POLICY

Resuscitation

Position responsible: Medical Director
Approved by: CGC

Issue Date : May 2022
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Related Documents	Magpas Consent Policy SOP 2.1 Advanced Cardiac Life Support SOP 2.23 Cardiac arrest in blunt trauma
Further information	Resuscitation Guidelines 2020, Resuscitation Council UK UK Ambulance Service National Clinical Practice Guidelines Quality Standards (Acute Care), Resuscitation Council 2020

1.0 Introduction

1.1 This policy relates to the techniques and clinical practice of cardio-pulmonary resuscitation for those in cardiac or respiratory arrest.

1.2 The purpose of this policy is to provide clinicians and employees of Magpas with a clear idea of what resuscitation training they can expect to receive, how their training should be kept updated, when to attempt resuscitation, and what to do should they encounter a patient who has an advance directive or living will.

1.3 The Clinical Governance Committee will, as de-facto Resuscitation Committee, provide assurance to the Trustee Board that the Resuscitation Policy is implemented fully and any risks identified are managed, monitor standards of resuscitation practice and provide expertise in all matters related to resuscitation including safety investigations

2.0 Competence Level

2.1 Resuscitation training within Magpas follows the current guidelines as published by the European Resuscitation Council and the Resuscitation Council (UK). Magpas takes these guidelines as its standards when considering accreditation of prior learning.

2.2 All clinicians involved in the provision of Magpas services are expected to be proficient in resuscitation appropriate to their skill level.

2.3 Clinical team members are expected to be proficient in advanced life support of the adult and paediatric patient, including use of a manual defibrillator.

2.4 Employees of Magpas, primarily office based staff, should also be proficient in basic life support and use of an Automated External Defibrillator (AED) in case of cardiac arrest occurring in people visiting the charity office or whilst attending an event.

3.0 Training

3.1 The Medical Director and Clinical Directorate are equivalent to resuscitation officers. The Clinical Governance Committee (CGC) oversees all clinical practice within Magpas, including resuscitation practice. The CGC is responsible for implementing operational policies governing cardio-pulmonary resuscitation, practice and training. Therefore the CGC can be regarded as the equivalent of a Resuscitation Committee.

3.2 The Medical Director and Clinical Directorate are responsible for the provision of training for clinical team members and Magpas employees.

3.3 The Medical Director will take into account prior certificated learning when considering the training needs of clinicians, and will provide training for all those who require it. All certificates and documents relating to proficiency in the necessary resuscitation skills will be recorded and kept in the member's personal file.

3.4 Training is provided by Magpas according to national guidelines.

3.4.1 Training by accredited Resuscitation Council (UK) Instructors in adult and paediatric resuscitation is used for members of the clinical team.

3.4.2 Magpas non-clinical employees are provided training with an appropriate instructor in BLS and AED use.

3.4.3 Any training carried out as part of the Magpas community CPR programme will be in-line with the Resuscitation Council UK guidelines and approved by the Clinical Directorate.

3.5 Magpas recognises 'skill fade' and aims to refresh the skills of those involved in resuscitation. If any trained person feels that they would benefit from refresher training at any point, it is their responsibility to inform the relevant manager in the first instance who will arrange appropriate training and inform the Medical Director as appropriate.

3.6 All clinical team members will provide evidence of annual resuscitation refresher, retraining or update. All non-clinical employees should have refresher training every six months.

4.0 Attempting resuscitation

4.1 Resuscitation of patients in cardiac arrest out of hospital can be difficult due to factors such as position of the patient, injuries to the patient, other people present, or numbers of people available to assist. In principle, patients in cardiac arrest should always be resuscitated unless there are factors, such as those detailed in this document.

4.2 When attempting resuscitation, Magpas teaching and SOPs should be followed at all times.

4.3 There are patients in whom there is absolutely no chance of survival, and where resuscitation would be futile and distressing for relatives, friends and healthcare professionals.

4.3.1 The following conditions are unequivocally associated with death and resuscitation should not be started:

- Decapitation
- Massive destruction of the head
- Hemicorporectomy
- Decomposition
- Incineration
- Rigor mortis

4.3.2 In these circumstances it should be explained to others around that resuscitation will not be started as there is, unfortunately, no chance of survival. Emotional support should be offered to those present.

