services are controlled and reviewed by the Trust Resuscitation Committee. The Resuscitation Officers/trainers will offer training to staff according to the needs of the service area and the responsibilities given to them as part of its duty of care to patients.

2. **Scope**

2.1 The document applies to all Trust staff and identifies the:

- Accountabilities, responsibilities and duties of staff
- Mandatory training requirements of staff
- Process for procuring, storing, replenishing, maintaining and cleaning of emergency and resuscitation equipment
- Procedure in relation to the initiation of resuscitation including obtaining emergency assistance
- Post incident reporting, recording, reviewing and support procedures in relation to resuscitation events
- Process for monitoring compliance with the policy.
3. Definitions

- Ambulance: Emergency ambulance following "(9) 999" call
- CPR: Cardio Pulmonary Resuscitation
- DNAR: Do Not Attempt Resuscitation
- DNACPR: Do Not Attempt Cardiopulmonary Resuscitation
- uDNACPR: unified Do Not Attempt Cardiopulmonary Resuscitation
- BLS: Basic Life Support
- ILS: Immediate Life Support
- AED: (semi) Automated External Defibrillator
- NEWS: National Early Warning Score
- TNA: Training Needs Analysis
- SBAR (D): Situation, Background, Assessment, Recommendation and Decision – Please see Physical Assessment and Monitoring Policy
- HCPs: Health Care Professionals, staff who are registered with their appropriate governing body (eg. GDC, GMC, HPC, NMC)
- Anaphylaxis: Anaphylaxis is a severe, life-threatening, generalised or systemic hypersensitivity reaction.
- IM: Intramuscular injection
- IV: Intravenous injection

4. Duties / Responsibilities

4.1 Healthcare organisations have an obligation to provide an effective resuscitation service to their patients and appropriate training to their staff. A suitable infrastructure is required to establish and continue support for these activities.

4.2 Training in resuscitation is a MANDATORY key skill for all registered health professionals as described in the TNA within Appendix 1

4.3 The Resuscitation Committee’s duties and responsibilities are:
- Ensuring that Trust policy is based on current Resuscitation Council (UK) guidelines and standards.
- Determining the levels of training required by staff across the Trust.
- Determining the minimum resuscitation equipment, including drugs that should be available in clinical areas.
- Ensuring that the Trust Resuscitation Policy is reviewed and updated in response to changes in recommended management guidelines.
- Ensuring regular audits to monitor compliance with this policy are completed.
- Ensuring that equipment for cardiopulmonary resuscitation is provided at a level appropriate to the expectation of intervention for each specific site and will comply with the recommended minimum equipment recommended by the Resuscitation Council (UK).
• Ensure annual audit cycles are completed and action plan designed to enable service improvement

4.4 The Resuscitation Officer’s duties and responsibilities are:
• Advising clinical areas on changes to recommended equipment levels/items through identified service leads.
• Advising clinical areas on changes to recommended treatment management algorithms through identified service leads.
• Ensuring that on receipt of a completed report from a service area, all reported resuscitation attempts are evaluated against current Resuscitation Council (UK) guidelines
• Ensuring that post incident support / remedial training are provided as required.
• Working with identified services leads and the Trust Resuscitation Committee to ensure the resuscitation policy is reviewed and updated in response to changes in recommended management guidelines.
• Providing advice relating to purchase of resuscitation equipment available on request from service leads.
• Providing professional advice to the Trust Resuscitation Committee through membership and attendance at meetings.
• Developing and implementing a programme of clinical audit of resuscitation processes and equipment.

4.5 Team Managers’ duties and responsibilities are:
• Ensuring that staff are aware of the procedure for initiating resuscitation including obtaining emergency assistance.
• Ensuring their staff are released for appropriate resuscitation training on an annual basis as required by the TNA in Appendix 1
• Ensuring resuscitation/medical emergency equipment and emergency drugs within their area conforms to the recommended requirements
• Ensuring that a robust system of checking all resuscitation equipment provided in their area is in place and that these checks are recorded.
• Ensuring that a Trust Incident form is completed on Ulysses for every resuscitation attempt occurring in their area.
• Ensuring that post incident support is available to staff following resuscitation incidents.
• Ensuring that the Resuscitation Officer is informed of the event

4.6 Individual staff working in a clinical area’s duties and responsibilities are:
• Reading the policy and being familiar with the procedure for initiation of resuscitation or emergency treatment and the location of relevant equipment, including drugs, within their working area.
• Accessing agreed training as required ensuring their competence is current.

4.7 Professionally Registered Health Professionals:
• Every Registered Health Care Professional (HCP) working within the Trust in a clinical provider role will need to attend resuscitation training on an annual basis as per the TNA in Appendix 1.
• Each Registered Health Care Professional, Mental Health Practitioner and Associate Practitioner is personally responsible for their own practice and must take individual responsibility to ensure they avail themselves of the training opportunities provided by the Trust.
• Ensure reporting and recording cardiopulmonary arrest incidents in accordance with Trust policy requirements.
5. Main policy content

The Trust is a complex organisation offering services to individuals (both adults and children) with a wide range of need on many different sites, including health centres, hospital inpatient and outpatient services, schools, community services and patients own homes.

As a result of this variety it is not possible for the Trust to offer the same medical emergency or resuscitation response across all of its services.

This policy seeks to establish the principles and standards by which more site specific procedures will operate.

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- Where care is being provided by Southern Health NHS Foundation Trust employed staff on non-owned premises the resuscitation/medical emergency procedure for that setting should be followed.
- In situations where Southern Health NHS Foundation Trust services are provided alongside other services within the same site, service leads/managers should ensure local arrangements are in place for patient/service users accessing the site to have access to appropriate equipment in the event of an emergency.
- In non-Southern Health NHS Foundation Trust premises a risk assessment must be undertaken by the local clinical team within that location to determine and provide the local procedure.

5.1 On confirmation of a medical emergency or cardio-pulmonary arrest staff will:

- Obtain appropriate assistance. This may be by activating the internal emergency call system and/or phoning a “999” ambulance as appropriate and per local policy.
- Begin appropriate initial treatment according to patient needs and skill level of the rescuer, as per current medical guidelines and continue until directed by the responding the emergency medical team or responding ambulance crew.
- Summon the emergency medical team on the appropriate hospital sites and/or the ambulance service in other Trust locations, giving the exact location and brief details of the incident.
- Ensure the resuscitation equipment is brought to the victim.
- Co-operate and assist the emergency medical team/ambulance crew, with the resuscitation attempt using the current Resuscitation Council (UK) guidelines according to the responding staffs level of ability.
- Take account of any “Do Not Attempt Cardio Pulmonary Resuscitation” (DNACPR) decisions.
- Support relatives, other patients, visitors and staff who are involved or witness a resuscitation attempt.
- Ensure appropriate documentation is completed (e.g. Ulysses Incident form, audit form, medical notes, nursing notes). In the event of a death, the Procedure for Reporting and Investigating Deaths should be followed.
- In the event of a sudden unexpected death the person in charge of the ward/unit should notify the management team/modern matron as soon as practicable.
In the event of a death an appropriate member of staff should inform the deceased next of kin as soon as practicable.

5.1.1 For Trust sites where a dedicated medical emergency or cardiac arrest team is in active service, designated bleep holders in possession of the dedicated bleep on activation of the cardiac arrest/medical emergency call must:
- Respond with best speed to the site of the incident
- Contact the switchboard immediately using the appropriate emergency number if they are unable to attend personally or have any queries relating to the call
- Carry out the duties assigned to them using current patient treatment/resuscitation guidelines
- Report any deficiencies to the site manager and complete the relevant documentation

5.2 Medical Emergency & Resuscitation Equipment including Drugs

5.2.1 In areas where staff have no access to resuscitation equipment i.e. a patients home, staff may choose to carry a pocket mask.

5.2.2 For community based staff who are administering parenteral medication with an identified risk of anaphylaxis i.e. immunisations, vaccinations and depot injections (Mental Health) as examples, staff should carry an anaphylaxis pack containing the appropriate dose Emerade adrenaline auto injector and a pocket mask.

5.2.3 In the Trust areas where resuscitation equipment is required, this equipment will be located in the Trusts standardised orange Medical Resus bags.

5.2.3 In addition to the Medical Resus bags, there will be stocked resuscitation trollies in ECT Suites and on each floor of Lymington New Forest Hospital.

5.2.4 It is accepted that in certain clinical areas (mental health, in particular) it will be appropriate to keep the resuscitation equipment in a secure location although equipment will need to be readily available and accessible in the event of a resuscitation incident. This will be assessed during planned and unplanned simulation exercises in both inpatient and non-inpatient areas.

5.2.5 All resuscitation equipment must be maintained in a state of readiness at all times and allow timely access.

5.3 Checking, Restocking and Management of the Medical Resus Bag

Refer to the Checking, Restocking and Management of Medical Resus Bag Procedure

5.4 Checking, Restocking and Management of Resuscitation Trollies (Lymington New Forest Hospital and ECT Suites)

5.4.1 The resuscitation trollies in Lymington New Forest Hospital and ECT Suites will be stocked, replenished and maintained by the service they sit within. There will be a resuscitation trolley on each floor of Lymington New Forest Hospital and in each ECT Suite

5.4.2 For resuscitation trollies at Lymington New Forest Hospital, please refer to Checking, Restocking and Management of Resuscitation Trollies at Lymington New Forest Hospital Procedure.

5.4.3 ECT Suites equipment will meet ECT Accreditation Standards (ECTAS) as a minimum as recommended by the Royal College of Psychiatrists and Royal College of Anaesthetists. Local decisions will be determined in line with the local Acute Hospital Trust in relation to additional equipment required. Checking documents will be created and held locally.

5.4.4 Where possible, resuscitation and medical emergency equipment will be single patient use.
5.5 **Relatives Present During a Resuscitation Attempt**

This policy follows guidance from the Resuscitation Council (UK), which states, “The presence of relatives during a resuscitation attempt is a controversial issue. There have been increasing requests by relatives to be present at the resuscitation of their loved ones. This statement and the guidelines do not supply all the answers, but attempt to enable a balanced decision to be made”. Unfortunately within the pre-hospital environment this is occasionally unavoidable. Staff need to be mindful of the needs of the patient as priority but also to consider any relatives that may be present. Ultimately, the decision will be made by the resuscitation lead clinician, based on the individual patient and the requesting family member at the time of the event, in order to enable a family member to attend the resuscitation. Further information please see: https://www.resus.org.uk/archive/archived-cpr-information/should-relatives-witness-resuscitation

5.6 **Post Incident Reporting, Recording and Reviewing Following Resuscitation Events.**

All resuscitation incidents will be reported, recorded and reviewed in accordance with the Trust’s Procedure for Reporting and Managing Incidents. Where there has been a resuscitation attempt, the Trust Resuscitation Officer must be informed and involved in the review process to provide feedback, learning and support to the staff involved. In the event of a death, irrespective of whether resuscitation was carried out or not, the death MUST be reported in accordance with the Trust’s Procedure for Reporting and Investigating Deaths.

