## Policy: B4
### Basic Life Support Policy

<table>
<thead>
<tr>
<th><strong>Version:</strong></th>
<th>B4/04</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ratified by:</strong></td>
<td>Trust Management Team</td>
</tr>
<tr>
<td><strong>Date ratified:</strong></td>
<td>15(^{th}) April 2015</td>
</tr>
<tr>
<td><strong>Name and Title of Author:</strong></td>
<td>Director of Primary Care</td>
</tr>
<tr>
<td><strong>Accountable Director:</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Governance Committee:</strong></td>
<td>Clinical Effectiveness &amp; Compliance</td>
</tr>
<tr>
<td><strong>Date issued:</strong></td>
<td>14(^{th}) May 2015</td>
</tr>
<tr>
<td><strong>Review date:</strong></td>
<td>February 2018</td>
</tr>
<tr>
<td><strong>Target audience:</strong></td>
<td>All staff Trust wide</td>
</tr>
<tr>
<td><strong>Disclosure Status B</strong></td>
<td>B Can be disclosed to patients and the public</td>
</tr>
</tbody>
</table>

| **EIA / Sustainability** | N/A |

### Other Related Procedure or Documents:
This policy is linked to:
M15p - National Early Warning Score procedure (previously MEWS)
**Equality & Diversity statement**

The Trust strives to ensure its policies are accessible, appropriate and inclusive for all. Therefore all relevant policies will be required to undergo an Equality Impact Assessment and will only be approved once this process has been completed.

**Sustainable Development Statement**

The Trust aims to ensure its policies consider and minimise the sustainable development impacts of its activities. All relevant policies are therefore required to undergo a Sustainable Development Impact Assessment to ensure that the financial, environmental and social implications have been considered. Policies will only be approved once this process has been completed.
**B4: Basic Life Support**

**Version Control Sheet**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Title of Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft</td>
<td>4th May 2010</td>
<td>Associate Director of Risk Reduction</td>
<td>New draft policy being developed</td>
<td>Consultation ends 28.05.10</td>
</tr>
<tr>
<td>B4/01</td>
<td>23rd July 2010</td>
<td>Associate Director of Risk Reduction</td>
<td>NEW Policy issued</td>
<td>Policy presented to Policy Review Group 20th July - approved.</td>
</tr>
<tr>
<td>B4/02</td>
<td>Sept 11</td>
<td>Associate Director of Risk Reduction</td>
<td>Revised policy</td>
<td>Policy updated to reflect mandatory training matrix. Present to 29th Sept Policy Review Group for approval.</td>
</tr>
<tr>
<td>B4/03</td>
<td>Jan 2012</td>
<td>Director of Primary Care</td>
<td>Revised policy</td>
<td>Reviewed by Physical Healthcare Group and Clinical Effectiveness and Compliance</td>
</tr>
<tr>
<td>B4/03</td>
<td>09/05/12</td>
<td>Director of Primary Care</td>
<td>Revised policy</td>
<td>Ratified by TMT 09/05/12 Amendments to appendices 7 &amp; 8</td>
</tr>
<tr>
<td>B4/04</td>
<td></td>
<td>Review</td>
<td></td>
<td>Trustwide consultation ending 04/11/2014 Approved at April 2015 TMT, issued 06.05.15 Amendments made to section 11.6 and Appendix 7, re-issued 14.05.15</td>
</tr>
</tbody>
</table>
## Contents

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Page no:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Summary</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>Scope</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>Definitions</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>Duties</td>
<td>7</td>
</tr>
<tr>
<td>6</td>
<td>Systems &amp; Recording</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>What Is Basic Life Support (Bls)</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>When To Use Bls</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>How To Summon Assistance</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>The Sequence Of Bls</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>Training</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>&quot;Do Not Attempt Resuscitation“ Decisions</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>Advance Directives Or Living Wills</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>Monitoring And Compliance</td>
<td>13</td>
</tr>
<tr>
<td>15</td>
<td>Fraud Statement (If Required)</td>
<td>13</td>
</tr>
<tr>
<td>16</td>
<td>References / Supporting Documents</td>
<td>13</td>
</tr>
<tr>
<td>17</td>
<td>Glossary Of Terms / Acronyms</td>
<td>14</td>
</tr>
</tbody>
</table>

### APPENDICES

| Appendix 1 | Adult Resuscitation Procedure | 15 |
| Appendix 2 | Adult Basic Life Support Procedure Flow | 18 |
| Appendix 3 | Adult Resuscitation Procedure Flow Chart | 19 |
| Appendix 4 | Paediatric Basic Life Support | 20 |
| Appendix 5 | Accountability | 21 |
| Appendix 6 | Practice Guidelines – Do Not Attempt | 24 |
| Appendix 7 | DNAR Form and Guidance | 27 |
| Appendix 8 | Standards For The Management Of Medical | 29 |
1. Summary:

- Introduction
- Clinical indications
- Delivering resuscitation
- Training for resuscitation
- Do Not Attempt to Resuscitate Orders
2. **Introduction**

2.1 The aim of this policy is to ensure that staff must follow the procedures in place to ensure prompt and effective management of any medical emergency where a respiratory or cardio-respiratory arrest is indicated.