4.4 Clinical team members should use their professional knowledge and expertise to decide whether starting, or continuing with, resuscitation is appropriate. This decision should be facilitated by knowledge of the history of events, clinical condition and circumstances of cardiac arrest, and may draw upon guidelines from the UK Ambulance Services National Clinical Practice. If this information is not forthcoming or there is any doubt, resuscitation should be started/continued until such time that it becomes available.

4.5 In cases of cardiac arrest at the Magpas office, cardiac arrest should be confirmed, 999 called, and resuscitation commenced whilst waiting for the ambulance crew to arrive.

5.0 Advance directives

5.1 An "advance directive" is a legally binding document detailing the patients' wishes in certain circumstances. This may involve a directive that the patient is not resuscitated when cardiac arrest occurs. It may be in the format of a 'DNACPR order' (Do not attempt cardiopulmonary resuscitation) or a 'living will'.

5.2 In the pre-hospital setting, validating a living will is extremely difficult. Confirming identity of the patient and establishing that the living will was made when the patient had mental capacity, was not coerced, and applies to the particular situation in hand is challenging. If validated, the directive should be followed.

5.3 A community DNACPR order has been a standardised form throughout the East of England (see appendix 1) and medical teams should check that they are satisfied that the form applies to the patient and remains valid. This has largely been replaced with the national ReSPECT form which allows greater involvement of individuals whilst still summarising recommendations for healthcare professionals to use in an emergency (appendix 2)

5.4 In the case of the clinical team, it is recommended that resuscitation is commenced, unless the team can be sure as to the validity of the living will and the identity of the patient.

6.0 Support

6.1 It is recognised that resuscitation in any situation, but especially in the pre-hospital environment, can be distressing to those resuscitating or observing. Frameworks exist within Magpas that allow those affected by a resuscitation to receive the appropriate support, and all are encouraged to make use of this service.

6.2 Many cardiac arrests will occur in the presence of friends, family, colleagues or carers. It may be appropriate for those people to be present or even to help with resuscitation, particularly parents of children in cardiac arrest, though they themselves may require additional support. Witnessing resuscitation is associated with helping the grieving process.

6.3 It is recognised that the religious and spiritual beliefs of the patient and loved ones need to be respected, particularly if the resuscitation is unsuccessful. Team members should assist with this where possible.

7.0 Equipment

7.1 All equipment appropriate to the competence level of the operator will be provided and maintained by Magpas and/or its partners, eg EEAST, EMAS or Cambridge University Hospitals.

7.2 Those using the equipment must ensure that they are familiar with the use, checking and maintaining of the individual items issued. Any problems should be reported immediately to the Manager or Medical Director.

7.3 All resuscitation equipment and drugs will be accessible for use as quickly as possible, and where necessary is tamper proof.

7.4 Magpas will provide an AED for use by clinicians, employees and visitors on each of its premises. This will be clearly marked and follow national guidance. A system will be in place on each site to comply with required checking of the AED.

7.5 Magpas does not provide event medical cover but recognises that trained members of Magpas (clinicians and employees) may attend events that are held in support of the organisation. Wherever possible, an AED and equipment for BLS shall be carried by the trained person in case of a sudden cardiac arrest.

8.0 Audit

8.1 After a patient has suffered a cardiac arrest, a full account of the events leading up to, during and after the event is documented. This will be on a Magpas Patient Care Record.

8.2 A cardiac arrest audit form or complete entry in the cardiac arrest section on HEMSbase will be completed by the duty team.

8.3 The Clinical Directorate will audit all cardiac arrests attended by the team, or Magpas employees.

8.4 Any clinical or organisational issues raised by Magpas members or as a result of audit will be dealt with by the Clinical Directorate.

8.5 Magpas will support our NHS partners in their cardiac arrest audit processes aiming to improve outcomes and care for patients.

Appendix 1 - ReSPECT form

ReSPECT **Recommended Summary Plan for Emergency Care and Treatment for:**

Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
clinician signature

Focus on symptom control as per guidance below
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended
Adult or child
clinician signature

For modified CPR
Child only, as detailed above
clinician signature

CPR attempts **NOT** recommended
Adult or child
clinician signature

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in making this plan.

☐ **B** This person does not have the mental capacity to participate in making these recommendations. This plan has been made in accordance with capacity law, including, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 (UK except Scotland) / 16 (Scotland) years old and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here. Document full explanation in the clinical record.

Record date, names and roles of those involved in decision making, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time

Senior responsible clinician

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend/other			
GP			
Lead Consultant			

9. Confirmation of validity (e.g. for change of condition)

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature