

Livewell Southwest

## **Resuscitation Policy**

Version 3:8

Review: May 2019

### **Notice to staff using a paper copy of this guidance**

**The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.**

**Author: Resuscitation Training Officer**

**Asset Number: 161**

## Reader Information

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<b>Author</b>	Resuscitation Training Officer
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## Document review history

Version no.	Type of change	Date	Originator of change	Description of change
For previous review history please contact the PRG secretary.				
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V3:1	Review	November 2011	A Field	
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V3:3	Extended	June 2014	A Field	Extended no changes.
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V3:5	Reviewed	January 2016	A Field	Appendices E to J updated. Appendix N added.
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# Resuscitation Policy

## 1. Introduction

1.1 This resuscitation policy fully supports the recommendations for Standards of clinical practice and training in cardiopulmonary resuscitation published by the Resuscitation Council (UK) (Oct 2010) and has been constructed to promote compliance with the National Health Service Litigation Authority risk management standards (NHSLA, 2007).

## 2. Purpose

2.1 The Purpose of the policy is to provide direction and guidance for the planning and implementation of a high-quality and robust resuscitation service for Livewell Southwest. To ensure where resuscitation would not be appropriate for the patient that a Do not attempt resuscitation (DNAR) order is in place, and that the information has been communicated to all relevant parties.

## 3. Duties

The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

3.1 Livewell Southwest has an obligation to provide an effective resuscitation service to our patients and appropriate training for our staff.

3.2 It is the responsibility of the Livewell Southwest's Board/ Directorate of Workforce Development/ Resuscitation Training Officer/ Resuscitation Committee/Risk Department for the implementation and compliance throughout Livewell Southwest of this policy.

3.3 Managers are responsible to ensure that their staff attend the appropriate level of resuscitation training and that all resuscitation equipment is checked in line with this policy.

3.4 All clinical staff are responsible for attending resuscitation training and checking the resuscitation equipment in line with this policy.

**3.5 The Resuscitation Committee** is the driving force for implementation for change in resuscitation for Livewell Southwest. The committee meets on a quarterly basis and is responsible for the monitoring and auditing of cardiac arrests and equipment within Livewell Southwest.

3.6 This committee is responsible for implementing operational policies governing resuscitation practice and training. The resuscitation committee should comprise of at least 5 members including a physician, General Practitioner, Resuscitation Training Officer (RTO), Nursing staff, junior medical staff, Dental, Paramedic and lay representative. Members should have an active interest in resuscitation.

3.7 The committee should advise on the appropriate response to emergency situations across the Livewell Southwest's various sites, considering the wide variation in

patients, staff and equipment / resources. It should ensure the provision of appropriate equipment throughout the Livewell Southwest both for resuscitation of patients and for training purposes.

#### 4. Definitions

- **ABCDE:** Airway, Breathing, Circulation, Disability, Exposure
- **AED:** Automated External defibrillator
- **ALS :** Advanced Life Support
- **BLS:** Basic Life Support i.e. CPR without the use of equipment except for airway protective devices.
- **CPR:** Cardiopulmonary resuscitation, which refers to chest compressions and ventilations
- **DNAR:** Do not attempt resuscitation
- **LCP:** Liverpool Care Pathway for the dying patient
- **MCA:** Mental Capacity Act
- **Advanced Decisions/Directive:** A formally recorded, witnessed, applicable statement made by the person (with capacity to do so) to limit their future care in some way.
- **EWS: Early Warning Score**
- **ESR: Electronic Staff Records**

## 5. Section 1 Active/Do Not Attempt Resuscitation

### 5.1 Active Resuscitation

Cardiopulmonary Resuscitation (CPR) should be attempted on any individual in whom cardiac or respiratory function ceases, unless a do not attempt resuscitation (DNAR) order is in place.

- Staff will be trained in resuscitation procedures relevant to their area of work e.g. adult or child.
- In areas that have defibrillators there should always be a member of staff who is trained in its operation. Managers will need to plan this into their staff duty rosters.
- All staff must know the location of and how to use all the resuscitation equipment in their clinical areas.
- Minimum requirements for non-clinical areas would be a pocket mask and first aid kit.
- All staff will be able to identify and assess a collapsed victim and dial (9) 999 for Ambulance Service and to commence basic life support if required.
- Mount Gould Hospital Site should also ring (9)999 and 2222 to access the support from Junior Doctor (not 24 hours) and the senior nurse, and porter.
- The duty Doctor, Nurse, and porter should ensure that they respond to the switchboard test call for the 2222 emergency number. Switchboard will activate the test on a Monday morning. (see switchboard protocol page 16)
- Glenbourne Unit is covered by Derriford Hospitals cardiac arrest team so should dial (9)999 and 2222.
- Each area must prominently display the current Basic Life Support Protocol that can be downloaded from this policy see **appendices on page 23**, completing the areas for post code and location of resuscitation trolley/defibrillator.
- All resuscitation incidents should be documented in the patient's records and a resuscitation incident form is to be completed and sent to the Resuscitation Training Officer as soon as possible, **See appendix page 20**.

