Dear

I am writing to respond to your request sent on the 5th September 2016. OUH can confirm that it holds the data that you requested. As per email correspondence on the 5th September 2016, the Trust will only provide data that is readily available and within s12 of FOIA.

Service Users
1. How many service users have made complaints against hospitals or staff within your trust?
a. Please provide brief status of complaints (total dismissed, total on going, total completed etc.)

| **Year** | **Total no. of complaints** |
|---|---|
| 2013 | 888 |
| 2014 | 1008 |
| 2015 | 1033 |
| 2016 | 830 |

The Trust is unable to provide data prior to 2013 due to change of system

| | **2013** | **2014** | **2015** | **2016** |
|---|---|---|---|---|
| **Complaint not upheld** | 149 | 170 | 176 | 117 |
| **Upheld** | 229 | 273 | 269 | 154 |
| **Withdrawn** | 7 | 9 | 22 | 16 |
| **Partially upheld** | 495 | 540 | 509 | 359 |

Status is not a mandatory field on the system therefore a number of outcomes will be unknown, were data is available the numbers are indicated in the above table.

2. How many service users have taken the hospitals or staff to court within your trust?
a. Please provide brief status of complaints (total dismissed, total on going, total completed etc.) **Information not readily available, individual case files have to be scrutinised – Withheld under s12 FOIA**

3. How many service users have made taken the hospitals or staff to Judicial Review within your trust?
a. Please provide brief status of complaints (total dismissed, total on going, total completed etc.) **N/A**

4. How many Serious Case Reviews are there within your trust?
a. Please provide details of these, on-going or completed. Information not readily available –

**Information not readily available, individual case files have to be scrutinised – Withheld under s12 FOIA**

5. How many staff working within your trust has made complaints against hospitals or other staff within your trust?
a. Please break down into positions of employment – i.e. Dr reporting admin. **N/A**

6. How many staff working within your trust are whistle blowers? Do they still work within your trust? **See below**
a. Please break down into positions of employment – i.e. Dr reporting admin. **See below**

7. How many staff working within your trust have gone to or approached employment tribunals? **8 (since September 2011)**
a. Do they still work within your trust? Please break down into positions of employment - **One staff member is still with the Trust**

8. What is your policy on whistleblowing? **See below**

9. How Many Service users are on service plans, (per hospital within your trust and please itemise short term or long term) – **As per email confirmation 4/9/16, The Trust will not respond to Q9**

10. Policy of any form of harassment from staff to service users **N/A**

11. Staffing costs over the last 5 years and forecast cost for next year breaking down into front line staff (doctor's nurses etc.) and Managers / Admin **See below**

12. Policy on paging resuscitation staff when needed at times of high service users **See below**

| Year | Job Title (if known) | Still at Trust? Y/N | |
|---|---|---|---|
| 2012 | Doctor | Y | 2 individuals still employed within the Trust. |
| 2012 | Physiotherapist | N | |
| 2012 | Secretary | Y | |
| 2012 | Nurse | N | |
| 2012 | Physiotherapist | N | |
| 2012 | Manager | N | |
| 2013 | Doctor | Y | 6 individuals still employed within the Trust. |
| 2013 | Physiotherapist | Y | |
| 2013 | Clinical Fellow | N | |
| 2013 | Nurse | Y | |
| 2013 | Nurse | N | |
| 2013 | Manager | Y | |
| 2013 | HR | Y | |
| 2013 | Systems Analsyt | Y | |

| | | | |
|---|---|---|---|
| 2014 | Doctor | Y | 8 individuals still employed within the Trust. |
| 2014 | HR | Y | |
| 2014 | Accounts Payable Officer | Y | |
| 2014 | Secretary | N | |
| 2014 | Nurse | Y | |
| 2014 | Nurse | Y | |
| 2014 | Systems Specialist | Y | |
| 2014 | Healthcare Assistant | Y | |
| 2014 | Assistant Coordinator | N | |
| 2014 | Manager | Y | |
| 2015 | Administrator | N | 5 individuals still employed within the Trust. |
| 2015 | Information Analyst | Y | |
| 2015 | Doctor | Y | |
| 2015 | Staff Nurse | Y | |
| 2015 | Occupational Therapist | Y | |
| 2015 | Physiotherapist | Y | |
| 2016 | Manager | Y | 3 individuals still employed within the Trust. |
| 2016 | Glinical Governance | Y | |
| 2016 | Nurse | Y | |

**Staffing Costs**

| | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|---|---|
| | | | | | | Forecast |
| | | | | | | |
| Front Line Staff | 367,018,000 | 379,924,255 | 408,831,157 | 436,289,641 | 459,036,865 | 510,155,170 |
| | | | | | | |
| Other Staff | 68,093,000 | 70,487,149 | 72,548,770 | 76,507,364 | 78,696,687 | 45,866,964 |
| | | | | | | |
| Total | 435,111,000 | 450,411,404 | 481,379,927 | 512,797,005 | 537,733,552 | 556,022,134 |