2.2 It also lays out the principles on which a "Do Not Attempt Resuscitation" decision may be made and describes the process for doing so. Guidance for staff on the issue of advance wishes or "living wills" as they are sometimes known is also included.

2.3 All clinical staff employed by West London Mental Health Trust (WLMHT) are expected to be familiar with this policy and to be up to date in all components that make up Basic Life Support mandatory training.

2.4 All new clinical staff will attend a half-day Basic Life Support training session during their primary induction period.

2.5 All Trust personnel are required to be aware of their accountability in respect of this policy. See appendix 9.

2.6 Basic life support and cardiopulmonary resuscitation is one and the same thing. The terminology has been used interchangeably.

2.7 This policy will be reviewed annually or more frequently in the case of new directives.

*Further Recommended Reading / Reference*


- Resuscitation Council (UK) 2008: www.resus.org.uk
  - Basic Life Support: Resuscitation Guidelines 2005
  - Adult Advanced Life Support: Resuscitation Guidelines 2005
• In-hospital Resuscitation Guidelines 2005
• Guidelines for the Use of Automated External Defibrillators. Resuscitation Guidelines 2005

• National Council for Hospice and Specialist Palliative Care Services & Association for Palliative Medicine of Great Britain & Ireland (Undated): Ethical Decision-Making in Palliative Care: Cardiopulmonary Resuscitation (CPR) for People who are Terminally Ill.

• Department of Health: Health Service Circular HSC2000/028 Resuscitation Policy
• General Medical Council: March 2007 Withholding and Withdrawing Life Prolonging Treatments: Good Practice in Decision Making. This guidance develops the advice in “Good Medical Practice (2006)” & “Seeking Patients’ Consent; The ethical consideration (May 1998)”. It sets out the standards of practice expected of Drs when they consider whether too withhold or withdraw life/prolonging treatments.

• Department of Health: Health Service Circular HSC 2001/023 Good Practice in Consent - Achieving the NHS Plan commitment to patient-centered consent practice
• Mental Capacity Act 2005: Person’s who lack capacity

3. Scope

This policy describes the characteristics of Basic Life Support (BLS), who should deliver BLS, and the need for specific staff to be trained in BLS techniques.

4. Definitions

• Respiratory arrest is the abrupt cessation of respiratory function (breathing).
• Cardio-respiratory arrest is the abrupt cessation of both respiratory and cardiac function breathing and heartbeat. Both conditions are potentially reversible.

5. Duties

5.1 The Chief Executive

To facilitate the implementation of the policy
a. The Medical Director

To oversee, through reporting arrangements (via Physical Health Group, and Clinical Effectiveness Group) that BLS skills are maintained, that DNAR decisions are reviewed regularly and that appropriate, effective equipment is
provided at appropriate sites

b. **Clinicians**

To ensure that their training is up to date, so that they can deliver effective BLS

### 6. Systems and recording

6.1 Where recorded – Electronic patient record

6.2 When recorded – Immediately following event

6.3 Recorded by who – Senior nurse or senior clinician attending

### 7. What is basic life support?

7.1 Basic Life Support (BLS) is a lifesaving technique that can be used in the event of someone being in respiratory or cardio-respiratory arrest. Throughout this policy we will refer to the technique as BLS.

7.2 Following someone suffering a cardio-respiratory arrest, their chances of survival are much improved if appropriate steps are taken to deal with the emergency. These steps are called the “Chain of Survival” which is taught through mandatory training:

i) recognition that cardio-respiratory arrest has occurred
ii) early summoning of the emergency services
iii) early basic life support
iv) early defibrillation
v) early advanced life support

7.3 The purpose of BLS is to maintain adequate ventilation and circulation until means can be obtained to reverse the underlying cause of the arrest. It is therefore, basically, a “holding operation” but is essential in helping to prevent irreversible brain damage due to a lack of oxygen. Delay in using BLS will lessen the eventual chances for a successful outcome for the patient.

BLS comprises:

i) initial assessment,
ii) maintenance of the airway,
iii) expired air ventilation (rescue breathing)
iv) chest compressions

### 8. When to use BLS

8.1 When a medical emergency occurs on Trust property (or in the case of community services, in the presence of Trust staff), staff will commence BLS, in line with this policy.
8.2 Resuscitation must always be attempted unless:

- a "Do Not Attempt Resuscitation" decision (DNAR) (*refer to section 10*) has already been recorded
- it is known that there is a valid advance wishes (*refer to section 11*)
- the most exceptional circumstances apply e.g. decapitated victim, and the patient’s physical condition leads to the doctor present pronouncing death.

In cases of doubt resuscitation must be commenced and attempts made to identify the necessary information in order for an appropriate decision to be made.

9. How to summon assistance

9.1 Having first ascertained that it is safe to do so, on discovery of a collapsed individual, check for a response, a patient airway & breathing. If these are not present, immediately summon assistance by following the standards for the Medical Emergencies see Appendix 2 &3.