5.7 **Documentation**

5.7.1 A Ulysses incident form must be completed in accordance with the Trust’s Procedure for Reporting and Managing Incidents. The incident must be reported and submitted by the end of the shift, or within 24 hours if immediate submission is not practicably possible. In the event of a Serious Incident, an incident form must be completed immediately as stipulated in the Trust’s Procedure for Reporting and the Management of Serious Incidents.

5.7.2 In the event of a resuscitation attempt, a Resuscitation Event Report Form must be completed. This form is located inside the Medical Resus bag, with the resuscitation trolley at Lymington New Forest Hospital and as an appendix to this policy. It is desirable that the person completing the Ulysses Incident Form completes the Event Report Form where possible. A copy of the Event Report Form must be sent confidentially to the Resuscitation Officers (LEaD, Tatchbury Mount) with other copies for patient notes and scanned into Ulysses form.

5.7.3 Patient records must be updated accordingly as soon as practicably possible.

5.7.4 In the event the Medical Resus bag has been used a re-order form must be completed immediately and sent to Openhouse as per the Checking, Restocking and Management of Medical Resus Bag Procedure. Any delay in this will result in a delay in the bag contents being replenished.

5.8 **Post Incident Support**

Ward / Team managers should consider the support required by staff and/or service users following resuscitation interventions in accordance with the Trust’s Managing Stress and Enhancing Wellbeing Policy.

In addition, the Critical Incident Stress Management (CISM) team can be contacted to provide confidential support and Critical Incident Stress Debriefings (CISD) should it be required. Contact details are available on the intranet or telephone 01425 622922.

5.9 **Manual 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) advice on manual handling during resuscitation in hospitals which can be found at: https://www.resus.org.uk/publications/guidance-for-safer-handling-during-cpr-in-healthcare-settings/. This should be read in context with the Trust’s Moving and Handling Policy

5.10 Risk to the rescuer

Whilst the risk of infection transmission from patient to rescuer during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. Whenever feasible a suitable barrier device will be used to deliver rescue breaths.

- All clinical areas should have immediate access to airway devices (e.g. a pocket mask) that conforms to current recommendations to minimise the need for mouth-to-mouth ventilation.
- Where airway protective devices are immediately available, start chest compressions combining with rescue breaths in the ratio currently recommended by the Resuscitation Council (UK).
- Should the rescuer be unable or unwilling to undertake rescue breathing without a barrier device and one is not immediately available chest compression alone should be commenced and continued without interruption while awaiting the arrival of a barrier device.
- The minimal level of personal protection for all community based staff is the pocket mask. If staff do not have a pocket mask readily available chest compressions should be started immediately rather than searching for a pocket mask.

5.11 Defibrillation

All defibrillators used within the Trust will be biphasic, hands free and of a type approved by the Resuscitation Service. Where defibrillators are provided they should be stored and accessed within areas where the Resuscitation Council (UK) guidance of a maximum of three minutes delay between collapse to first shock can be met.

Where an Automated External Defibrillator (AED) has been used, Openhouse will collect the data from the AED and send it to the Resuscitation Service for audit, incident review and staff training purposes.

The Trust provides AED training via its ILS and BLS training courses but does acknowledge the following statement:

“The Resuscitation Council (UK) advises that NHS Trusts should ensure that no restriction is placed on the use of an AED by an untrained NHS employee confronted with a patient in cardiac arrest when no more highly trained individual is present. The administration of a defibrillatory shock should not be delayed waiting for more highly trained personnel to arrive. The same principle should apply to individuals whose period of qualification has expired.”

Full text http://www.resus.org.uk/pages/AEDtrnst.htm

5.12 Procurement

All resuscitation equipment purchasing is subject to the organisation’s standardisation strategy. The Resuscitation Committee will produce recommendations in relation to the type and specification of resuscitation equipment. Advice should be sought from the Resuscitation Officers prior to the purchase of any resuscitation or medical emergency related equipment.

5.13 Medical Emergencies

Please see Appendices 5 & 6
6. **Financial Impact & Resource Implications**

6.1 The Trust needs to ensure it provides sufficient training for staff to comply with the training need analysis.

6.2 The Trust needs to ensure staff are released to attend essential resuscitation training on a regular basis.

7. **Training Requirements** [refer to TNA in Appendix 1]

7.1 Staff identified within the TNA at Appendix 1 need to attend training on the frequency described in relation to their working environment.

7.2 The strategy for resuscitation training shall embody the statements and guidelines published by the Resuscitation Council (UK), incorporating the most recent updates to these guidelines. This explicitly incorporates the identification of patients at risk from cardiac arrest and a strategic approach to implement preventative measures such as physiological observation chart – (adult track and trigger or NEWS) and Situation Background Assessment Recommendation and Decision (SBARD) communications tool. Please see Physical Assessment and Monitoring Policy.

7.3 The level of training is determined by the duties that staff would be expected to undertake when in attendance at a cardiac arrest or medical emergency during their usual role and in accordance with the Resuscitation Council (UK) and related guidelines / professional body requirements.

7.4 This training is not essential for any non-clinical or administrative staff. However if a need is identified following a local risk assessment, this should be included in the locality training plan.

7.5 The NICE Guidance (NG10) Violence and aggression: short-term management in mental health, health and community settings states that:

7.6 In line with the Electro Convulsive Therapy Accreditation Standards (ECTAS) all qualified nurses and medical staff working in ECT units will receive training to the level of Immediate Life Support.

7.7 As part of their local induction all new staff must be familiar with this policy and the equipment relevant to their area of work. Where appropriate, staff should be made aware of the procedure to summon medical help. Line Managers will ensure that ALL STAFF are aware of the process by which an emergency call is made in the event of medical emergency / cardiac arrest.

8. **Monitoring Compliance**

8.1 All cardiac arrests will be audited (DoH HSC 2000/028):

8.2 Incidents will be reported using the Trust approved incident reporting procedure.

8.3 The following methods will be used to monitor compliance with the requirements of this policy:

- Recording of attendance on Basic Life Support and Immediate Life Support training and informing managers of staff who were booked onto training but did not attend.
- This information can be obtained from the Leadership, Education and Development Department data base.

8.4 A rolling programme of audit will be carried out and will include audits to monitor:

- Availability and accessibility of resuscitation equipment including resuscitation drugs where appropriate.
- Implementation of systems for the checking of resuscitation equipment.
- Staff awareness of the process for the initiation of resuscitation including the system for summoning help.
• Formulation and implementation of action plans to address deficiencies identified by audits to improve performance regarding the management of resuscitation across the Trust.

8.5 The findings of the rolling programme of audit will be reported to the Resuscitation Committee.

9. Policy Review

9.1 This policy will be reviewed every two years or whenever a national policy or guideline are changed or introduced that relates to resuscitation or medical emergencies defined in the appendix of this document.

10. Associated Documents

- SH HS 12  Bariatric Moving and Handling Policy
- SH CP 04  Guidelines for Training in and Administration of Midazolam Hydrochloride Oromucosal Solution (Buccolam®) 10mg/2ml for the Management of Tonic-Clonic Status Epilepticus in Adults with a Learning Disability
- SH CP 03  Management of Seizures: What to do when an inpatient has a seizure
- SH HR 08  Managing Stress and Wellbeing Policy
- SH CP 40  Medical Device Management Policy
- SH CP 1  Medicines Control, Administration and Prescribing Policy (MCAPP)
- SH HS 05  Moving and Handling Policy
- SH CP 43  Physical Assessment and Monitoring Policy
- SH CP 182  Procedure for Delegation of Administration of Buccal Midazolam to Non-Registered Practitioners and Paid Carers by Nurses within Inpatient Services in the Learning Disability Division
- SH NCP 75  Procedure for Reporting and Investigating Deaths
- SH CP 24  Slips, Trips and Falls Policy
- SH CP 31  Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy (uDNACPR)
- Standard Operating Procedure: The Use of Ligature Cutters in Mental Health and Learning Disabilities

11. Supporting References

- JRCALC Clinical Practice Guidelines 2016
- Mental Capacity Act 2015 Department of Health
- Royal College of Psychiatrists (2015) ECT Accreditation Service Standards for the Administration of ECT
### APPENDIX 1: Training Needs Analysis

<table>
<thead>
<tr>
<th>Training Programme</th>
<th>Frequency</th>
<th>Course Length</th>
<th>Delivery Method</th>
<th>Facilitators</th>
<th>Recording Attendance</th>
<th>Strategic &amp; Operational Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Life Support</td>
<td>Annual</td>
<td>1 day</td>
<td>Face to face</td>
<td>Resuscitation Officer/Trainers</td>
<td>LEaD</td>
<td>Strategically: Director of Education Operationally: Resuscitation Officer</td>
</tr>
</tbody>
</table>

#### Directorate | Service | Target Audience
---|---|---
MH/LD/TQ21 | Adult Mental Health | All registered nurses and mental health practitioners (Assistant/Associate Practitioner/Practitioner) who work in the following services: Elmleigh (Elmleigh Inpatients, Elmleigh PICU); ECT Services; Antelope House (Hamtun Ward, Trinity Ward, Saxon Ward & Abbey Ward); South Outpatients; Parklands Hospital (Hawthorns Inpatients, Hawthorns MOD & Hawthorns PICU); Melbury Lodge (Kingsley Ward & Mother & Baby Unit); Hollybank; Forest Lodge

Specialised Services | All registered nurses and mental health practitioners (Assistant/Associate Practitioner/Practitioner) who work in the following services: Leigh House, Ravenswood House (RSU Medical, RSU Management, RSU Ashurst, RSU Lyndhurst, RSU Malcolm Faulk Ward, RSU Mary Graham Ward, Meon Valley Ward & RSU Clinical Risk & Security Liaison); Southfield (Southfield Nursing & Southfield Medical; Bluebird House (Bluebird Nursing & Security, Bluebird House Medical, Hill Ward, Moss Ward & Stewart Ward)

Learning Disabilities | All registered nurses who work in the following services: Willow Assessment & Treatment Unit; Ashford; Evenlode; House 2 Step Down; The Ridgeway Centre and Inpatient Services Management Oxon

TQtwentyone | Not Applicable

ISD’s | Older Persons Mental Health | All registered nurses and mental health practitioners (Assistant/Associate Practitioner/Practitioner) who work in the following services; Gosport War Memorial Hospital (Dryad Ward & Daedalus Ward); Parklands Hospital (Elmwood Ward & Beechwood Ward); Western Community Hospital (Beaulieu Ward, Berrywood Ward & Minstead Ward); Melbury Lodge (Stefano Olivieri Unit)