Livewell Southwest has adopted the Resuscitation Council (UK) Guidelines, for ease of use these have been made into flow charts. If detailed information is required, the documents can be downloaded from the Resuscitation Council (UK) website [www.resus.org.uk](http://www.resus.org.uk)

**Adult Basic Life support algorithm appendix E page 23**

**Adult choking algorithm appendix F page 24**

**AED defibrillation algorithm appendix G page 25**

**In-hospital Resuscitation H page 26**

**Advanced Life Support algorithm appendix I page 27**

**Paediatric Basic Life Support algorithm appendix J page 28**

**Paediatric choking algorithm appendix K page 29**

## **5.2 Do Not Attempt Resuscitation (DNAR)**

- 5.2.1 The primary goal of healthcare is to benefit patients, by restoring or maintaining their health, and minimising harm. If treatment fails; or ceases to benefit the patient; or if an adult patient with capacity has refused treatment then treatment is no longer justified.
- 5.2.2 Prolonging a patient's life usually provides a health benefit to that patient. Nevertheless, it is not appropriate to prolong life at all costs with no regard to its quality or to the potential burdens of treatment for the patient. The decision to use any treatment should be based on the balance of burdens, risk and benefits to the individual receiving the treatment, and that the principle applies as much to cardiopulmonary resuscitation (CPR) as to any other treatment.
- 5.2.3 Uncommonly, some patients for whom a DNAR order has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking, induction of anaesthesia, anaphylaxis or blocked tracheotomy tube, in such situations CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention. In these circumstances for example an advanced directive which states that they do not want CPR "under any circumstances", must be in place and be respected.
- 5.2.4 Decisions about CPR must be made on the basis of an individual assessment of each patient's case. It is important not to discriminate for example on the basis of age, disability or a professional's subjective view of patient's quality of life.
- 5.2.5 The Human Rights Act 1998 sets out clear decisions that are particularly relevant to CPR, including the right to life (Article 2), to be free from inhuman or degrading treatment, (Article 3) the respect for privacy and family life (Article 8) to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and to be free from discriminatory practice in respect of these rights (Article 14) The spirit of the act , which aims to promote human dignity and transparent decision making, is reflected in these ethical guidelines.
- 5.2.6 Advanced care planning, including decisions about CPR, is an important part of good clinical care for those at risk of arrest.
- 5.2.7 Patients may have an advanced directive that clearly states a DNAR order, this needs to be viewed by the healthcare team and a copy made and recorded in the patients records. In some cases the patient who has capacity may say verbally that they do not want to be resuscitated, this needs to be documented in the patients records.
- 5.2.8 Patients who are on a Liverpool Care Pathway will have a DNAR order in place, this will need to be communicated to the family and carers and will need to be shown to the ambulance service should they be called.

- 5.2.9 Where the expected benefit of attempted CPR may be outweighed by the burdens, the patient's informed views are of paramount importance. If the patient lacks capacity those close to the patient should be involved in discussions to explore the patient's wishes, feelings, beliefs and values, however they cannot make the final decision. Then refer to Mental Capacity Act 2005 code of practice. A patient may have a welfare or court appointed deputy or guardian, lasting power of attorney should be consulted.
- 5.2.10 The overall responsibility for making a DNAR decision rests with the Consultant or General Practitioner in charge of the patients care. This should be made after appropriate consultation and consideration of all aspects of the patient's condition. Decisions must be taken in the best interests of the patient, an assessment of which should include clinical outcome, and the patients known wishes, which may include an advanced directive. Medical staff must communicate in a language that patients understand bearing in mind different learning abilities.
- 5.2.11 If a patient, family or staff member are not happy with the DNAR order then a second opinion from an experienced Consultant/General Practitioner should be sought as soon as possible. The occurrence and outcome of that consultation should be reported in the notes and to the Medical Director at the earliest opportunity.

### **5.3 Child and young people**

- 5.3.1 Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, their families and the healthcare team. Where CPR may re-start the heart and breathing for a sustained period but there are doubts about whether the potential benefits outweigh the burdens, the views of the child or young person should be taken into consideration in deciding whether resuscitation should be attempted.
- 5.3.2 Young people of 12 years and above with capacity are entitled to give consent to medical treatment, and where they lack this capacity, it is generally those with parental responsibility who make decisions on their behalf. In England, refusal of treatment by competent young people up to age of 18 is not necessarily binding upon doctors since the courts have ruled that consent from people with parental responsibility, or the court, still allows doctors to provide treatment. Where a young person with capacity refuses treatment, the potential harm caused by violating the young person's choice must be balanced against the harm caused by failing to give treatment. If this situation occurs the Medical Director will need to be contacted and legal advice may be necessary.