9.1.1 It is essential that staff familiarise themselves with the process of summoning assistance within their workplace which must be provided by secondary induction into the work place.

9.2 Broadmoor Hospital CSU

- For a medical emergency *within the secure perimeter* at Broadmoor Hospital, call staff in the Control Room either
  - by telephone on extension 2222 or
  - by use of the radio

9.2.1 Additional staff, the doctor on-call, emergency equipment will then be sent to the location. A 999 call for an emergency ambulance is also required with the responding ambulance/crew being directed to the incident site.

9.3 Hammersmith and Fulham CSU

9.3.1 On the Hammersmith and Fulham site, emergency assistance will be summoned through the Hammersmith and Fulham Switchboard Operator by telephone on extension 2222

9.3.2 This will activate the cardiac arrest audible speech bleep system, which alerts members of the Cardiac Arrest Team, stating “Cardiac Arrest” followed by the location of the incident three times.
9.3.4 Until the Cardiac Arrest Team arrive, West London Mental Health NHS Trust staff are responsible for all aspects of the management of the medical emergency.

9.4 **Hounslow CSU**

9.4.1 On the Hounslow site, emergency assistance will be summoned through the Switchboard by telephone on extension 2222

9.4.2 This will activate the cardiac arrest automated system, alerting the crash team in West Middlesex Hospital.

9.4.3 Until the Cardiac Arrest Team arrive, West London Mental Health NHS Trust staff are responsible for all aspects of the management of the medical emergency

9.5 **St Bernard's Site**

9.5.1 On the St Bernard’s site, including Local Services and Forensic Services, emergency assistance will be summoned by dialling extension 2222 and making the following request(s)

(a) To request assistance from the on-call doctors
   If it is evident that an ambulance is required after the original emergency call is made, a call from the allocated person at the scene of the medical emergency to the ambulance emergency service must be initiated by calling 2222.

(b) To request an ambulance
   The Contact Centre will put through the call to 999 and the caller will relay details directly to the emergency services operator. **DO NOT HANG UP until you have relayed full details to the Emergency Services operator.**

9.6 **Other Trust Sites**

9.6.1 Other Trust sites may also have a dedicated Medical Emergency extension number and, if this is the case, immediate assistance must be summoned by dialling the appropriate number and following the agreed local policies, which are identified at secondary induction.

9.6.2 Where there is no dedicated medical emergency number, assistance must be summoned by “internal” telephone, **dialling 9999** for the Emergency Operator and asking for the Ambulance Service who will dispatch paramedic assistance to the address.

10. **The sequence of BLS**

10.1 Begin immediate initiation of one or two person BLS once a risk assessment of personal safety to attending staff has been made.
10.2 If additional appropriate equipment is available immediate use must be made of airway adjuncts and defibrillation techniques initiated, as appropriate.

10.3 If medical emergency is relating to a patient, the appropriate Consultant (or their deputy) must be informed of the incident as soon as possible.

10.4 The person in charge of the ward, department or area, must arrange for the immediate care and support of any patients who may be present.

10.5 When the crash team/ambulance crew arrive, they must be given a full and comprehensive history of events, including any pre-existing condition(s) the individual may suffer from.

10.6 The staff carrying out BLS must not stop and handover until they are instructed it is safe to do so by the crash team/ambulance crew.

10.7 Staff who are able to must offer prompt and effective assistance to the crash team/ambulance crew in the initiation of advanced life support techniques, as required. See appendix 3.

10.8 The crash team/ambulance crew must be given all necessary assistance in making the arrangements for the casualty's early transfer to a general hospital, if this is what is clinically indicated.

10.9 Staff must complete the carbon-backed Resuscitation Record which can be found in the back of the Basic Life Support Bags or First responder Bags—one copy of which must be given to the ambulance crew if they are transferring the casualty to an acute hospital. If the casualty is a patient, a second copy must be placed in their notes, and the third copy must be sent to the Patient Safety Lead, via the Risk Reduction Department.

10.10 All relevant documentation must be completed RIO, MDT notes & electronic 1R1 forms.

10.11 Any resuscitation equipment used in the resuscitation attempt must be replenished in line with local procedures.

11. Training

11.1 Basic Life Support training will be provided for staff as part of their induction and, subsequently, as part of mandatory training, in accordance with the Trust’s Mandatory Training Policy and Matrix (M12).

11.2 All frontline staff i.e. staff who have patient contact, who have attended and been assessed in BLS techniques will be competent in the following:

- Recognition of respiratory and cardio-respiratory arrest.
- Performance of both a one and two man CPR rescue
- Recognition of unconsciousness in an individual, and maintenance of a basic airway.
- Recognition of choking in an individual, and the application of all approved ‘lay’ techniques for the safe removal of a foreign body in the airway.
• Location of all types of resuscitation equipment within their respective site.
• The use of AEDs (for staff who have attended training in AEDs).
• Use of the correct procedures to check emergency equipment.