ISD’s | Adults | All registered nurses and who work in the following services; SE ISD; Nursing Cedar & Rowan Wards and Minor Injuries Unit - Petersfield, Rapid Assessment Unit, Sultan Ward, Outpatients, Ark Royal Ward – GWMH West ISD; Minor Injury Unit, Respiratory Assessment Unit, Medical Assessment Unit, Deerleap Ward, Longbeech Ward, Wilverley Ward, Theatres, Endoscopy, Knightwood Ward, Medical Day Unit-Lymington New Forest Hospital, Romsey Nursing – Romsey Hospital, Ford Ward – Fordingbridge Hospital All Assistant/Associate Practitioners who work in minor injury units. North ISD; Anstey Ward - Alton Hospital

ISD’s | Childrens Services | Not Applicable


Medical Emergencies & Resuscitation Policy  
Version: 4  
October 2017
<table>
<thead>
<tr>
<th>Training Programme</th>
<th>Frequency</th>
<th>Course Length</th>
<th>Delivery Method</th>
<th>Facilitators</th>
<th>Recording Attendance</th>
<th>Strategic &amp; Operational Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Support</td>
<td>Bi-annual (Year 1,3,5,7 etc)</td>
<td>3 hours</td>
<td>Face to face</td>
<td>Resuscitation Officer/Trainers</td>
<td>LEaD</td>
<td>Strategically: Director of Education Operationally: Resuscitation Officer</td>
</tr>
<tr>
<td></td>
<td>Bi-annual (Year 2,4,6,8 etc.)</td>
<td>E-Assessment</td>
<td>E-Assessment and Face to face</td>
<td>Resuscitation Officer/Trainers</td>
<td>LEaD</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>followed by 1 hour face to face</td>
<td></td>
<td></td>
<td></td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Directorate</td>
<td>Service</td>
<td>Target Audience</td>
<td></td>
<td></td>
<td></td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MH/LD/TQ21</td>
<td>Adult Mental Health</td>
<td>All registered healthcare professionals and clinical staff that have patient contact who are not required to complete Immediate Life Support training.</td>
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<tr>
<td></td>
<td>Specialised Services</td>
<td>All registered healthcare professionals and clinical staff that have patient contact who are not required to complete Immediate Life Support training.</td>
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<tr>
<td></td>
<td>Learning Disabilities</td>
<td>All registered healthcare professionals and clinical staff that have patient contact who are not required to complete Immediate Life Support training.</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>TQtwentyone</td>
<td>All registered healthcare professionals and clinical staff that have patient contact.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ISD's</td>
<td>Older Persons Mental Health</td>
<td>All registered healthcare professionals and clinical staff that have patient contact who are not required to complete Immediate Life Support training.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ISD’s</td>
<td>Adults</td>
<td>All registered healthcare professionals and clinical staff that have patient contact who are not required to complete Immediate Life Support training.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ISD’s</td>
<td>Childrens Services</td>
<td>All registered healthcare professionals and clinical staff that have patient contact.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>All</td>
<td>All clinical staff who work in the following services;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Director of Nursing Directorate; Tissue Viability Team, Continence Advisory Service, Falls Nurses &amp; Director of Nursing team.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Directorate; Comprehensive Local Research Network Research &amp; Dev, Focus Study, MARC, Medical Directorate, Medicines Management Team.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Workforce&amp; Development Directorate; Undergraduate Med Education</td>
<td></td>
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</tbody>
</table>
Appendix 2

Southern Health NHS Foundation Trust:
Equality Impact Analysis Screening Tool

Equality Impact Assessment (or ‘Equality Analysis’) is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team

<table>
<thead>
<tr>
<th>Name of policy/service/project/plan:</th>
<th>Medical Emergencies and Resuscitation Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Number:</td>
<td>SH CP 30</td>
</tr>
<tr>
<td>Department:</td>
<td>Learning, Education and Development</td>
</tr>
<tr>
<td>Lead officer for assessment:</td>
<td>Simon Johnson Resuscitation Officer</td>
</tr>
<tr>
<td>Date Assessment Carried Out:</td>
<td>15 June 2012</td>
</tr>
</tbody>
</table>

1. Identify the aims of the policy and how it is implemented.

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Answers / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe purpose of the policy including</td>
<td>The purpose of the policy is to provide direction and guidance for the planning and implementation of a high-quality and robust resuscitation service ensuring a consistent approach is applied in relation to the management of cardiopulmonary resuscitation and medical emergencies across the Trust.</td>
</tr>
<tr>
<td>How the policy is delivered and by whom</td>
<td></td>
</tr>
<tr>
<td>Intended outcomes</td>
<td></td>
</tr>
<tr>
<td>This Medical Emergency and Resuscitation policy is based on the Quality</td>
<td></td>
</tr>
<tr>
<td>Standards for Clinical Practice and Training in Cardiopulmonary Resuscitation published by the Resuscitation Council (UK) (November 2013, updated 2014, 2016) and has been developed to describe the process for managing and mitigating risks associated with resuscitation, as detailed in current NICE Guidance, The ECT Handbook (Royal College of Psychiatrists 2005), the Mental Health Act Revised Code of Practice (2015) and Resuscitation Council (UK) Decisions Relating to Cardiopulmonary Resuscitation (2014, updated 2015) for use within the Trust.</td>
<td></td>
</tr>
</tbody>
</table>
### 2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data**
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

<table>
<thead>
<tr>
<th><strong>Key questions</strong></th>
<th><strong>Data, research and information that you can refer to</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong></td>
<td>What is the equalities profile of the team delivering the service/policy?</td>
</tr>
<tr>
<td><strong>2.2</strong></td>
<td>What equalities training have staff received?</td>
</tr>
<tr>
<td><strong>2.3</strong></td>
<td>What is the equalities profile of service users?</td>
</tr>
<tr>
<td><strong>2.4</strong></td>
<td>What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?</td>
</tr>
</tbody>
</table>

**Key Research:**

Resuscitation Group, Mental Capacity Act Resuscitation Council (UK) (2010)
<table>
<thead>
<tr>
<th>2.5</th>
<th>What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6</td>
<td>What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations</td>
</tr>
</tbody>
</table>

In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:
In the case of negative impact, please indicate any measures planned to mitigate against this
<table>
<thead>
<tr>
<th>Positive impact (including examples of what the policy/service has done to promote equality)</th>
<th>Negative Impact</th>
<th>Action Plan to address negative impact</th>
</tr>
</thead>
</table>
| This policy applies to all ages  
A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings across all ages | Age Concern warned that the UK's elderly feared they were at risk of not being revived simply because of their age  
The balance may not always correctly be struck between recognising parental responsibilities, children's rights and patient's best interests, in consideration of do not resuscitate orders for children. | Old age alone should not be a criterion in deciding on a do not resuscitate order.  
The wishes taken by competent children should be respected, that parents can consent to treatment for children up to the age of 16 and that advice should be sought where treatment deemed appropriate is refused by the patient or parents.  
DNAR Data audit: Incidents will be reported using the Trust approved incident |

<table>
<thead>
<tr>
<th>Age</th>
</tr>
</thead>
</table>

Age Concern warned that the UK's elderly feared they were at risk of not being revived simply because of their age  
The balance may not always correctly be struck between recognising parental responsibilities, children's rights and patient's best interests, in consideration of do not resuscitate orders for children.
| **Disability** | The Trust will respond positively to requests of information in alternative formats to ensure information is understood by all patients and staff | Patient’s/carer’s having low vision may not be able to see/read the patient information leaflets about Cardiopulmonary Resuscitation | Staff need to know how to access alternative communication tools and/or more appropriate leaflets, e.g. with larger print. Patients/carer’s with hearing loss may require a BSL interpreter when discussing decisions relating to cardiopulmonary resuscitation. Any extra information required for patients/carer’s with learning disabilities should be given accordingly after assessing their individual needs. |
| **Gender Reassignment** | A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings across all | No negative impacts identified at this stage of screening | |
| Marriage and Civil Partnership | A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings | No negative impacts identified at this stage of screening |

| Pregnancy and Maternity | Effective resuscitation of the mother will provide effective resuscitation for the foetus. | Foetuses may suffer, if pregnant patients who suffer cardiac arrest are not given obstetric care. There are a multitude of physiological and anatomical changes during pregnancy that may influence the management of the pregnant patient:  
- Cardiac Output increases by 20-30% in the first 10 weeks  
- The average maternal heart rate increases by 10-15 beats per minute  
- Both systolic and diastolic blood pressure fall, on average by 10-15mmHg | Consideration of individual care plans |

*Effects of Pregnancy on Maternal Resuscitation, Obstetrics Emergencies, Warwick University, October 2006*
| Race | A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings across all Black and Minority Ethnic groups. A patients first language may not be English and may require information in alternative formats or access to an interpreter. | Interpreting and Translation: Access to Communications | |
| Religion or Belief | The Trust has a unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) policy which should be read in conjunction with this policy to ensure that CPR is only initiated for patients when it is appropriate and in their best interests. It is the responsibility of each member of the multidisciplinary team to know whether a patient is for CPR or not. All teams within the Trust should establish a process to ensure this responsibility is recognised. **If there is any doubt about the CPR status of an** | Policy applies to all regardless of religion or belief unless an advance decision or DNR is in place. | |
| **Sex** | A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings for males and females. |
| **Sexual Orientation** | A key component of this policy is the communication between professional, patient and carer. The policy will positively promote equality of opportunity as it seeks to improve communication and decision making across care settings for lesbian, gay and bi-sexual people. | No negative impacts identified at this stage of screening |
Sign Off and Publishing

Once you have completed this form, it needs to be ‘approved' by your Divisional Director or their nominated officer. Following this sign off, send a copy to the Equality and Diversity Team who will publish it on the Trust website. Keep a copy for your own records.

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designation:</td>
</tr>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>
APPENDIX 3

Guidance sheet for summoning appropriate help in the event of a medical emergency or cardiac arrest

All staff must be aware of the method of obtaining emergency assistance in their place of work.

Local procedures must comply with the following minimum requirements:

- First person on scene to check for danger to self and injured parties.
- Check responsiveness.
- Summon for additional help and support by shouting for other staff and/or activating alarm.
- If alone, leave the casualty and get appropriate help, ambulance/emergency team and return to patient and begin appropriate first aid/CPR procedures.
- If there are two or more staff members present, one will phone (9)999/2222 * as appropriate and one will assess the casualty for further interventions.
- If required, commence cardiopulmonary resuscitation to the competence level of staff who are available until ambulance arrives.

* NB –
  
  Lymington New Forest Hospital: use code blue call button for emergencies
  Petersfield Hospital: dial 555 if downstairs or 222 if upstairs
  A “999” ambulance may still be required at these locations

Communication for summoning help on sites with designated emergency teams, where hospital sites are serviced by appropriate emergency teams:

The emergency team will be summoned using a specific and tested call system known to all members of the clinical staff and prominently displayed in clinical areas. The use of the universal number 2222 is strongly supported. The precise location of the patient must be communicated promptly and clearly to the responding emergency team/ambulance service.

Where a ‘crash’ system exists all bleeps will be alerted simultaneously.

Each member of the appropriate emergency team must respond at their earliest opportunity.

Phoning (9)999 to request ambulance

Ambulance Control/switchboard may require the following information during the telephone call

- The telephone number you are calling from
- The name of the caller
- The location of the incident – including the ward name, unit name and hospital site - if applicable
- Chief complaint
- Is the patient breathing?
- Is the patient conscious?
- What is the level of consciousness?
- What colour are they?
- Is resuscitation in progress?
- Other information concerns or advice
- The approximate age and sex of the patient
- Any relevant history (medical or event)
Consider (a) informing porters or reception staff so they can direct the ambulance to the correct location, (b) allocating a member of staff to assist with access codes and to take ambulance staff to where the incident is within the building.

If the patient condition changes after the initial 999 call a further call may be required.
Use of Oxygen during a Medical Emergency

Introduction

The administration of supplemental oxygen is an essential element of appropriate management for a wide range of clinical conditions; however oxygen is a drug and therefore requires prescribing in all but emergency situations. Failure to administer oxygen appropriately can result in serious harm to the patient. The safe implementation of oxygen therapy with appropriate monitoring is an integral component of the Healthcare Professionals role.

This section makes reference to the guidance that has been proposed by the British Thoracic Society, Emergency Oxygen Guideline Group for Emergency use of Oxygen for adult service users

Emergency situations

In the emergency situation an oxygen prescription is not required. Oxygen should be given to the patient immediately without a formal prescription or drug order but documented later in the patient’s record.

All unwell, sick and critically ill patients should be given high flow oxygen (15 l/min reservoir mask) whilst awaiting immediate medical review. Patients with COPD and other risk factors for hypercapnia (increased amount of carbon dioxide) who develop critical illness should have oxygen therapy to be able to aim for their normal oxygen saturation range. This is normally 88% - 92% unless stipulated otherwise.

All patients who have had a cardiac or respiratory arrest should have high flow oxygen provided along with resuscitation appropriate to the provider’s skill and equipment provision.

Unwell patients whose clinical presentation indicates hypoxia should receive emergency oxygen aimed at maintaining an oxygen target of 94% or above. If no reliable oxygen saturation monitor is available; administer high flow oxygen initially until saturation can be measured then adjust to meet appropriate oxygen target.

A subsequent written record must be made of what oxygen therapy has been given to every patient alongside the recording of all other emergency treatment.

Any registered nurse/ health professional can commence oxygen therapy in an emergency situation and then get the person appropriately reviewed (i.e. medical, clinical or ambulance review)

Check pulse oximetry, administer oxygen and adjust flow rate if indicated.

Immediately inform senior nursing staff and medical doctor on duty as appropriate.

Ensure the prescription and recording of oxygen administration is done when immediately convenient.

Nebulised therapy and oxygen

All patients requiring 35% or greater oxygen therapy should have their nebulised therapy by oxygen at a flow rate of 4 - 6 litres/minute. A nebuliser mask cannot be used with oxygen > 6 litres/minute.
Pregnancy

Women that are more than 20 weeks pregnant should be managed in the left lateral tilt position to improve cardiac function.

The same target saturation should be sought as for any other seriously ill users (94% or above).

THE LEFT LATERAL TILT POSITION FOR PREGNANT FEMALES

Use of Oxygen Summary

The aim of oxygen therapy is to achieve normal or near-normal oxygen saturation for all acutely ill service users apart from those at risk of hypercapnic respiratory failure.

The usual target saturation range is 94% or above.

Breathless non-hypoxemic patients do not benefit from oxygen therapy.

For patients with COPD (Chronic Obstructive Pulmonary Disease) or other conditions that increase a risk of hypercapnic respiratory failure (e.g. asthma) then the target oxygen saturation should be in the range of 88-92% and dependent on further investigations more suitably conducted with acute medical services.

For all acutely unwell hypoxemic patients in an emergency, oxygen should be given first and then recorded appropriately.
Summary guide to the Emergency Administration of Oxygen in acutely unwell patients

RECOGNISE HYPOXAEMIA – (low level of oxygen)

- Check pulse oximetry of person
- Give oxygen if saturation is less than 94%
  OR 88-92% in those with Hypercapnic respiratory failure (due to Asthma or Chronic Obstructive Pulmonary Disease)

GIVE OXYGEN

- Ensure medical gas source (wall or cylinder) is oxygen. If using cylinder ensure it is switched on and contains sufficient oxygen
- Connect mask and tubing to oxygen source and switch on, ensuring oxygen is flowing
- Apply connected oxygen mask to patient

RECOGNISE HYPOXAEMIA – (low level of oxygen)

INFORM

- Obtain appropriate assistance – medical staff / ambulance
- Phone (9)999 ambulance or activate internal emergency call system as appropriate
- Shift lead
- Doctor on duty or on call

REVIEW OXYGEN THERAPY

- Discontinue oxygen if patient is maintaining oxygen saturation levels or is no longer indicated
- Decision to discontinue should be made by senior nurse or Doctor

RECORD IN NOTES

- Ensure oxygen is recorded in patient notes
- Record oxygen saturation of patient, flow rate, time given and duration given
APPENDIX 5

MEDICAL EMERGENCIES

Guidance on the initial approach and management of common medical emergencies.

Please read this section in conjunction with any local protocols or clinical escalation algorithm

Early identification and recognition of the ‘unwell or sick’ patient is important to be able to prevent the event of a cardiac arrest. Pre-empting any medical emergency by recognising a compromise in airway, breathing and/or circulation, allows appropriate help to be summoned e.g., ambulance, senior nurse, doctor as appropriate prior to any patient collapse occurring.

Clinical locations using the Track and Trigger Tool or National Early Warning Scoring System (NEWS) should initiate action as identified in the clinical escalation algorithm. Medical assistance, if required, should be accessed as soon as possible by activating the appropriate system as indicated by the patient’s condition and local procedure and protocol. SBAR(d) should be used when communicating information to another health care professional i.e. doctor on the telephone.

On sites where medical staff are not present or may be delayed in assessing/treating the patient, arranging urgent transfer to a higher level of care by dialling (9)999 and summoning an ambulance may be the appropriate intervention.

Accurate documentation of the patient’s medical history should further allow those ‘at risk’ of certain medical emergencies to be identified in advance of any proposed treatment.

A systematic approach to recognising the acutely ill patient based on the ‘ABCDE’ principles is recommended and described below.

1. Staff should undergo regular training in the management of medical emergencies to a level appropriate to their expected clinical responsibilities.

2. Clinical staff must be trained in cardiopulmonary resuscitation (CPR) so that in the event of recognised cardiac and respiratory arrest:
   - Summon appropriate help (dial 999).
   - Start CPR
   - If an AED is available attach as soon as possible after collapse. Follow the prompts from the machine and attempt defibrillation when indicated.

Statements and recommendations

1. In the event of any significant medical emergency an appropriate response ambulance should be summoned at the earliest opportunity. All clinical areas should have a defined protocol for how to summon the emergency services, including calling (9)999 or activating the Medical Emergency Teams where appropriate (e.g. blue code button at Lymington New Forest Hospital). This protocol should include clear directions on how to find the clinical area and whether or not there may be a difficult access point.
2. Ambulance personnel will provide equipment, expertise, practical help and a range of treatments. Should the emergency not turn out to be as serious as first thought, no harm will be done.

3. Immediately after any medical emergency many patients may be clinically unstable and may require admission to hospital. This will depend on factors such as previous health, nature and severity of illness and underlying diagnosis. If the practitioner does not feel competent to make this judgement it is their duty to ensure that an appropriate individual (for example a doctor or paramedic) is contacted to assess the patient's immediate treatment needs.

4. When a patient remains unwell (or if there is any doubt concerning their health) they should be assessed by a doctor. Depending on the clinical setting, this will usually mean attending hospital by ambulance, if there is no medical cover present.

5. The patient’s condition should be stabilised as far as possible before transfer but this should not delay further assessment or treatment.

6. Relatives should be informed about the transfer of a patient as per local procedure.
General principles

Follow the Airway, Breathing, Circulation, Disability, and Exposure approach (ABCDE) to assess and treat the patient.

- Treat life-threatening problems as they are identified before moving to the next part of the assessment.
- Continually re-assess starting with Airway if there is further deterioration.
- Assess the effects of any treatment given.
- Recognise when you need extra help and call for help early. This may mean dialling (9)999 for an ambulance.
- Use all members of your team. This will allow you to do several things at once, e.g., collect emergency drugs and equipment, dial 999.
- Organise your team and communicate effectively. Use SBAR(d) principles as outlined in the Physical Assessment and Monitoring Policy. The aims of initial treatment are to keep the patient alive, achieve some clinical improvement and buy time for further treatment whilst waiting for help.
- Remember - it can take a few minutes for treatment to work.
- The ABCDE approach can be used irrespective of your training and experience in clinical assessment or treatment. Individual experience and training will determine which treatments you can give.
- Document physical observations on the Track and Trigger Tool or National Early Warning Scoring System (NEWS) depending local area.
- Often only simple measures such as laying the patient down or giving oxygen are needed.

First steps

- In an emergency, stay calm. Ensure that you and your colleagues are safe.
- Look at the patient generally to see if they 'look unwell'.
- In a conscious patient ask, “How are you?” If the patient is unresponsive, shake him and ask, “Are you all right?” If they respond normally, they have a clear airway, are breathing and have brain perfusion. If they speak only in short sentences, they may have breathing problems. Failure of the patient to respond suggests that they are unwell. If they are not breathing and have no signs of life, start CPR according to current resuscitation guidelines.

Airway (A)

Airway obstruction is an emergency.

1. Look for the signs of airway obstruction:
   - See saw respiratory movement and use of accessory muscles
   - Colour change – cyanosis (going blue) is a late sign
   - Unable to speak
   - Noisy breathing: expiratory ‘wheeze’ (lower airways)/ inspiratory ‘stridor’ (upper airway)/ gurgling (fluid)/ snoring (tongue)
   - Silent breathing: completely obstructed airways
   - Visual check for blood, swelling, foreign body, ligature etc.

2. In most cases, only simple methods of airway clearance are needed
   - Head tilt / chin lift or jaw thrust
   - Turn the head to one side and remove visible foreign bodies, debris or blood from the airway (use suction or forceps as necessary).
3. **Give oxygen initially at a high inspired concentration:**
Use a non rebreathe mask (oxygen mask with a reservoir bag). Ensure that the oxygen flow is sufficient (15 litres per minute) to prevent collapse of the reservoir during inspiration. If you have a pulse oximeter, titrate the oxygen delivery aiming for normal oxygen saturation levels (94% and above). In very sick patients this may not be possible and a lower oxygen saturation (more than 90%) is acceptable for a short period of time.

**Breathing (B)**

1. **Look, listen and feel for the general signs of respiratory distress**
   - Chest movement: visible and equal both sides?
   - Noisy/ silent breathing
   - Respiratory rate (12 – 20/ min for an adult, 20 – 30 /min for a child)
   - Oxygen saturation levels decreasing
   - Effort of breathing: accessory muscle use/ abdominal breathing
   - Getting tired
   - Unable to complete a full sentence

2. **Treat any breathing compromise to the level of training and competence**
   - Ensure patent airway – manage any obstructions
   - Consider patient position i.e. sitting up/ leaning forwards
   - Oxygen (as above)
   - Treat cause i.e. salbutamol for asthma, adrenaline 1:1000 for anaphylaxis
   - Ventilate if breathing fails – consider use of an iGel.
   - Call for additional help

**Circulation (C)**

1. **Recognition of circulation compromise**
   - Skin colour, temperature and texture
   - Chest pain
   - Fluid loss inc. bleeding, D&V etc.
   - Pulse (increase or decrease)
   - Blood pressure (increase or decrease)
   - ECG changes
   - Collapse, dizziness, faint

2. **Treat any circulation compromise to the level of training and competence**
- Stop any external bleeding
- Consider positioning i.e. lying down and legs elevated
- Medication i.e. aspirin, GTN and oxygen for suspected cardiac related chest pain
- IV access
- Fluid therapy
- Call for help

Disability (D)

1. Recognising causes of changes in neurological status (reduced conscious levels)
   - AVPU (Alert, responds to Voice, responds to Pain, Unconscious)
   - Glasgow Coma Scale
   - Blood sugar levels (BM)
   - Pupils (equal and reactive to light? size?)
   - Limb movement (moving all limbs normally?)
   - Speech (normal? slurred? confused?)
   - Drugs (prescribed? legal?)
   - Temperature
   - FAST test for stroke

2. Treat cause of changes in neurological status
   - Assess and manage Airway, Breathing Circulation
   - Recovery position
   - Emergency medication i.e. naloxone for opiate overdose, flumazenil for benzodiazepine overdose, Buccolam or rectal diazepam for seizures, glucose/ Glucogel/ glucagon/ IV glucose for diabetic hypoglycaemia
   - Consider oxygen
   - Call for additional help

Exposure/ Environment /Examination (E)

To assess and treat the patient properly loosening or removal of some of the patient’s clothes may be necessary. Respect the patient’s dignity and minimise heat loss. This will allow you to see any rashes (e.g., anaphylaxis, septicaemia) or perform procedures (e.g. defibrillation).

Look in the patient's notes for any further information

Are there any clues in the environments e.g. cause of the accident, trip hazard etc.
Asthma

The quantity of medication used in an asthmatic patient’s treatment is often a good guide to the severity of their illness. Those at highest risk of having an asthma emergency include those taking oral medications in addition to inhaled medication and those who regularly use a nebuliser at home. Those who have required oral steroids for their asthma within the last year and those admitted to hospital with asthma within the last year represent high risk patients. Patients with asthma (both adults and children) may have an attack while in our care. Most attacks will respond to a few ‘activations’ of the patient’s own short-acting beta₂-adrenoceptor stimulant inhaler such as salbutamol (100 micrograms/actuation). Repeat doses may be necessary. If the patient does not respond rapidly, or any features of severe asthma are present, an ambulance should be summoned. Patients requiring additional doses of bronchodilator should be referred for medical assessment after emergency treatment. If the patient is unable to use the inhaler effectively, additional doses should be given through a large-volume spacer device. If the response remains unsatisfactory or if the patient develops tachycardia, becomes distressed or cyanosed (blueness around the lips or extremities), arrangements must be made to transfer them urgently to the Emergency Department.

Symptoms and Signs

### ACUTE SEVERE ASTHMA

<table>
<thead>
<tr>
<th>CHILDREN 2-12 YEARS OF AGE</th>
<th>ADULTS &amp; CHILDREN &gt; 12 YEARS OF AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wheezing</td>
<td>• Wheezing</td>
</tr>
<tr>
<td>• Oxygen saturation &lt; 92%</td>
<td>• Oxygen saturation &gt; 92%</td>
</tr>
<tr>
<td>• Too breathless to talk</td>
<td>• Cannot complete a sentence in one breath</td>
</tr>
<tr>
<td>• Use of accessory neck muscles</td>
<td>• Respiratory rate &gt; 25/min</td>
</tr>
</tbody>
</table>
| • Respiratory rate:  
  2 -5 years > 40/min  
  > 5 years > 30/min   | • Heart rate (pulse) >110 bpm        |
| • Heart rate (pulse):  
  2 -5 years > 140/min  
  > 5 years > 130/min   |                                       |

### LIFE THREATENING ASTHMA

<table>
<thead>
<tr>
<th>CHILDREN 2-12 YEARS OF AGE</th>
<th>ADULTS &amp; CHILDREN &gt; 12 YEARS OF AGE</th>
</tr>
</thead>
</table>
| Oxygen saturation < 92% plus any of the following:  
  Silent chest  
  Agitation  
  Altered consciousness  
  Poor respiratory effort  
  Cyanosis | Oxygen saturation < 92% plus any of the following:  
  Silent chest  
  Cyanosis  
  Poor respiratory effort  
  Arrhythmia  
  Hypotension  
  Exhaustion  
  Altered consciousness |

Medical Emergencies & Resuscitation Policy
Version: 4
October 2017
Treatment

Encourage the person to take their salbutamol inhaler, whilst awaiting ambulance transfer, oxygen (15 litres per minute) should be given. All emergency ambulances in the UK carry nebulisers, oxygen and appropriate drugs. If asthma is part of a more generalised anaphylactic reaction or if signs of life threatening asthma are present, an intramuscular injection of adrenaline (see Anaphylaxis) should be given.

The perceived risk of giving patients with chronic obstructive pulmonary disease too much oxygen is often quoted but this should not distract from the reality that ALL sick, cyanosed patients with respiratory difficulty should be given high flow oxygen until the arrival of the ambulance. This short term measure is far more likely to be of benefit to the patient than any risks of causing respiratory depression.

If any patient becomes unresponsive always check for ‘signs of life’ (breathing and circulation) and start CPR in the absence of signs of life or normal breathing (ignore occasional ‘gasps’).
Anaphylaxis

The UK incidence of anaphylactic reactions is increasing. The Trust will take all reasonable steps to provide the initial first aid response for anaphylaxis emergencies and in all instances refer for subsequent specialist treatment and care. It is important that emergency medical aid is sought immediately to improve patient’s outcome. It is therefore appropriate that Trust staff have the training, knowledge and skills to recognise and initiate emergency initial management of acute anaphylactic reactions appropriate to their level of training. Individuals should use skills that they know and use regularly. This will make it more likely that these skills are used effectively on the rare occasions when they are needed to treat an anaphylactic reaction.

Anaphylaxis Procedure

The Trust delivers care in a wide variety of settings. As a result of this variety it is not possible for the Trust to offer the same response across all of its services. This section should be read in context with any local procedures and standard operating procedures for the relevant clinical area.

On suspicion of an anaphylaxis emergency staff will:

- Obtain appropriate assistance. This may be 999 ambulance or active internal emergency call system where applicable (e.g. blue code button at Lymington New Forest Hospital).
- Follow the key steps as currently recommended “Anaphylactic reactions – initial treatment” guidelines as per www.resus.org.uk/pages/anaalgo2.pdf
- Support relatives, other patients, visitors and staff who are involved at the event
- Ensure appropriate documentation is completed (e.g. Incident form, audit form, medical notes, nursing notes)
- If appropriate and where expert skills and equipment are available (e.g. theatres, minor injuries, ECT) “Anaphylaxis Algorithm” may be appropriate following initial treatment http://www.resus.org.uk/pages/anaalgo.pdf

Patients having an anaphylactic reaction should expect the following as a minimum:

1. Recognition that they are seriously ill
2. An early call for help
3. Initial assessment and treatments based on an ABCDE approach
4. Adrenaline therapy if indicated
5. Investigation and follow-up by an allergy specialist

Patient positioning

All patients should be placed in a comfortable position. The following factors should be considered:

- Patients with Airway and Breathing problems may prefer to sit up as this will make breathing easier
- Lying flat with or without leg elevation is helpful for patients with a low blood pressure (Circulation problem). If the patient feels faint, do not sit or stand them up – this can cause cardiac arrest.
- Patients who are breathing and unconscious should be placed on their side in the recovery position
- Pregnant patients should lie on their left side to prevent caval compression

Remove trigger if possible

- Do not delay treatment if removing the trigger is not feasible
Cardiorespiratory arrest following an anaphylactic reaction

In the event of a cardiac arrest due to anaphylaxis, start cardiopulmonary resuscitation (CPR) immediately. Rescuers should ensure that help is on its way as early advanced life support is essential. The intramuscular route for adrenaline is not recommended after cardiac arrest has occurred.

Anaphylaxis Drugs

As anaphylaxis reactions are a relatively rare occurrence it is important that staff have access to simple, safe, effective drug delivery devices. Therefore after careful consideration an auto injector device has been recommended by the resuscitation committee as the Trust preferred choice. Training on these devices will be provided during Basic/Immediate Life Support training.

In exceptional areas ampoules of 1:1,000 adrenaline along with appropriate needles, syringes and sharps boxes will be issued to staff. Training on the drawing up of ampoules and subsequent administration is not covered during Basic/Immediate Life Support Training.

Adrenaline injection is a Prescription Only Medicine. However, it is exempt from this restriction when administered for the purpose of saving life in an emergency.

Please note: - The Medicines Act 1968 states Adrenaline can be administered for the purpose of saving lives in an emergency without prescription. This means that in an emergency situation, where the practitioner recognises the signs and symptoms of anaphylaxis and is competent to administer an Intra-Muscular Adrenaline Injection, an Adrenaline Injection can be administered without a prescription and without the Practitioner being signed off to work under a PGD.

Intramuscular (IM) Adrenaline

The intramuscular (IM) route is the best route for individuals who have to give adrenaline to treat an anaphylactic reaction. Monitor the patient as soon as possible (physical observations). This will help monitor the response to adrenaline.

The IM route has several benefits:

- There is a greater margin of safety.
- It does not require intravenous access.
- The IM route is easier to learn.

The best site for IM injection is the anterolateral aspect of the middle third of the thigh. The needle used for injection needs to be sufficiently long to ensure that the adrenaline is injected into muscle.

Frequently asked questions (FAQ's)

Please access the following link to the resuscitation council for the latest questions and answers relating to anaphylaxis [http://resus.org.uk/pages/FAQana.htm](http://resus.org.uk/pages/FAQana.htm) the full document

Information on auto injectors and how to use them can be found via the following links:

Emerade is the current preferred supplier

- Emerade - [http://www.emerade.com/](http://www.emerade.com/)
- Epipen – [http://www.epipen.co.uk/hcp/](http://www.epipen.co.uk/hcp/)
- Jext – [http://www.jext.co.uk/](http://www.jext.co.uk/)
Cardiac emergencies

The signs and symptoms of cardiac emergencies include chest pain, shortness of breath, fast and slow heart rates, increased respiratory rate, low blood pressure, poor peripheral perfusion (indicated by prolonged capillary refill time) and altered mental state. This list is not exhaustive.

Angina

If there is a history of angina the patient will probably carry glyceryl trinitrate (GTN) spray or tablets and they should be allowed to use them. Where symptoms are mild and resolve rapidly with the patient’s own medication, hospital admission is not normally necessary. Sudden alterations in the patient’s heart rate (very fast or very slow) may lead to a sudden reduction in cardiac output with loss of consciousness. Medical assistance should be summoned by dialling (9)999.

Myocardial Infarction

The pain of myocardial infarction is similar to that of angina but generally more severe and prolonged. There may only be a partial response to GTN.

Symptoms and signs of myocardial infarction can include:

- Progressive onset of severe, crushing pain in the centre and across the front of chest. The pain may radiate to the shoulders and down the arms (more commonly the left), into the neck and jaw or through to the back.
- Skin becomes pale and clammy.
- Shortness of breath
- Nausea and vomiting are common
- Changes in blood pressure and pulse

Initial Management of Chest Pain (Myocardial Infarction)

- Summon appropriate help immediately which should include calling 999 immediately for an ambulance.
- Allow the patient to rest in the position that feels most comfortable; in the presence of breathlessness this is likely to be the sitting position. Patients who faint or feel faint should be laid flat; often comfortable position (dictated by the patient) will be most appropriate.
- Give sublingual GTN spray if this has not already been given.
- Reassure the patient as far as possible to relieve further anxiety. Give aspirin in a single dose of 300 mg orally, crushed or chewed. Ambulance staff should be made aware that aspirin has already been given as should the hospital. High flow oxygen may be administered (15 litres per minute) if the patient is cyanosed (blue lips), conscious level deteriorates or oxygen saturation levels < 94%.
- If the patient becomes unresponsive always check for ‘signs of life’ (breathing and circulation) and start CPR in the absence of signs of life or normal breathing (ignore occasional ‘gasps’).
Seizures

Where a person has a “seizure plan or similar titled document” please follow that specific guidance for that person. Where there is no specific plan please follow guidance below.

Epileptic patients may not volunteer the information that they are epileptic; there are many different types of epilepsy but there should be little difficulty in recognising a tonic clonic (grand mal) seizure.

Symptoms and signs
- There may be a brief warning or ‘aura’.
- Sudden loss of consciousness, the patient becomes rigid, falls, may give a cry, and becomes cyanosed (tonic phase). After a few seconds, there are jerking movements of the limbs; the tongue may be bitten (clonic phase).
- There may be frothing and blood from the mouth and urinary incontinence.
- The seizure typically lasts a few minutes; the patient may then become floppy but remain unconscious.
- After a variable time the patient regains consciousness but may remain confused.
- Seizures may be a presenting sign of Hypoglycaemia and should be considered in all patients, especially known diabetics and children. An early blood glucose measurement is essential in all patients actively having a seizure (including known epileptics).
- Check for the presence of a very slow heart rate (<40 per minute) which may drop the blood pressure. This is usually caused by a vasovagal episode (see Syncope section below). The drop in blood pressure may cause transient cerebral hypoxia and give rise to a brief seizure.

Treatment
- If a patient has a seizure management care plan, this must be followed and may include the administration of emergency medication (see below). In this situation, staff will have been trained to administer the emergency medication.
- If a patient does not have a seizure management care plan, the role of staff is to maintain patient safety and call for an emergency ambulance. In areas where there is doctor available, the doctor must be summoned to attend the emergency. Management of a seizure in this situation whilst waiting for a doctor/ ambulance to arrive will include:
  - During a seizure try to ensure that the patient is not at risk from injury i.e. remove an obstructing furniture, but make no attempt to put anything in the mouth or between the teeth (in the mistaken belief that this will protect the tongue). Do not attempt to insert an oropharyngeal airway or other airway adjunct while the patient is actively fitting. Give high flow oxygen (15 litres per minute).
  - Do not attempt to restrain convulsive movements.
  - After convulsive movements have subsided place the patient in the recovery position and reassess checking for any injuries sustained.
  - If the patient remains unresponsive always check for ‘signs of life’ (breathing and circulation) and start CPR in the absence of normal breathing and signs of life.
  - Check blood glucose level to exclude hypoglycaemia. If blood glucose <4.0 mmol per litre or hypoglycaemia is clinically suspected, give oral/buccal glucose, or glucagon (see Hypoglycaemia section below).
After the seizure the patient may be confused (‘post-ictal confusion’) and may need reassurance and sympathy. The patient should not be sent home until fully recovered and they should be accompanied. It may not always be necessary to seek medical attention or transfer to hospital unless the convulsion was atypical, prolonged (or repeated), first ever seizure, or if injury occurred.

The National Institute for Clinical Excellence (NICE) guidelines suggest the indications for sending to hospital are:

- Status epilepticus
- First time have needed emergency medication
- Emergency medication not working
- High risk of recurrence.
- First episode
- Difficulty monitoring the individual’s condition i.e. breathing and vital signs

Emergency Medication:

Medication should only be given if seizures are prolonged (convulsive movements lasting 5 minutes or longer), recur in quick succession or as part of a care plan. In this situation an ambulance should be summoned urgently. However, in exception to the recommended 5 minute delay, carers of service users known to suffer tonic-clonic seizures that usually last more than 5 minutes with loss of consciousness, should be advised to administer midazolam immediately or even at the first indicative signs of seizure onset. For those service users, until experience indicates otherwise, it may be advisable to call an ambulance and/ or the doctor without delay.

Until recently the most commonly used medication was rectal diazepam. Buccal midazolam provides an alternative treatment to, but not a replacement for, rectal diazepam for tonic - clonic status epilepticus. This is an unlicensed use of midazolam, but there is evidence that it is effective and well tolerated. It is being used increasingly both in the community and specialised epilepsy units. It is clinically shown to be as effective as rectal diazepam in the acute treatment of seizures and is a more acceptable route for the patient. Buccal Midazolam is NOT for intravenous use.

- child 1-5 years 5mg
- child 5-10 years 7.5mg
- above 10 years AND adults 10mg

These single doses can be given in half doses, one in each buccal cavity (space between the gum and the cheek), to the left and right sides. A second or repeat dose when seizures reoccur after an initial response should not be given without prior medical advice. Monitor vital signs (respiratory rate, pulse blood pressure and conscious levels) after administration. After receiving midazolam, the patient should be warned not to drive or operate a machine until completely recovered.
Hypoglycaemia

Diabetes
Insulin dependent diabetics are those most likely to become hypoglycaemic. Diet or tablet controlled diabetics are a much lower risk. Diabetics with poor control or poor awareness of their hypoglycaemic episodes have a greater chance of developing problems.

Patients with diabetes should eat normally and take their usual dose of insulin or oral hypoglycaemic agent. If food is omitted after having insulin, the blood glucose will fall to a low level (hypoglycaemia). This is usually defined as blood glucose <4.0 mmol per litre, but some patients may show symptoms at higher blood sugar levels. Patients may recognise the symptoms themselves and will usually respond quickly to glucose.

Symptoms and signs
- Shaking and trembling.
- Sweating.
- Headache.
- Difficulty in concentration / vagueness.
- Slurring of speech.
- Aggression and confusion.
- Fitting / seizures.
- Unconsciousness.

Treatment
The following staged treatment protocol is suggested depending on the status of the patient. If any difficulty is experienced or the patient does not respond, the doctor or ambulance service should be summoned immediately.

Confirm the diagnosis by measuring the blood glucose.

Early stages - where the patient is co-operative and conscious with an intact gag reflex, give oral glucose (sugar milk with added sugar, glucose tablets or gel). If necessary this may be repeated in 10 -15 minutes.

In more severe cases, where the patient has impaired consciousness, is uncooperative or is unable to swallow safely, buccal glucose gel and / or glucagon should be given.

Glucagon should be given via the IM route (1mg in adults and children >8years old or >25 kg, 0.5mg if <8 years old or <25 kg).

Remember it may take 5-10 minutes for glucagon to work and it requires the patient to have adequate glucose stores. Thus, it may be ineffective in anorexic patients, alcoholics or some non-diabetic patients.

Re-check blood glucose after 10 minutes to ensure that it has risen to a level of 5.0 mmol per litre or more, in conjunction with an improvement in the patients mental status.

If any patient becomes unconscious, always check for 'signs of life' (breathing and circulation) and start CPR in the absence of normal breathing and signs of life.

It is important, especially in patients who have been given glucagon, that once they are alert and able to swallow, they are given a drink containing glucose and if possible some food high in carbohydrate.
Syncope

Inadequate cerebral perfusion (and oxygenation) results in loss of consciousness. This most commonly occurs with low blood pressure caused by vagal over activity (a vasovagal attack, simple faint, or syncope). This in turn may follow emotional stress or pain. Some patients are more prone to this and have a history of repeated faints.

Symptoms and signs

- Patient feels faint / dizzy / light headed.
- Slow pulse rate.
- Low blood pressure.
- Pallor and sweating.
- Nausea and vomiting.
- Loss of consciousness.

Treatment

- Lay the patient flat as soon as possible and raise the legs to improve venous return.
- Loosen any tight clothing, especially around the neck and give oxygen (15 litres per minute).
- If any patient becomes unresponsive, always check for ‘signs of life’ (breathing, circulation) and start CPR in the absence of normal breathing and signs of life
  Unresponsive patients may require airway management by manual manoeuvre or use of the recovery position

Other possible causes

Postural hypotension can be a consequence of rising abruptly or of standing upright for too long. Several medical conditions predispose patients to hypotension with the risk of syncope. The most common culprits are drugs used in the treatment of high blood pressure, especially the ACE inhibitors and angiotensin antagonists. When rising, patients should take their time. Treatment is the same as for a vasovagal attack. Under stressful circumstances, many anxious patients hyperventilate. This may give rise to feelings of light headedness or faintness but does not usually result in syncope. It may result in spasm of muscles around the face and of the hands. In most cases reassurance is all that is necessary.
Choking and Aspiration

Symptoms and Signs
- The patient may cough and splutter.
- They may complain of difficulty breathing.
- Breathing may become noisy with wheeze (usually aspiration) or stridor (usually upper airway obstruction).
- They may develop ‘paradoxical’ chest or abdominal movements.
- They may become cyanosed and lose consciousness.

Treatment
- The algorithm below should be followed in the first instance
- The treatment of the choking patient involves removing any visible foreign bodies from the mouth and pharynx.
- Suction, if available, is of value for semi solids or liquids but has no immediate value in the management of solid particle obstruction.
- Medical support obtained urgently use clinical escalation algorithm as appropriate. Be aware that following the successful management of choking the patient may require supplemental oxygen to regain normal saturation, medical review to exclude injury and assessment of the risk of aspiration of gastric content.
- If the choking episode was related to eating a swallowing assessment may be indicated.
- Where ever patient with reduced swallowing ability are offered meals they must be under direct supervision and a suction unit must be readily available.
- If breathing / circulation is compromised appropriate life support measures must be instigated. The management of choking episodes is considered a reversible event and a DNACPR order may be suspended until the choking episode is reversed. Example the patient can now breathe or you can ventilate them.
- If any large pieces of foreign material have been aspirated, e.g., teeth, the patient should be referred to hospital for a chest x-ray and possible removal. Where the patient is symptomatic following aspiration they should be referred to the Emergency Department.
Suspected Opiate Overdose

Opiate based painkillers are medicines with effects similar to opium. They act by stimulating opioid receptors in the brain and nervous system. Opiate based medicines include codeine, morphine, dihydrocodeine, methadone and diamorphine (also known as heroin). Although opiate painkillers will vary in how powerful they are, they are all sedative painkillers that can depress the nervous system. They are also highly addictive. Some people who use opiate painkillers regularly become dependent on them. If they are taken primarily to get high and to feel better, the risk of addiction is greater. People may take opiates due addiction but people can also take opiates during an inpatient stay on a ward for pain relief purposes. Many people will also take opiates at home for pain relief, such as in management of end of life care. All people can be at risk of the opiate related respiratory depression, no matter the reason they are taking them.

Signs and symptoms

- Shallow breathing and/ or reduced respiratory rate
- Turning blue
- Reduced conscious levels
- Unable to be roused
- Pinpoint pupils

Treatment

- Call 999 and check for immediate risks i.e. discarded needles
- Assess the person using ABCDE approach:
  - if breathing, place in the recovery position
  - if not breathing normally, start resuscitation
- Administer naloxone (where available) see below

NALOXONE

Naloxone is the emergency antidote for overdoses caused by opiate based medicines. The main life threatening feature of opiate overdose is to slow down and stop breathing. Naloxone blocks this and reverses the breathing impairment. Naloxone should be given to ANY person if they are suspected of experiencing an overdose where opiates are involved, even if the overdose was not witnessed. Naloxone will do no harm even if it does not help.

Naloxone is short acting and wears off quickly. For example, an opiate overdose can last up to 8 hours whilst naloxone can wear off in 20 minutes. It is therefore vital that everyone who is given naloxone is monitored - this will invariably mean admission to hospital.

The dose of naloxone will be dependent on the patient. In the event that a patient who is known to misuse opiates presents in an overdose state, a dose of 400mcgs naloxone should be administered via the intramuscular route. Lower doses should be administered to individuals who are dependent on opiates for conditions such as chronic pain or are taking opiates as part of their end of life care. Local protocols should be followed.

Naloxone injection is a Prescription Only Medicine. However, it is exempt from this restriction when administered for the purpose of saving life in an emergency.

Please note: - The Medicines Act 1968 states Naloxone can be administered for the purpose of saving lives in an emergency without prescription. This means that in an emergency situation, where the practitioner recognises the signs and symptoms of opiate overdose and is competent to administer an Intra-Muscular Adrenaline Injection, a Naloxone Injection can be administered without a prescription and without the Practitioner being signed off to work under a PGD.
Management of Suspected Opioid Overdose in Adults

**PATIENT WITH KNOWN DRUG MISUSE/DEPENDANCE**
Administer **NALOXONE 400 micrograms (1ml) I.M.**
(into outer aspect of thigh or upper arm)

**PALLIATIVE CARE PATIENT** or where recurrence of pain is an issue e.g. chronic opioid user
Administer **NALOXONE 100 micrograms (0.25mls) I.M.**
(onto outer aspect of thigh or upper arm)

Re-assess respiratory rate:
- a) If respiratory rate ≤ 8, repeat dose at **3-5 minute** intervals if no improvement (vary site of injection)
  OR
- b) If respiratory rate is ≥ 9, continue to monitor respiratory rate
  **Avoid** completely reversing the effects

Palliative Care Patient – Naloxone is **not** indicated for opioid induced drowsiness and/ or delirium which is not life threatening and **not** indicated for patients on opioids who are dying.

For LYMINGTON NEW FOREST HOSPITAL only: In the event that patient is not transferred under medical advice, physical observations, inc. **RESPIRATORY RATE** must be assessed at least every 30 minutes. Consultant advice must be sought for patients on long acting opioids or methadone.
Medical Emergency and Resuscitation Bag

Algorithms for

The management of medical emergencies in adults
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Life threatening signs of Anaphylaxis:
- **Airway:** Swollen tongue, unable to swallow, drooling.
- **Breathing:** Wheeze, stridor, respiratory rate >20, use of accessory muscles.
- **Circulation:** feeling dizzy, loss of consciousness, systolic blood pressure <90mmHg.

Signs of allergy:
- Itching
- Urticarial rash

**If patient loses consciousness check for breathing and signs of life.**

**If breathing:** recovery position.

**Not breathing, no signs of life:** CPR

---

**Anaphylaxis**

**Suspect allergic reaction, administer**
- 10mg Chlorphenamine IM
- 200mg Hydrocortisone IM

**Monitor closely for development of life threatening symptoms**

**Medical review, investigate cause and document**

**Presence of life threatening symptoms?**

**Yes**

**Consider positioning (lay flat and raise legs if no breathing problems are present)**

**Administer 500mcg of 1:1000 Adrenaline IM (Emerade pen). Deliver oxygen if oxygen saturations < 94%**

**Repeat every 5 minutes if no improvement. Await arrival of ambulance**

**Ulysses form and documentation**

**Email Openhouse to restock bag**

**No**

**Note time**

**Access ‘Anaphylaxis’ pouch and give to Primary care giver**

**Call for help, consider 999**

---

**999**

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https://www.resus.org.uk/anaphylaxis/emergency-treatment-of-anaphylactic-reactions/
Benzodiazepine Overdose

Assess symptoms and check pupils using pen torch

Deliver oxygen 15 litres via non-rebreath mask if oxygen saturations <94%. Consider airway management if required

If benzodiazepine overdose is suspected and staff are trained in IV administration administer 200mcg of Flumazenil over 15 seconds IV. Is there improvement after 60 seconds?

If patient loses consciousness check for breathing and signs of life.

If breathing: recovery position.

Not breathing, no signs of life: CPR

Administer further 100mcg of Flumazenil IV. If no response after 60 seconds give further 100mcg. Repeat every 60 seconds up to a total of 1mg. Monitor physical observations, document and await ambulance.

Note time

Access ‘Flumazenil’ pouch and give to Primary care giver if IV trained and medical personnel present

Call for help 999

Ulysses form and documentation

Email Openhouse to restock bag

BNF online via NICE
Symptoms of breathing difficulties:
- Respiratory rate >20
- Central cyanosis
- Accessory muscle use
- Oxygen saturations <94% (<88% in diagnosed COPD patient)
- Unable to complete sentence in one breath

Considerations:
- Positioning
- Ipratropium 500mcg nebuliser

If signs of Anaphylaxis, see Anaphylaxis guidelines

Deliver oxygen 15 litres via non-rebreath mask if oxygen saturations <94%

Able to use inhaler and spacer?

Yes

Administer Salbutamol Inhaler up to 10 puffs using spacer device. Improved?

Yes

Monitor physical observations and document. Medical review

No

Administer Salbutamol 5mg nebuliser via nebuliser mask. Improved?

Yes

Monitor physical observations. May require further Salbutamol nebulisers every 15 minutes. Medical review

No

Call for help, Medical review, consider 999

Note time

Access ‘Breathing Difficulties’ pouch and give to person 1

Considerations:
- Positioning
- Ipratropium 500mcg nebuliser

If patient loses consciousness check for breathing and signs of life.

If breathing: recovery position.

Not breathing, no signs of life: CPR

British thoracic society: https://www.brit-thoracic.org.uk/document-library/clinical-information/asthma/btssign-asthma-guideline-2016/
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 Symptoms of a heart attack

- chest pain: tightness, heaviness, pain or a burning feeling.
- pain in arms, neck, jaw, back or stomach.
- sweating
- feeling light-headed
- shortness of breath
- nausea or vomiting

Chest Pain

Deliver oxygen 15 litres via non-rebreath mask if oxygen saturations <94%

Administer GTN spray, two puffs under tongue

Administer Aspirin 300mg tablet, to be chewed then swallowed

Monitor patient condition and record physical observations while awaiting ambulance. Further GTN doses may be required.

Note time

Access ‘chest pain pouch’ and give to Primary care giver

Call for help, medical review and 999

Ulysses form and documentation

Email Openhouse to restock bag

Considerations:
- ECG
- Furosemide 20-40mg IV

If patient loses consciousness check for breathing and signs of life.

If breathing: recovery position.

Not breathing, no signs of life: CPR

British Heart Foundation. https://www.bhf.org.uk/heart-health/conditions/heart-attack
Choking & Aspiration

Symptoms of choking & aspiration

- Patient may cough and splutter
- Breathing may become noisy
- Patient may have difficulty breathing
- Patient may become cyanosed and lose consciousness

Assess severity

Severe airway obstruction (ineffective cough)
- Unconscious? Start CPR
- Conscious? 5 back blows followed by 5 abdominal thrusts. Repeat if necessary

Severe airway obstruction (effective cough)
- Encourage cough check for deterioration to ineffective cough or relief of obstruction

Note time

Call for help

Medical review and 999

Unconscious? Start CPR

Email Openhouse to restock bag

If patient loses consciousness check for breathing and signs of life.

If breathing: recovery position.

Not breathing, no signs of life: CPR
Adult Choking

Assess severity

Severe
Airway obstruction (ineffective cough)

Mild
Airway obstruction (effective cough)

Unconscious
Start CPR

Conscious
5 back blows
5 abdominal thrusts

Encourage cough
Continue to check for deterioration to ineffective cough or until obstruction relieved
Hypoglycaemia

Symptoms of hypoglycaemia:
- Sweating
- Fatigue
- Dizziness
- Confusion
- Agitation
- Loss of consciousness

Check blood sugar if < 4mmol/l

Access ‘Hypoglycaemia’ pouch and give to primary care giver

Note time

Airway management if needed. Deliver oxygen 15 litres via non-rebreather mask if oxygen saturations < 94%

AVPU score A or V

Administer Fast acting Dextrose Gel

Recheck BG in 10 minutes, aim > 5mmol/l. Further Fast acting Dextrose Gel may be required. Continue to monitor physical observations and document. Medical review.

A = ALERT
V = VOICE
P = PAIN
U = UNRESPONSIVE

AVPU score P or U

Administer Glucagon 1mg IM

Recheck BG after 10 minutes. BG > 5mmol/l?

Yes
Encourage patient to eat, continue to monitor blood sugar closely, monitor physical observations and document. Medical review.

No
Apply recovery position.

999

Encourage patient to eat, select Fast acting Dextrose Gel, continue to monitor blood sugar closely, monitor physical observations and document. Medical review.

Call for help, medical review, consider 999
Ulysses form and documentation
Email Openhouse to restock bag

If patient loses consciousness check for breathing and signs of life.

If breathing: recovery position.

Not breathing, no signs of life: CPR

http://www.diabetes.co.uk/diabetes-and-hypoglycaemia.html
Opioid Overdose

Assess symptoms and check pupils using pen torch

Access ‘Naloxone’ pouch and give to Primary car giver

Note time

Note time

If opioid overdose is suspected administer Naloxone 400mcg IM and observe for 3-5 minutes. Has respiratory depression improved? (>8)

Call for help 999

If opiod overdose is suspected administer Naloxone 400mcg IM and observe for 3-5 minutes. Has respiratory depression improved? (>8)

If patient loses consciousness check for breathing and signs of life.

If breathing: recovery position.

Not breathing, no signs of life: CPR

Considerations:
- Effects of opioid are longer lasting than effects of Naloxone
- Recovery position
- Safety of team

Symptoms of opioid overdose
- Drowsiness
- Loss of consciousness
- Respiratory rate <8
- Pinpoint pupils (<3mm diameter)

Deliver oxygen 15 litres via non-rebreath mask if oxygen saturations <94%. Consider airway management if required

Administer further 400mcg of Naloxone IM every 3-5 minutes or until respiration rate is 9 or above. Monitor physical observations, document and await ambulance.


Email Openhouse to restock bag

Ulysses form and documentation
Seizures

Symptoms of seizures:
- Jerking of arms, legs or torso.
- Loss of consciousness.
- Frothing at mouth.
- Urinary incontinence.
- May experience a warning or ‘aura’.

Airway management if needed. Does the patient have a seizure management careplan?

No. Deliver oxygen 15 litres via non-rebreath mask if oxygen saturations <94%.

Check blood sugar (if <4mmol/l see hypoglycaemia algorithm)

Monitor patient condition repeat physical observations

If seizure lasts longer than 5 minutes, call 999

Note time

Access emergency medication if indicated and give to Primary care giver

Call for help, medical review, consider 999

Ulysses form and documentation

Email Openhouse to restock bag

If patient loses consciousness check for breathing and signs of life.

If breathing: recovery position.

Not breathing, no signs of life: CPR

Signs and symptoms of syncope:
- Patient feels faint/dizzy
- Slow pulse rate
- Low blood pressure
- Pallor & sweating
- Nausea and vomiting
- Loss of consciousness?

If patient loses consciousness check for breathing and signs of life.

If breathing: recovery position.

Not breathing, no signs of life: CPR

Syncope/Faint

Note time

Email Openhouse to restock bag

Lay the patient flat as soon as possible
- Raise the legs
- Loosen any tight clothing
- Deliver oxygen 15litres via non re-breath mask if oxygen saturations <94%

Consider diagnosis of postural hypotension or hyperventilation

Hyperventilation may give rise to feelings of light headedness or faintness but does not usually result in syncope. In most cases reassurance is all that is necessary.

Postural hypotension when rising, patients should take their time. Treatment is the same as for a faint. Medical review.
Advanced Life Support Algorithm

During CPR
- Ensure high quality chest compressions
- Minimise interruptions
- Give adrenaline after 3 shocks

Immediately resume CPR for 2 min
- Minimise interruptions

1 Shock
- Minimise interruptions
- Shockable (VF/PEF/asystole)

Return of spontaneous circulation
- Assess rhythm
- Non-shockable (PEA/Asystole)

Immediate post cardiac arrest treatment
- Treat reversible cause
- Tension pneumothorax
- Torsades - cardiac
- Tumor
- Thrombosis - coronary or iliac
- Hyperkalaemia
- Hypothermia

CPR 30:2
- Attach defibrillator/monitor
- Minimise interruptions
- CPR 30:2
- Call resuscitation team

Unresponsive and not breathing normally

Treat Reversible Causes
- Hypoxia
- Hypovolaemia
- Hypertension
- Hypothyroidism
- Hypernatraemia
- Metabolic/Endocrinology

Consider
- Ultrasound imaging
- Extracorporeal CPR

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APPENDIX 7

RESUSCITATION EVENT REPORT FORM

SECTION 1: PATIENT DETAILS (complete or affix patient label to ALL copies)

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS No.:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Gender: M/F</td>
</tr>
</tbody>
</table>

Reason For Admission (if in an inpatient area):

SECTION 2: INITIAL EVENT DETAILS

Date of Event: ___ / ___ / ___
Time of Event (24 hr clock): ___:___
Witnessed? YES ☐ NO ☐

Type of arrest: Respiration only ☐ Cardiac ☐
Time of Arrest (if different from above): ___:___

Location of the Event ..................................................
Precipitating event i.e. chest pain, head injury etc..........................

Ambulance Called: YES ☐ NO ☐
If no, please state reason:................................................................

Time Ambulance Called: ___:___
Time Ambulance Arrived: ___:___
Time Ambulance Departed: ___:___

CPR in progress on ambulance arrival: YES ☐ NO ☐

SECTION 3: BASIC LIFE SUPPORT MANAGEMENT – Please indicate which were used.

AIRWAY MANAGEMENT:
Head Tilt Chin Lift/ Jaw Thrust ☐ Suction ☐ iGel ☐ Oropharyngeal Airway ☐ Nasopharyngeal Airway ☐

BREATHING:
Mouth to Mouth ☐ Face Shield ☐ Pocket mask ☐ Bag Valve Mask ☐ Oxygen ☐

SECTION 4: DEFIBRILLATION

Time Defibrillator with Patient: ___:___
Type of Defibrillator: AED ☐ Manual ☐

Time of 1st Analysis: ___:___
Initial Rhythm: Shockable ☐ Non-Shockable ☐
No. of Shocks Delivered:

Time First Cardiac Arrest Drug Administered: ___:___
Total no. of cycles of CPR:

SECTION 5: ANY OTHER INTERVENTIONS

Autopulse ☐ Time: ___/___
Cannulation ☐ Time: ___/___
Drug Therapy ☐ Fluid Therapy ☐ None ☐

IF DRUGS AND/ OR FLUIDS HAVE BEEN ADMINISTERED, PLEASE LIST BELOW:

<table>
<thead>
<tr>
<th>TIME</th>
<th>DRUG/ FLUID</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
**SECTION 6: POST EVENT – what was the reason resuscitation was stopped?**

<table>
<thead>
<tr>
<th>Patient deceased □</th>
<th>Return of spontaneous circulation □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient transferred □</td>
<td>If patient was transferred, was CPR in progress □ YES □ NO □</td>
</tr>
</tbody>
</table>

If patient transferred, where was the patient transferred to:

If patient transferred, what was the outcome:    Dead on arrival □    Admitted □    Unknown □    Other □ (please state):………………………………………………….  

<table>
<thead>
<tr>
<th>Patient deceased □</th>
<th>Return of spontaneous circulation □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient transferred □</td>
<td>If patient was transferred, was CPR in progress □ YES □ NO □</td>
</tr>
</tbody>
</table>

If patient transferred, where was the patient transferred to:

If patient transferred, what was the outcome:    Dead on arrival □    Admitted □    Unknown □    Other □ (please state):………………………………………………….  

**SECTION 7: ANY OTHER RELEVANT INFORMATION (i.e. additional drugs administered, other interventions carried out, other individuals in attendance etc.)**

**SECTION 8: TO BE COMPLETED BY A MEMBER OF THE TEAM**

Name of person completing the form: ________________________________

Designation of the person completing the form: __________________________

Signature of the person completing the form: __________________________

Who else was present during the event:

<table>
<thead>
<tr>
<th>NAME:__________________</th>
<th>POSITION:__________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME:__________________</td>
<td>POSITION:__________________</td>
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<tr>
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<tr>
<td>NAME:__________________</td>
<td>POSITION:__________________</td>
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</tbody>
</table>

DATE FORM COMPLETED: ___ / ___ / ___  

**NEXT STEPS**

<table>
<thead>
<tr>
<th>Have you remembered to:</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Send a stock replacement form to Openhouse if the Medical Resus bag has been used?</td>
<td>□ ___</td>
</tr>
<tr>
<td>2. Replenished and checked the resuscitation trolley (LNFH and ECT Suites only)?</td>
<td>□ ___</td>
</tr>
<tr>
<td>2. Carried out a defibrillator battery test on X Series ONLY (as per manufacturers instructions)?</td>
<td>□ ___</td>
</tr>
<tr>
<td>3. Updated the patients notes?</td>
<td>□ ___</td>
</tr>
<tr>
<td>4. Completed an online incident form (Ulysses)</td>
<td>□ ___</td>
</tr>
<tr>
<td>5. Informed your manager and/ or any other relevant other?</td>
<td>□ ___</td>
</tr>
<tr>
<td>6. Debrief (where as soon as practically possible)?</td>
<td>□ ___</td>
</tr>
<tr>
<td>7. Place a photocopy of this form in the patient notes</td>
<td>□ ___</td>
</tr>
<tr>
<td>8. Send completed form to the Resuscitation Officers at LEaD, Tatchbury Mount</td>
<td>□ ___</td>
</tr>
</tbody>
</table>