### **5.4 Documentation**

An interim decision on resuscitation DNAR must be made at the time of a patient's admission to hospital or other healthcare setting within the Livewell Southwest. All discussions about DNAR must be recorded in the patient's notes and the Resuscitation Status form completed. If patients

have an advanced directive this must be checked by healthcare staff and copy made and placed in the patients records.  
Healthcare providers, including ambulance staff, who may come into contact with the patient, must be made aware of any DNAR/Advanced directives that are in patient's notes. **Please see appendix L Resuscitation DNAR form.**

**This policy links to**

- Infection Control policies
- Confirmation (Verification) of Life Extinct (Death) by Registered Nurses Protocol
- The Liverpool Care Pathway.
- The deceased patient's policy.
- Anaphylaxis policy
- Medical devices policy

## **6. Section 2 Resuscitation Training**

### **6.1 Clinical Staff**

All Doctors, Nurses, Public health nurses, Allied Health professionals, support workers, will be required to attend resuscitation training once a year.

### **6.2 Non-Clinical Staff**

All locations that have regular direct contact with patients will require basic life support training. Staff who do not have patient contact will be required to have completed a first aid at work course or have provision for first aid within their work area.

### **6.3 Primary Care**

GP practices that are directly employed by the Livewell Southwest must update their resuscitation training once a year.

Independent GP practices can follow the GP contract allowing clinical staff to update every 18 months and non-clinical staff every 3 years; however the Resuscitation Committee recommends training to be completed on a yearly basis.

### **6.4 Livewell Southwest Induction days**

Appointed staff will be identified by their line manager to what level of training will be required for their post. For those that have been identified as requiring resuscitation training, this will be completed in the Livewell Southwest induction days.

## **6.5 Resuscitation Courses**

6.5.1 Courses are available throughout the year and are advertised via the Plymouth Healthnet and Livewell Southwest News. The courses are held at the Livewell Southwest's training department and by arrangement with the Resuscitation Training Officer at other locations.

6.5.2 Staff appraisals are required to be completed on an annual basis and managers should discuss and agree, with the individual, the type of resuscitation training required for the post and personnel development. If managers or staff are unsure as to what level of training is required then contact the Resuscitation Training Officer. Please see training matrix chart on page 13.

### **6.6 Adult Basic Life Support (BLS)**

This course covers Adult basic life support with and without airway adjuncts, management of choking, DNAR and recovery position.

## **6.7 Paediatric Basic Life Support (PBLS)**

This course covers Infant and Child basic life support with and without airway adjuncts, management of choking, DNAR and recovery position.

## **6.8 Clinical Responders Course**

This course is the replacement for the one day first aid course and will cover Adult basic life support with airway adjuncts, automated external defibrillation (AED) (FR2 and XL) , choking , recovery position, ABCDE approach to patient, unconsciousness, anaphylaxis, and DNAR.

## **6.9 Anaphylaxis**

This course covers the management and treatment of severe allergic reaction, see anaphylaxis policy

## **6.10 ALERT**

This course covers acute life-threatening recognition and treatment of the deteriorating patient and supports the Early Warning Score system (EWS). This is a one day course.

## **6.11 Immediate Life Support (ILS)**

This course covers the management of the ill patient and management of cardiac arrest until support arrives. It covers airway management, AED defibrillation and Basic Life Support and is a one day Resuscitation Council (UK) accredited course.

## **6.12 Basic Life Support Instructors Course and assessment**

This course covers the basic delivery of resuscitation training for staff in line with the Resuscitation Council (UK) and supports the Resuscitation Training Officer in the delivery of training across Livewell Southwest.

Public Health Nurses on competing this course can teach and support clients in the baby clinics on infant basic life support.

## **6.13 In House Doctors/Consultant resuscitation training**

This course covers Basic Life Support and AED defibrillation, Advanced airway management, cardiac arrest drugs, Anaphylaxis training.

## Training Matrix Chart

Course	Base	Target group
Basic Life Support for non clinical staff	All locations that have regular direct patient contact.	Administration & Clerical staff
Basic Life Support	Community Based clinical teams	Allied Health Professionals Community/District Nurses Public Health Nurses Mental Health Nurses Support Workers Community Public Health Nurses
Basic Life Support with defibrillator (AED) (Clinical Responders)	Wards, Clinics/Department, GP Practices, Dental practices, MIU,	Allied Health Professionals Nursing Staff Mental Health Nursing staff Support Workers GP, Doctors, Consultants Practice Nurses
Basic Life Support with defibrillator (AED) and Airway management , Anaphylaxis for Doctors/Consultants	All clinical locations	GP, Doctors, Consultants
Medical Emergencies in Dental Practices	Dental Practice	Dental Nurses Dental Surgeons
RAPID Course	Wards, Clinics/Department, GP Practices, Dental practices, MIU,	Nursing Staff Mental Health Nursing staff Support Workers GP, Doctors, Consultants Practice Nurses
Immediate Life Support	Wards, Clinics/Department, GP Practices, Dental practices, MIU,	Allied Health Care Professionals Nursing Staff/HCAs Mental Health Nursing staff Support Workers GP, Doctors, Consultants Practice Nurses
Anaphylaxis training	All clinical locations	Allied Health Care Professionals Nursing Staff/HCAs Mental Health Nursing staff Support Workers GP, Doctors, Consultants Practice Nurses Community Public Health Nurses

## Section 3 Equipment

- All resuscitation equipment in Livewell Southwest must be fit for purpose and is regularly monitored by the Resuscitation Committee. Any new provision of service or department moving to a different location must contact the Resuscitation Training Officer for advice and support on resuscitation equipment provision and local protocols. Any change in equipment provision will require approval via the Resuscitation and Provider Governance committees.
- A comprehensive inventory of equipment requirements for each clinical area must be held with the emergency equipment. The inventory list and level of equipment required is available from the Resuscitation Training Officer. As a minimum standard, equipment must be checked at least once in every 24 hour period and after each use. A written record of all checks must be documented and returned to the resuscitation officer on a monthly basis.
- For clinics that are open only on certain days the resuscitation equipment must be checked prior to the commencement of each clinic.
- District and Community Nurses/Public Health Nurses administering injections should have an anaphylaxis kit and pocket mask.
- N.B. The expiry dates of any resuscitation equipment and the time taken for order and receipt of replacement items must be considered. It is unacceptable to have out of date emergency equipment especially defibrillator electrodes and could lead to disciplinary action.

### 3.1 Equipment maintenance

It is the responsibility of the manager of each clinical area to ensure that all equipment is kept in full working order. Staff also have a responsibility to inform the manager of problems with the equipment and as necessary report to Medical Equipment Management Service (MEMS) at Derriford Hospital, and also inform the Resuscitation Training Officer of the problem. See Medical Devices Management Policy.

Website

[www.resus.org](http://www.resus.org)

## 7. Monitoring Compliance and Effectiveness

The process and outcome of resuscitation attempts should be the subject of audit

- a. Audit of all Cardiac Arrest incidents throughout the whole Livewell Southwest is to be completed by the Resuscitation Training Officer and present to the Resuscitation Committee on yearly basis. Both the incident and Cardiac arrest forms are to be completed post areas and sent to the appropriate departments and resuscitation training officer. This is to identify patients that have been picked up by the early warning score and also to see reduction in cardiac arrest due to the EWS and RAPID/ILS courses. Also data stored by the AED's during resuscitation attempts is an additional resource
- b. Audit of all 2222 calls made to switchboard at Mount Gould Hospital site will be complete by the Resuscitation Training Officer and Director of Nursing, to review calls that have been made and to highlight training needs if required and to be present to the Resuscitation committee to be complete on monthly basis.
- c. Audit of resuscitation equipment in clinical areas will be complete on yearly basis by member of the Resuscitation Committee or operational director.
- d. All Resuscitation courses that staff attended are documented and signed and inputted on the Livewell Southwest's ESR system. Non attendance on course is documented and line manager informed and a charge is made out of the line manager's budget.

**All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.**

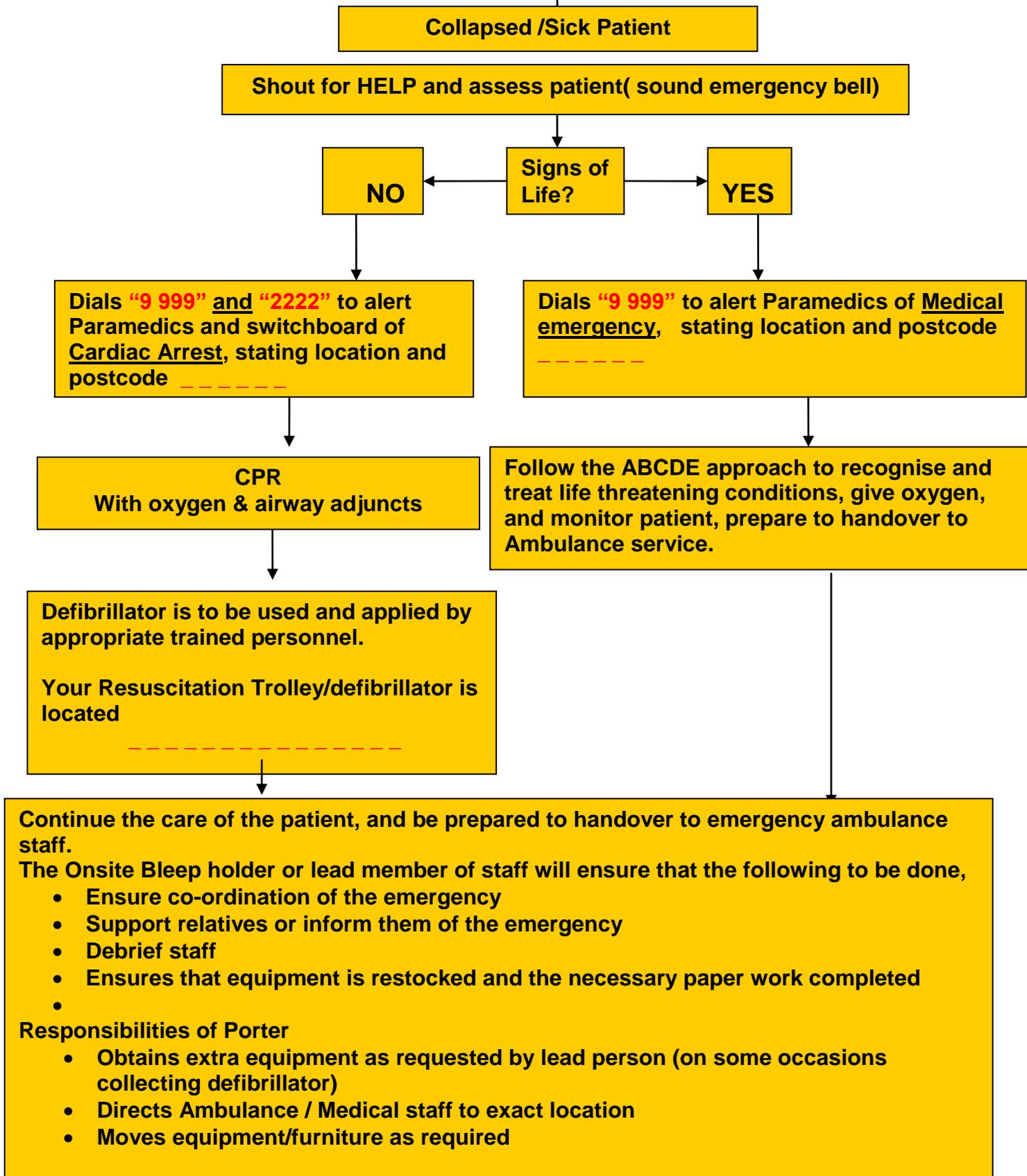
**The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.**

**The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.**

Signed: Director of Professional Practice Safety and Quality

Date: 3rd May 2016

PROTOCOL FOR THE PROVISION OF BASIC LIFE SUPPORT/MEDICAL EMERGENCY AT MOUNT GOULD HOSPITAL SITE



**SWITCHBOARD MOUNT GOULD HOSPITAL**  
PROTOCOL FOR THE PROVISION MEDICAL EMERGENCY 2222 TELEPHONE  
NUMBER

**2222 CALL COMES IN**

- Operator asks for Location/Site
- Operator asks if the caller has Dialed "9 999" IF NOT requests that the caller completes this immediately

Operator will activate the pager/phone system to call Doctor, Coordinator, and Porter to inform them of location/site

Switchboard will send a test call/page to:-

- Co-ordinator and Porters phone/pager on a weekly basis (A.M.)
- Doctor's phone/pager Monday - Friday (A.M.) as Doctor is not on site at weekends.

All test calls to be logged by Switchboard.

If staff do not respond to the daily test the following must be completed

- Continue Paging/phone system
- Phone direct to department /ward to find out why they have not responded. If it is a fault with pager/phone or a flat battery, this should be reported and sorted ASAP.
- If it is because the staff member forgot or too busy this needs to be documented and brought up to the line managers attention.