11.3 Automated External Defibrillator (AED) Use and Provision of Equipment

11.4 Electrical defibrillation is well established as the only effective therapy for cardiac arrest due to ventricular fibrillation (VF) or pulse-less ventricular tachycardia (PVT). The scientific evidence to support early defibrillation is overwhelming, the single most important determinant of survival being the delay from collapse to delivery of the first shock. Implementation of early defibrillation is therefore strongly recommended as per Resuscitation Council directives. Please see flow chart in appendix 3.

11.5 The trust will maintain contracts with external companies for the supply, provision and maintenance of BLS and AED equipment to all trust sites. Please see Medical Devices Policy

11.6 An AED should be available within two minutes of any potential incident

11.6.1 AEDS should be located in a room/area which is not locked and is easily accessible. The only exception to this principle is on those wards, where locating the AED in a more accessible area, would represent a security risk. An example would be the wards at Broadmoor Hospital.

11.6.2 The location of the AED should be made clear using DH/LAS approved signage

11.6.3 The AED should be checked:
   a. Daily if it is on a ward
   b. Weekly if it is in a community or administrative area

11.6.4 The AED should also be switched on once a month.

11.6.5 The checks should be recorded in a suitable log book that includes the type of check, and who has carried out the check

11.6.6 Each ward/community area/administrative area will identify two leads who share responsibility for checking that the AED has been checked.

11.6.7 AEDs in community sites, and administrative areas, do NOT need a full grab bag, as they do on a ward environment.

11.6.8 The Trust Resuscitation Officer will carry out an annual audit of these manuals to ensure that checks are being completed. The audit will be reported to the resuscitation subgroup of the trust wide physical health group.
11.7 Instructor Qualifications

11.8 Training and assessment must be provided by appropriately trained individual’s i.e.

- National Health Service Resuscitation Training Officer,
- Advanced Life Support Provider or Instructor,
- Ambulance Service Training Officer, or
- First Aid Trainer accredited in AED training

12. “Do not attempt resuscitation” decisions
(see Appendix 7 for DNAR form and guidance to complete)

12.1 BLS can be attempted on any individual in whom cardiac or respiratory function ceases. Failure of these functions is inevitable as part of dying, and thus BLS can theoretically be used on every individual prior to death. It is therefore essential to identify those patients for whom cardiopulmonary arrest represents a terminal event in their illness, and in whom BLS is inappropriate.

12.2 The factors surrounding a decision whether or not to initiate BLS involve complex clinical considerations and emotional issues. Patients, (and where appropriate their relatives and/or significant others) have as much right to be involved in these decisions as they do other decisions about their care and treatment. Therefore, communication and explanation of the decision both to relevant health professionals and people close to the patient is essential which is fully documented. However, DNA CPR is a clinical decision, and not a decision that can be made by family members unless they have an Enduring Power of Attorney.

12.3 Appended to this policy are Practice Guideline for DNAR decisions. These are based on “Decisions Relating to Cardiopulmonary Resuscitation. A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (Oct 2007. Resuscitation Council) and Resuscitation Guidelines 2005.

13. Advance wishes or living wills

13.1 A patient’s informed and competently made refusal (verbal or written) of treatment, relating specifically to the circumstances that have arisen, is legally binding upon doctors. Such a refusal of treatment may be referred to as an "applicable directive", an "anticipatory refusal" or "living will". The competently made advance directive remains legally binding even if the patient later does not have capacity.

13.2 Any advance wishes made by a patient who is not deemed to be mentally competent at the time of making it, is not legally binding.

13.3 In any case where the clinician has doubts or concerns regarding the patient’s capacity to make this decision, legal advice must be sought and the matter referred to the courts for decision.
14. Monitoring and compliance

14.1 On a quarterly basis the Trust Physical Health Care Group will receive and review, from the Trust incident reporting system, a summary report of medical emergency incidents.

14.2 The Procurement department will monitor and manage the maintenance contracts for the renewal of BLS equipment on behalf of the trust. The Medical Devices Policy contains details around auditing maintenance of equipment. These will be commissioned by the Trust Physical Healthcare Group & a report submitted to the Trust Quality & Risk Committee.

15. Fraud statement (if required)
N/A

16. References / supporting documents

The Resuscitation Council (UK) website provides further guidance and info on resuscitation: www.resus.org.uk

17. Glossary of terms/acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLS</td>
<td>Basic life Support</td>
</tr>
<tr>
<td>MEWS</td>
<td>Modified Early Warning Score</td>
</tr>
<tr>
<td>DNAR</td>
<td>Do Not Attempt Resuscitation</td>
</tr>
<tr>
<td>AED</td>
<td>Automatic Electronic Defibrillator</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>VF</td>
<td>Ventricular Fibrillation</td>
</tr>
<tr>
<td>PVT</td>
<td>Pulseless ventricular tachycardia</td>
</tr>
<tr>
<td>LMA</td>
<td>Laryngeal mask airway</td>
</tr>
<tr>
<td>iGel</td>
<td>A type of LMA</td>
</tr>
</tbody>
</table>
Appendix 1

ADULT RESUSCITATION PROCEDURE

Ensure personal safety.

Check the patient for a response.

- When a healthcare professional sees a patient collapse, or finds a patient apparently unconscious in a clinical area, she/he must first shout for help, then assess if the patient is responsive by gently shaking his/her muster and asking loudly, 'Are you all right?'

- If other members of staff are nearby it will be possible to undertake actions simultaneously.

If the patient responds:

- Urgent medical assessment is required.

- While awaiting this, assess the patient using the AB approach (airway, breathing).
Give the patient oxygen if available.

If the patient is unresponsive and not breathing normally start BLS:

- Shout for help (if this has not already been done).
- Turn the patient onto his/her back.
- Open the airway using head tilt and chin lift.
- Look in the mouth. If a foreign body or debris is visible, attempt to remove it, using suction or forceps which ever is appropriate & where available.
- Keeping the airway open, look, listen, and feel for no more than 10 seconds to determine if the victim is breathing normally:
  - Listen at the victim’s mouth for breath sounds.
  - Look for chest movement.
- Feel for air on your cheek.

If the patient has a pulse or other signs of life:

- Urgent medical assessment is required. Local protocols dictate response teams.
- While waiting for the resuscitation team, assess the patient using the Airway, Breathing, Circulation, Disability & Exposure (A.B.C.D.E.) approach.
- Give the patient oxygen, where available

If there is no signs of life:

- One person must start BLS as others call the resuscitation team and collect the resuscitation equipment and a defibrillator. If only one member of staff is present, this will mean leaving the patient.
- Give 30 chest compressions followed by 2 ventilations.
- The correct hand position for chest compression is the middle of the lower half of the sternum. The recommended depth of compression is 4 to 5 cm and the rate is 100 compressions min-1.
- Maintain the airway and ventilate the lungs with the most appropriate equipment immediately at hand. A pocket mask, which may be supplemented with an oral airway, is usually readily available. Alternatively, use a bag, valve and mask (Ambu Bag), using a “two person” technique.
- Emergency bags will be fitted with both airways, and LMA/Igels. Use an inspiratory time of 1 sec and give enough volume to produce chest rise as in
normal breathing. Add supplemental oxygen as soon as possible, fifteen Litres per minute (LPM).

- Once the patient’s airway has been secured, continue chest compression uninterrupted (except for defibrillation) at a rate of 100 min⁻¹, and ventilate the lungs at approximately 10 breaths min⁻¹. Avoid hyperventilation

- If there is no airway and ventilation equipment available, give mouth-to-mouth ventilation. If there are clinical reasons to avoid mouth-to-mouth contact or unable to do this, give continuous chest compressions alone until help or airway equipment arrives. A pocket mask must be rapidly available in all clinical areas.

- When the defibrillator arrives, apply the electrodes to the patient.

- If self-adhesive defibrillation pads are available, and there is more than one rescuer, apply the pads without interrupting chest compression.

- Follow the instructions given by the verbal prompts of the defibrillator.

- Recomence chest compressions immediately after the defibrillation attempt. Do not pause to assess the pulse or heart rhythm. Minimise interruptions to chest compression.

- Continue resuscitation until the resuscitation team/ambulance team arrives and instructs you to stop, or the patient shows signs of life.

- Identify one person to be responsible for handover to the resuscitation/ambulance team leader. Locate the patient’s records.

- Change the person providing chest compression about every 2 min to prevent fatigue.

If the patient is not breathing but has a pulse (respiratory arrest):

- Ventilate the patient’s lungs as described above. If there are any doubts about the presence of a pulse, start chest compression and continue until more experienced help arrives.

If a patient has a witnessed cardiac arrest:

- Confirm cardiac arrest and shout for help.

- If the Automated External Defibrillator (AED) is immediately available, give a shock first if indicated by the (AED).

- Start BLS immediately after the shock is delivered as described above.

- Continue resuscitation as described above.
Appendix 2

ADULT BASIC LIFE SUPPORT
Open airway

NOT BREATHING NORMALLY?

Call 999

30 chest compressions

2 rescue breaths 30 compressions
Appendix 3

ADULT RESUSCITATION
PROCEDURE FLOW CHART

Unresponsive person

Assess using AB (Airway & Breathing)
Open airway

Call for help

Send or go for AED
Call Emergency number

CPR 30:2 Until AED is attached

AED Assesses Rhythm

Shock Advised

Ensure safe area And Shock

Immediately resume CPR 30:2
For 2 min

No shock Advised

Immediately resume CPR 30:2

Continue until the person starts To breathe normally Or you are instructed to stop By the doctor/ambulance/resus team

Shock Advised
Appendix 4

PAEDIATRIC BASIC LIFE SUPPORT

Resuscitation Council (UK)

Paediatric Basic Life Support

(Healthcare professionals with a duty to respond)

1. UNRESPONSIVE?
   - Shout for help
   - Open airway

2. NOT BREATHING NORMALLY?
   - 5 rescue breaths

3. STILL UNRESPONSIVE?
   (no signs of a circulation)
   - 15 chest compressions
   - 2 rescue breaths

After 1 minute call resuscitation team then continue CPR

November 2005
Appendix 5

ACCOUNTABILITY

Responsibilities of the Trust Board

The Trust Board, through its Clinical Governance Committee, must ensure

- That the Trust's Basic Life Support policy is agreed, implemented and regularly reviewed annually or in response to new directives.

Responsibilities of the Medical Director

The Medical Director will ensure that;

- A copy of the Basic Life Support policy is available to all members of the Trust's staff.

- The Trust has contemporary, regularly checked and maintained equipment, suitable for the level of practice within the Trust, is provided for use in the event of a respiratory or cardio-respiratory arrest. Please refer to Medical Device Policy

- Training in cardiopulmonary resuscitation techniques is available to all staff members at a level appropriate to their experience, knowledge and in accordance with the mandatory training needs matrix identified by Learning & Development Centre.

- The number and level of training sessions provided, is sufficient to secure adequate BLS, and BLS + defibrillation trained staff are available on each site in order to provide efficient management of a respiratory or cardio-respiratory arrest at all times prior to the victim’s transfer to a general hospital.

- The setting and maintenance of standards in the training and assessment of Automated External Defibrillator (AED) users, and that competence is maintained as per mandatory training policy dictates.

- Heads of Department follow the contents of the policy.

- Local procedures are implemented where the victim of respiratory or cardio-respiratory arrest is transferred to an acute hospital.

- A post arrest debrief of staff must take place.

- Regular clinical audit of the process and management of cardiopulmonary resuscitation, along with ‘Do Not Attempt Resuscitation’ decisions takes place. This will be done

Responsibilities of Heads of Department and Clinical Managers

Each Ward/Department Head must ensure that
• Staff within their respective department/ward/area are aware of the location of a copy of the Basic Life Support Policy, and that it is available at all times.

• All resuscitation equipment kept in the vicinity of their respective ward, department or area is checked and maintained as appropriate, and that this checking of equipment is properly documented to include any discrepancies, the actions taken by the individual discovering the discrepancy(s) and the outcome(s) of those actions. See Medical Devices Policy.

• The correct procedure is followed in order that all discrepancies in resuscitation equipment that becomes apparent, either as a result of daily/weekly checking, or following an incident, are made good at the earliest opportunity and as per local procedures.

• All documentation required for audit purposes with regard to the checking of equipment, is complete and sent to the appropriate department when required.

• All members of staff for whom they are responsible are given the opportunity to attend post arrest debriefing and or counselling sessions as necessary.

• A record of all training sessions is maintained (in respect of both basic and advanced cardiopulmonary resuscitation techniques, and staff attendance)

• All staff for which they are responsible have attended an initial BLS training session, and thereafter are able to attend an annual update in line with the hospital policy of mandatory training requirements.

• Managers must ensure that they have staff that are trained in defibrillation techniques, and are able to attend annual update sessions in order to maintain a minimum 'safe' level of cover within the working hours of that ward, department or area.

• Heads of department and managers of clinical areas are responsible in ensuring that the appropriate signs are displayed which show the location of medical emergency equipment and who the First Aid trained staff.

• Any ward, department or area based, secondary induction programme includes:
  - the location of resuscitation equipment within the area,
  - the correct procedure for the checking of resuscitation equipment,
  - the correct procedure to be followed in order to summon local, site wide and paramedic help in the event of a respiratory or cardio-respiratory arrest,
  - the correct procedure to ensure that restocking of resuscitation equipment and drugs occurs promptly.
The Individual’s Responsibilities

Each trust staff member must ensure that;

- They are aware of the location of all resuscitation equipment available to them, in the event of another individual suffering a respiratory or cardio-respiratory arrest, in each and every area that they work.

- They are aware of the contents of the current Basic Life Support Policy, and the current guidelines published by the Resuscitation Council (UK). Qualified nursing staff must refer to the NMC Code of Professional Practice.

- Their own practice with regard to cardiopulmonary resuscitation techniques remains competent, and contemporary, by making every effort to attend pre-arranged training as appropriate, according to the current Basic Life Support Policy.

In an acute medical emergency nursing staff are required to carry out emergency procedures in order to save life and this is clearly expected by the NMC Code which states that ‘You must be able to demonstrate that you have acted in someone’s best interests if you have provided care in an emergency’.1

The NMC Code further states that ‘as a professional you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions’

Dignity and respect are of paramount importance in caring for individuals with any mental health or physical health condition and therefore it is important to incorporate the need for privacy, safety and security into all activities undertaken. Privacy is a major issue, particularly for female patients and therefore gender specific issues have to be addressed at all times in care plans.

When a situation arises that could not have been foreseen or previously care planned, the need for appropriate treatment has to be addressed and in the case of acute medical emergencies the priority is to save life as quickly as possible.

Staff should be aware that preserving dignity as a priority by not removing items of clothing would seriously impede the successful initiation of AED at the required time as discussed above. Furthermore, this would also mean that the correct procedures for resuscitation would not be adhered to and this could be seen as withholding life saving treatment which could come under legal scrutiny of their actions and omissions when considering the following issues:

- A medical emergency requires a course of action specifically to preserve life and prevent death
- The views of the patient at that time are not available to us and we cannot assume that they would choose dignity as opposed to a life saving procedure
- Omitting to remove certain items of clothing in order to carry out CPR and AED is likely to lead to the death of the patient.
It is therefore necessary for all staff to follow the procedures as outlined in the WLMHT Policy for Resuscitation and use of AED for all medical emergencies where a cardiac arrest has occurred.
IMPORTANT NOTE:  This document is only a summary and clinicians must make themselves familiar with the up-to-date guidelines from various professional bodies, including the Resuscitation Council. At the time of writing the up-to-date guidance is "Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing 2001".

Making the Decision

1. Overall responsibility for a "Do Not Attempt Resuscitation" (DNAR) decision rests with the consultant in charge of the patient’s care.

2. Each case depends on the individual circumstances but the following are relevant considerations. It is appropriate to consider a DNAR decision in the following circumstances:
   a) where the patient’s condition indicates that effective BLS is unlikely to be successful i.e. the patient’s heart/respiration will not restart.
   b) where BLS is not in accord with the recorded, sustained wishes of the patient who is mentally competent.
   c) where BLS is not in accord with a valid applicable advance directive (or anticipatory refusal or living will).
   d) M.C.A, 2005 requires all advanced directives post April 2007 to be witnessed, and specific. Any pre April 2007 advanced directives must be closely looked at. See section (1) Paragraph (25).
   e) where successful BLS is unlikely to confer a benefit, or the burdens of treatment outweigh the benefits to the patient.

3. Where a patient is considered to be mentally competent regarding resuscitation, and is at risk of cardiac or respiratory failure, or has a terminal illness, a sensitive exploration of their wishes in respect of BLS must be carried out by the consultant. This must also include referral to the mental capacity act advocate. See the mental capacity act 2005 part (1) paragraph 37 (5) taking into account any information given or submission made by the independent mental capacity advocate. Such discussions and any anticipatory decisions must be documented, signed and dated in the patient's notes.

4. As with all clinical decision-making, doctors have a duty to act in accordance with the practice of a responsible body of medical opinion.

A DNAR decision must only be made after appropriate consultation with the team treating the patient (this must also include clinicians from other hospitals involved in the patient’s health care, their GP etc) and consideration of all
aspects of the patient’s condition. Any assessment of the patient where a DNAR decision is considered must include:

a) The likely clinical outcome
b) The patient’s known or ascertainable wishes
c) The perspectives of the other members of the multidisciplinary team
d) With due regard for patient confidentiality, the perspective of the patient, his/her relatives or close friends

6 If the patient cannot express a view, the views of family, carers etc. may be sought, regarding what would be in the patient’s best interests. Alternatively, in the absence of any family or carers, consideration must be given to the asking a patient’s advocate to represent their interests. However, the role of any and all of these individuals is to try and reflect the patient’s views, not to make decisions on behalf of the patient.

7 Relatives and others close to the patient must be assured that their views on what the patient would have wanted/may want will be taken into account in any decision-making. However, they cannot determine a patient’s best interests, nor give consent to, or refuse treatment on the patient’s behalf.

8 When the basis for a DNAR decision is based on the likely benefit to the patient, then the views of the patient are of particular importance. If the patient is not competent to make a decision then careful consideration needs to be given to the likely benefits for the patient, from the patient’s perspective.

After the Decision is made:

9 The consultant in charge of a patient’s care must ensure that any decision reached is effectively communicated to other members of staff; including ambulance personnel and the appropriate hospital doctor must the patient be admitted to a general hospital.

10 A patient’s primary nurse, or the most senior available member of the nursing team, is responsible for the effective communication of any decision to other members of the nursing team.

11 It must be made clear that a DNAR decision applies solely to BLS. All other appropriate treatment and care are not to be precluded or influenced by the DNAR decision (see para 16 below).

12 Any decision reached will, of necessity, need to be reviewed and documented by the consultant in charge, in light of changes in the patient’s condition.

13 When the basis for a DNAR decision is the absence of any likely medical benefit, discussion with the patient or others close to them must aim at securing an understanding and acceptance of the clinical decision that has been reached. Where relatives, carers etc disagree with a DNAR decision, and further discussion has not secured an agreement, a second opinion must be sought from another consultant.

Documenting the DNAR Decision
Any discussions, between a patient and their consultant, or between members of the multidisciplinary team, and any anticipatory decisions, must be documented, signed and dated in the patient’s medical, and/or multidisciplinary notes. This must be made by the most senior member of the medical team available, and include a rationale for the decision, in order to facilitate proper understanding and acceptance of it.

Any entry in the patient’s nursing notes must be made by their primary nurse or the most senior available member of the nursing team at the time.

To avoid any confusion, documentation in the patient’s medical, multidisciplinary and/or nursing notes of a decision NOT to resuscitate a patient must state “DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION”

Audit of DNAR Decisions

The instance of a DNAR decision within the Trust is potentially very rare. However, an annual, or more frequently where a need has been identified, clinical audit of the process and management of cardiopulmonary resuscitation, along with ‘Do Not Attempt Resuscitation’ decisions will take place. The audit will be commissioned by the Trust Physical Healthcare Group & a report will be submitted to the Trust Quality & Risk Committee.