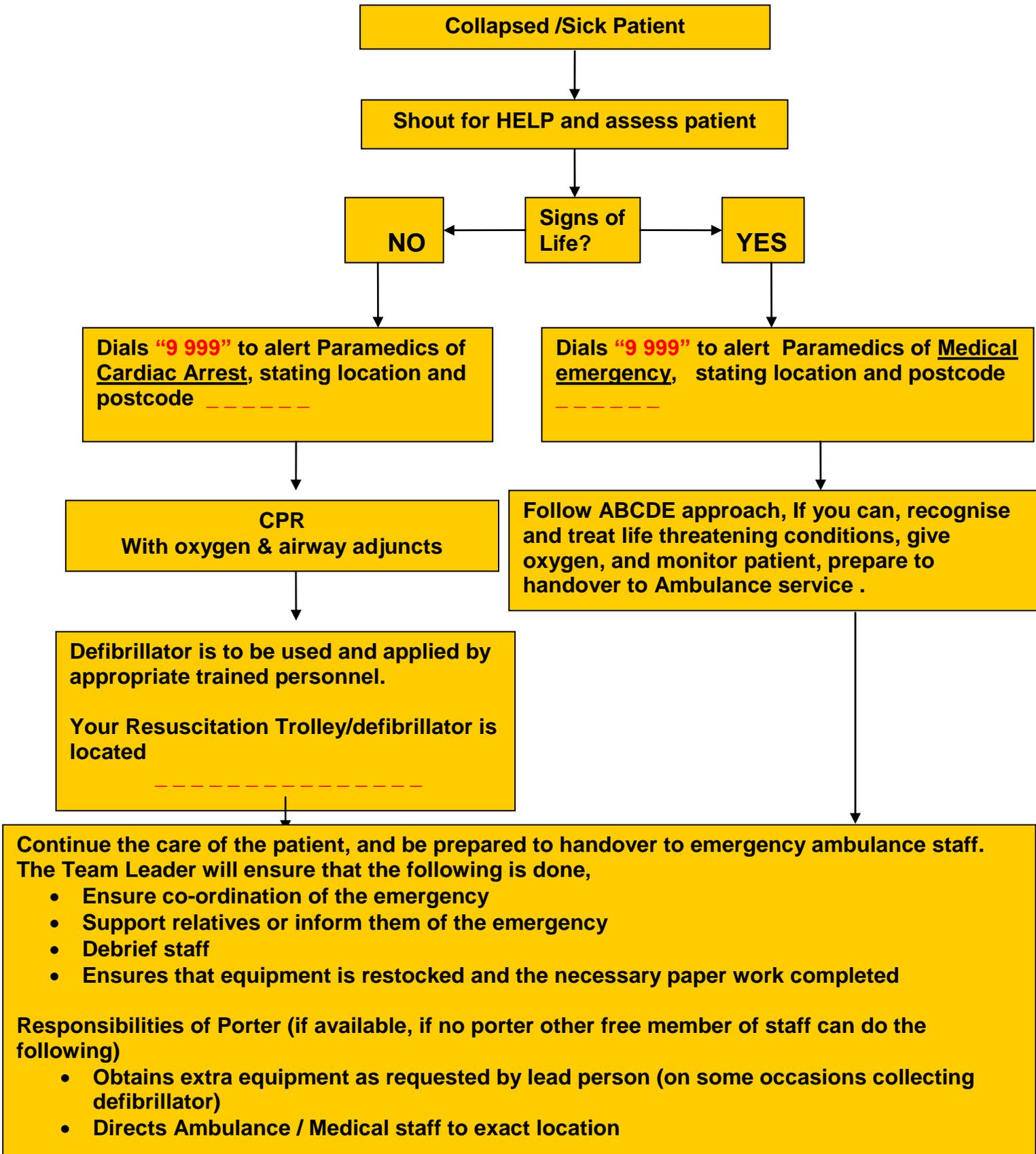
**Porters Responsibilities**

- Obtains extra equipment as requested by lead person. (On some occasions may include collecting defibrillator).
- Directs Ambulance / Medical staff to exact location

**Location of Defibrillators**

- Local Care Centre Kingfisher Ward (Phillips XL)
- Local Care Centre Skylark Ward (Phillips XL, FR2)
- Local Care Centre Main Reception (FR2 Heart start)
- Admin Block Switch board office (FR2 Heart start)
- Edgumbe (FR2 Heart start)
- Greenfields (FR2 Heart start)
- Plym Neuro Rehabilitation Unit (Phillips XL)
- Cotehele (FR2 Heartstart)

PROTOCOL FOR THE PROVISION OF BASIC LIFE SUPPORT/MEDICAL EMERGENCY





**Outcome**

Dead on arrival  Died at arrest  Survived

Discharged to:  Acute Livewell Southwest  RoSC

Other (please state).....

**Name of patient**..... **Date of birth** \_ / \_ / \_ \_ \_ \_

**NHS Number** ..... **Or patient identification sticker**

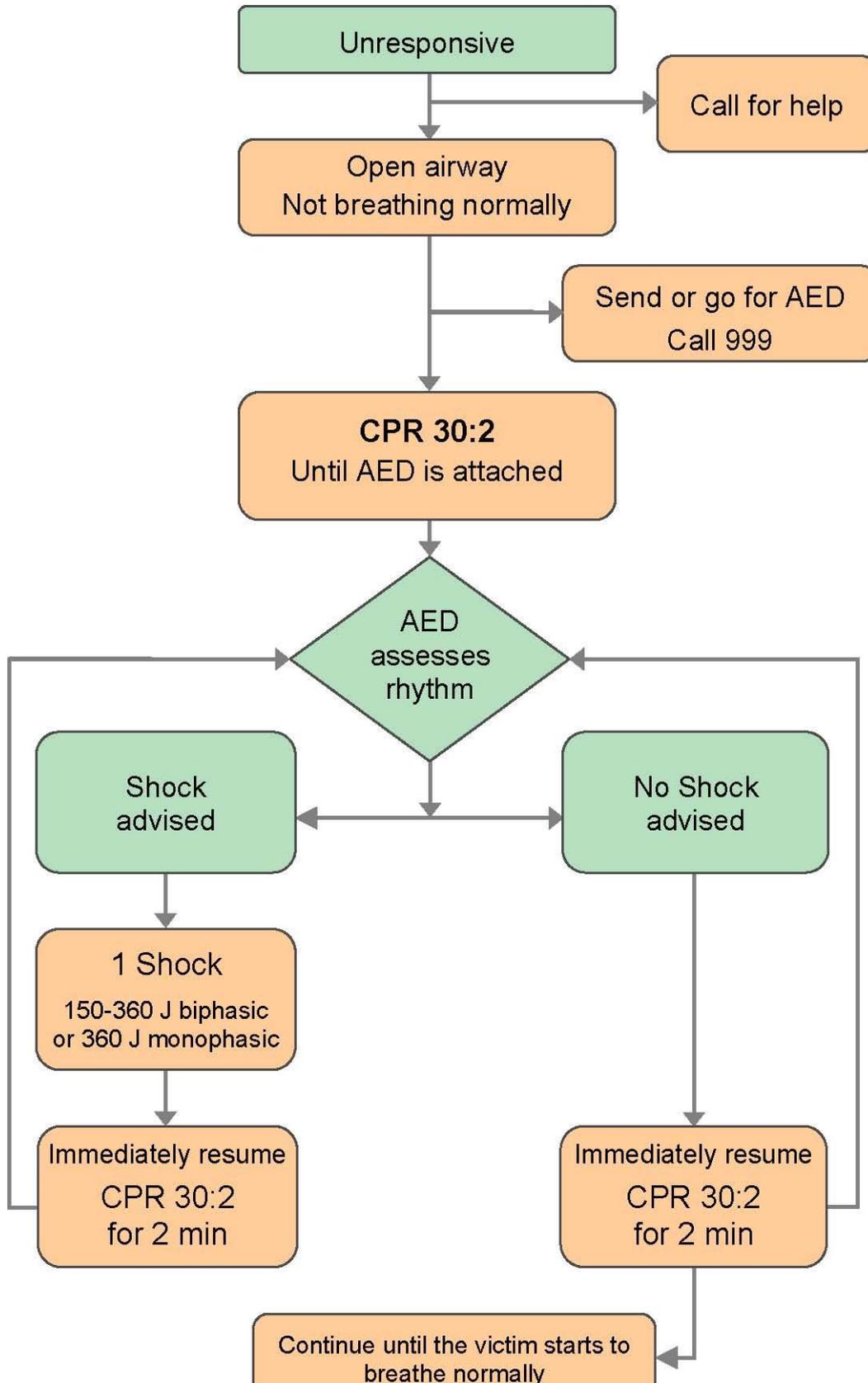
Drugs	Time	Given by
Adrenaline 1 in 10,000 1mg/10ml		
Adrenaline 1 in 10,000 1mg/10ml		
Adrenaline 1 in 10,000 1mg/10ml		
Adrenaline 1 in 10,000 1mg/10ml		
Adrenaline 1 in 10,000 1mg/10ml		
Adrenaline 1 in 10,000 1mg/10ml		
Atropine 3mg		
Amiodarone 300mg		
<b>Please add names below of all staff attending this resuscitation incident team leader first.</b>		
<b>Name</b>	<b>Grade</b>	<b>Specialty</b>

<b>Pre arrest comments – Resuscitation status, Events what happened? Was the Acute Life Threatening Events Recognition and Treatment/ Early Warning Score system used to identify the patients’ condition?</b>	<b>Post arrest comments</b>
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**Please photocopy this form and leave one copy in patients’ notes and send the other to: Resuscitation Training Officer Beauchamp Centre Mount Gould Hospital Plymouth PL4 7QD. Tel: 01752 435163/ Internal: 35163**

Appendix E. Adult Basic Life Support Algorithm  
[Adult Basic Life Support Algorithm](#)

Appendix F. Adult choking treatment Algorithm  
[Adult choking treatment Algorithm](#)



Appendix H. In-hospital Resuscitation  
[In-hospital Resuscitation](#)

Appendix I. Adult Advanced Life Support Algorithm  
[Adult Advanced Life Support Algorithm](#)

Appendix J. Paediatric Basic Life Support  
[Paediatric Basic Life Support](#)

Appendix K. Paediatric FBAO Treatment  
[Paediatric FBAO Treatment](#)

Appendix L DNAR Orders (Do not attempt to resuscitate) information on how to complete form and flow chart  
[DNAR Orders \(Do not attempt to resuscitate\) information on how to complete form and flow chart](#)

Appendix M

**Community Contraception and Sexual Health Service  
Management and provision of drugs for emergencies – Standard Operating  
Procedure  
Policy No. 22**

Version No 1

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# Management and provision of drugs for emergencies – Standard Operating Procedure - Policy No. 22

## 1 Introduction

Procedures undertaken within Community Contraception and Sexual Health Service clinics are generally extremely safe. Rarely, a client may suffer anaphylaxis to a substance and/or cervical shock following insertion of an intra-uterine device or system. It is essential to have a ready supply of drugs to be used in these circumstances. Historically, this has been through the supply of 'cervical shock packs' issued from Derriford Hospital pharmacy, which were frequently returned unopened once they had reached the 'use-by' date. In the interests of efficiency and cost savings, these drugs will now be supplied individually as required. This Standard Operating Procedure (SOP) has been written to support this development.

## 2 Purpose

The purpose of this SOP is to ensure that efficient and reliable processes are in place to ensure the constant availability of drugs for use in an emergency.

A SOP is an unambiguous document describing the responsibilities of staff, the processes to be followed and the monitoring that must occur to manage the use of drugs safely and accountably.

## 3 Duties

The **CCASH service** has a responsibility to implement and monitor the use of this policy within Livewell Southwest. CCASH Service responsibilities include:

- Coordinate training and regular updating as necessary in regard to mandatory training, including anaphylaxis and basic life support, keeping an accurate record of all training received by staff
- Ensure that treatments delivered are monitored and recorded for audit purposes
- Ensure that clinicians are informed of any changes regarding this policy
- Maintain secure facilities for the storage of medicines.

### Individuals' responsibility

All Clinicians must:

- Have read and understood LSW "Safe and Secure Handling of Medicines Policy"; "Management of Severe Anaphylaxis Protocol"; and "Resuscitation Policy" and act in accordance with these at all times. These are available on [Plymouth Healthnet](#).
- Ensure they adhere to their own professional code of conduct

- Be accountable for their own practice and must ensure that they maintain their competency through continuous professional development (CPD) and be able to demonstrate their competency as required by their individual service manager
- Take responsibility for ensuring they are up-to-date with mandatory training, and in particular with Basic Life Support and Anaphylaxis
- Inform the Service Manager of any training and updating carried out
- Work to this policy
- Ensure that clinics for which they have a responsibility have adequate supplies of suitable equipment and drugs, prior to commencement of the clinic.

## 4 Definitions

**Clinician** refers to any Doctor or Nurse employed within Community Contraception and Sexual Health Service on a temporary or permanent contract.

**CASH Clinic:** Any session run by Community Contraception and Sexual Health Service for the supply of contraception and sexual health advice

**Emergency drugs** refer to those drugs used specifically for collapse during or following any clinical procedure, e.g.

- hyperventilation syndrome,
- vasovagal episodes,
- bradycardia,
- epileptic seizures,
- anaphylactic reaction to any administered medication or as a result of contact with another provoking agent
- Spontaneous collapse unrelated to sexual and reproductive procedure but related to an underlying medical condition (e.g. diabetes, epilepsy, cardiac or pulmonary problems)

### ABBREVIATIONS USED IN THIS POLICY

CASH	Contraception and Sexual Health
CCASH	Community Contraception and Sexual Health Service
CPD	Continuous professional development
FSRH	Faculty of Sexual and Reproductive Healthcare
LSW	Livewell Southwest
SOP	Standard Operating Procedure

## 5. Management and provision of drugs for emergencies – Standard Operating Procedure - Policy No. 22

### 5.1 Safe and Secure handling of Medicines

All drugs must be ordered and kept securely in accordance with the “Safe and Secure Handling of Medicines Policy”

### 5.2 Emergency drug supply

5.2.1 The following drugs must be available at all times when CASH clinics are running:

- Adrenaline 1 in 1000. One milligram in one ml. for intra-muscular injection. Minimum of three ampoules are to be held in stock
- Atropine Sulphate 600 microgram in 1 ml. for intravenous injection (if clinically competent) or intra-muscular injection. Minimum of two ampoules to be held in stock
- Sodium Chloride 0.9%. Minimum of two x 5ml ampoules to be held in stock (required for flushing of venflons if appropriate)
- Diazepam Rectal tubes 2mg/ml in 10mg tubes x one tube (two tubes for Outreach box).

5.2.2 Emergency drugs are to be kept boxed together, with a ready supply of needles, syringes, venflons and tape.

5.2.3 Each clinic venue will keep its own supply of emergency drugs.

5.2.4 The delegated nurse will check the supply of emergency drugs on a weekly basis to verify sufficient stock and take action for any drugs nearing their expiry date.

### 5.3 Ordering of drugs

5.3.1 The ordering of stock drugs lies with the Nurse delegated to this responsibility in each clinic location. She will also ensure that emergency drugs are ordered appropriately. However, in cases where emergency drugs have been used, it is the duty of all Clinic Nurses to ensure that another supply is ordered immediately.

### 5.4 Use of emergency drugs

In cases of suspected anaphylactic reaction, drugs will be used in accordance with the Trusts’ “Management of Severe Anaphylaxis” policy. See Appendix A for the pathway for treatment of Anaphylaxis

Non life-threatening conditions usually respond to simple measures. If in doubt seek medical advice early.

A full written record of an event requiring use of emergency drugs must be documented in the client's notes. This must include a record of all drugs used. An Incident form must be completed.

## 6 Monitoring Compliance and Effectiveness

The Line Manager will conduct a review of each Incident. This review will include:

- Documentation
- Recording of drugs
- Confirmation that emergency drugs have been ordered to replace those used

Any problems identified will be dealt with – a plan of action must be prepared and implemented within 5 working days of the incident.

## 7 Associated Documentation

Resuscitation Council (UK) Anaphylaxis flow chart, taken from Plymouth Healthnet "[Resuscitation Policy](#)"

Equality and Human Rights Impact Assessment

**Standard Operating Procedure for the administration of intravenous medication, and Standard Operating Procedure for the preparation and administration of intramuscular injections**

Both available on Plymouth Healthnet "[Injectable drug administration policy](#)" 2011

## Annex A

[Resuscitation Council Anaphylaxis pathway](#)

Appendix N. Inpatient Sepsis Screening Tool and Care Pathway and Community Sepsis Screening Tool

[Inpatient Sepsis Screening Tool and Care pathway and Community Sepsis Screening Tool](#)