Clinical staff’s awareness of the policy and the effective dissemination of its information must be monitored regularly.
### Appendix 7

**DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION**

*Adults aged 16 years and over*

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Date of birth</th>
<th>NHS number</th>
<th>Date of DNA CPR decision:</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
</table>

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.

1. **Does the patient have capacity to make and communicate decisions about CPR?**
   - If “YES” go to box 2
   - If “NO”, are you aware of a valid advance decision refusing CPR which is relevant to the current condition?* If “YES” go to box 6
   - If “NO”, has the patient appointed a Welfare Attorney to make decisions on their behalf?* If “YES” they must be consulted.
   - All other decisions must be made in the patient’s best interests and comply with current law. Go to box 2

2. **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests:**

3. **Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:**

4. **Summary of communication with patient’s relatives or friends:**

5. **Names of members of multidisciplinary team contributing to this decision:**

6. **Healthcare professional recording this DNA CPR decision:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

7. **Review and endorsement by most senior health professional:**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review date (if appropriate):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>Name</td>
<td>Date</td>
</tr>
<tr>
<td>Signature</td>
<td>Name</td>
<td>Date</td>
</tr>
</tbody>
</table>
This form should be completed legibly in black ball point ink  
All sections should be completed

- The patient’s full name, date of birth and address should be written clearly.
- The date of writing the order should be entered.
- This order will be regarded as “INDEFINITE” unless it is clearly cancelled or a definite review date is specified.
- The order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and “CANCELLED” written clearly between them, signed and dated by the healthcare professional cancelling the order.

1. **Capacity / advance decisions**  
   Record the assessment of capacity in the clinical notes. Ensure that any advance decision is valid for the patient’s current circumstances.  
   **16 and 17-year-olds:** Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.

2. **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests**  
   Be as specific as possible.

3. **Summary of communication with patient...**  
   State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why this was inappropriate. It is not essential to discuss CPR with every patient. If a patient is in the final stages of a terminal illness and discussion would cause distress without any likelihood of benefit this situation should be recorded.

4. **Summary of communication with patient's relatives or friends**  
   If the patient does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.  
   If the patient has capacity ensure that discussion with others does not breach confidentiality.

   State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

5. **Members of multidisciplinary team...**  
   State names and positions. Ensure that the DNAR order has been communicated to all relevant members of the healthcare team.

6. **Healthcare professional completing this DNAR order**  
   This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available.

7. **Review / endorsement...**  
   The decision must be endorsed by the most senior healthcare professional responsible for the patient’s care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.
Appendix 8

STANDARDS FOR THE MANAGEMENT OF MEDICAL EMERGENCIES

Professional accountabilities

Be aware of current roles and responsibilities in regards to your professional codes of conduct and duty of care.

Emergency Occurs

Seek Assistance

- Summon immediate assistance – activate alarm
- Assess situation – are paramedics required?
- Identify staff member to proceed with call (if deemed necessary)
- Emergency assistance (2222) Wait for a response, do not hang up and state clearly “medical emergency”. Ambulance and Doctor required to attend”. State exact location

Direct Assistance

- Identify team member to brief and direct ambulance and Doctor
- Person in charge: to provide support or direct activity

Obtain Equipment

Identify staff member to obtain equipment as necessary

- BLS bag contains medical equipment and defibrillator/paddles
  - Alternatively crash trolley (depending on the available equipment in your area)
- Oxygen cylinder with oxygen mask where available

Patient Care

- Identify staff to remain with patient
- Monitor vital signs airway and breathing
- Commence First Aid / Basic life Support as required

Environment

- Ensure safety of all
- Designate identified staff to manage/monitor/support other patients/visitors
- Consider privacy/dignity of casualty

Record Keeping

- Complete resuscitation record
- Time BLS commenced
- Record any drugs given/what time /by whom as per resuscitation record
  - Utilize information to brief supporting staff e.g. paramedics/Doctor and to complete accurate incident report
Note: prepared documentation in the event of an emergency will help the smooth running of the incident and prevent further trauma thus improving the survival rate

**Escort**

Identify staff to escort patient (if required) as per escorting requirements to A & E Department following the local guidelines for the service

**Communication**

- Call all relevant personnel (multidisciplinary team directly involved in the patients care)
- Arrange to inform next of kin unless instructed not to
- Inform police (in the event of sudden death, serious assault
- In the event of a staff member being the casualty, next of kin should be called via senior management
- In the event of a serious assault inform the local security management specialist

**Record time of calls and events in the required documentation.**

**Post Incident Review/Debrief**

- Identified senior team member to facilitate immediate post incident review (establish facts)
- Identified senior team member to facilitate initial debrief for: other patients, staff and witnesses/visitors

**Ensure all individuals involved in incident are given an opportunity to debrief**

**Reporting and Recording**

- Complete resuscitation record
- Complete Electronic IR1 form
- Record events accurately in patient’s notes or where appropriate

**Maintenance**

- Check equipment
- Download defibrillation information at central point, (identify)
- Clean and replace equipment as required

**Following up as necessary as per incident policy**