# Resuscitation Policy

| | |
|---|---|
| **Category:** | Policy |

| | |
|---|---|
| **Summary:** | This policy aims to ensure that decisions regarding resuscitation are made appropriately; respecting patients' rights and involving them as much as possible. Also that patients, visitors and staff who may need and are likely to benefit from resuscitation have rapid access to care by appropriately trained and competent staff, that resuscitation practice follows nationally recognised guidelines and that suitable equipment and medicines are readily available. |
| **Equality Analysis undertaken:** | Updated March 2016 |
| **Valid From:** | 05 April 2016 |
| **Date of Next Review:** | 05 April 2019 |
| **Approval Date/ Via:** | 21 December 2015, Resuscitation Committee<br>05 April 2016, Clinical Policy Group |
| **Distribution:** | Trustwide: Via Trust distribution network to:<br>• Divisional Management teams<br>• Policies Intranet site<br>Via PFI Client Contract Office to:<br>• Carillion Health<br>• G4S |
| **Related Documents:** | Resuscitation of Newborn Babies Policy & Procedures<br>First Aid Provision Guidance<br>Manual Handling Policy<br>Policy for Identifying and Responding to Acutely Ill Patients<br>Recognition of the Severely Ill Woman Procedure<br>Bleep Policy<br>Medical Devices Training Procedure<br>Mental Capacity Act 2005: Joint Oxfordshire Policy<br>Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy<br>Child and Young Persons Advance Care Plan Policy |
| **Author(s):** | Resuscitation Services Manager |
| **Further Information:** | Resuscitation Services Department |
| **This Document replaces:** | Resuscitation Policy Version 9 |

Medical Director

**Lead Director:**

**Issue Date:** 08 April 2016

## Contents

## Introduction

1. It is a Health Service requirement that appropriate resuscitation policies which respect patients' rights, are understood by all relevant staff, that are accessible when needed and are subject to audit and monitoring, are in place.

2. "Quality standards for cardiopulmonary resuscitation practice and training" (Resuscitation Council (UK) 2015) sets out guidelines and recommendations relating to the clinical practice of resuscitation. This includes the arrangements regarding resuscitation teams, equipment, resuscitation decision making and audit and the organisation and training required by staff within healthcare settings. This policy aims to support the application of these standards within the Oxford University Hospitals NHS Trust.

### Policy Statement

3. It is the policy of the Trust that:

   3.1. Resuscitation will be attempted for any patient, visitor or member of staff who suffers a cardiac or respiratory arrest, unless a valid 'Do Not Attempt Cardio- Pulmonary Resuscitation' (DNACPR) decision[1] is in place or staff are made aware that the patient has an Advance Decision to Refuse Treatment (ADRT) which precludes resuscitation in the specific circumstances.

   3.2. Each patient's resuscitation status should be considered and documented as part of the admission process; recognising that no decision is, in effect, a decision to resuscitate. This Trust endorses the RC(UK) statement that leaving people in the default position of receiving CPR, regardless of their views and wishes, denies them of the opportunity to refuse treatment that may offer no benefit and may not be what they want.

   3.3. Each patient should be involved in the decision-making regarding DNACPR and they or their representative must be informed of any DNACPR decision. The exception is when such information or discussion would cause psychological or physical harm. Guidance on DNACPR policy and its application is available.

   3.4. It may be appropriate to reconsider a DNACPR decision as part of the continuing care pathway and in the event of any significant change in the patient's condition.

   3.5. A unified approach to policy and procedures in relation to decisions about attempting resuscitation, as set out in the current version of the unified policies will be followed.

   3.6. Patients at risk of cardiopulmonary arrest will be identified and appropriate

medical management planned, with an aim to prevent further deterioration and/or support those patients for whom a resuscitation attempt would be inappropriate.

3.7. Early warning scoring systems will be used to help identify and respond appropriately to in-patients at risk of deterioration with the exception of adult patients receiving level 3 care and children being cared for within children's critical care( these patients are continuously monitored) and newly born infants (see *Resuscitation of Newborn Babies*) and those patients detailed as exceptions in the *Recognising and Responding to Acutely Ill Patients Policy*

[1] In line with the current DNACPR policies for adults and for Children and Young Persons (via link)

3.7.1. For the majority of adult patients early warning scoring will be using the System for Electronic Notification and Documentation (SEND) which provides an electronic Track and Trigger system. Track and trigger charting on paper will be used to provide EPR downtime backup and until SEND roll out is fully implemented across all applicable inpatient and day treatment areas.

3.7.2. For obstetric patients in Maternity this will be the MEOWS system and for paediatric patients this will be the PEWS system. These systems include guidance on appropriate monitoring of vital signs and responding to patient observations, including escalation of care if indicated.

3.8. Suitable care will be provided for patients following successful resuscitation, including stabilisation and safe transfer to specialist areas if appropriate.

3.9. For further guidance in relation to acutely ill patients, including use of early warning systems and prevention of further deterioration in patients who are post resuscitation see the *Recognising and Responding to Acutely Ill Patients Policy* available via the Trust intranet.

3.10. The unified South of England (Central) SHA policy and the Child and Young Person's Advance Care Plan Collaborative in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions apply as relevant to Adults, Children and Young Persons. Operational guidance on the implementation of these policies within the Trust is available on the Trust intranet.

3.10.1. A decision not to attempt cardiopulmonary resuscitation is one aspect of continuing care and does not in itself determine or exclude any other treatments or care for the patient. For further guidance see End of Life Care.

3.11. Resuscitation teams will be identified for each main hospital site and procedures put in place to ensure their swift deployment.

3.11.1. In addition to a core 'Adult Resuscitation Team' available for each Trust site there will be specialist teams appropriate to the patient groups for the Horton and John Radcliffe hospitals. These teams include but are not limited to, a Paediatric team and a Newborn team. A full list of teams for each site can be accessed in Appendix 2.

3.12. Readily accessible, clean, well maintained and standardised resuscitation equipment and medicines that are appropriate to the clinical environment will be provided. The equipment standard and associated actions apply for all clinical areas and can be accessed here or via the link in Appendix 4.

3.13. Resuscitation will be carried out to appropriate standards (current European Resuscitation Council protocols) by appropriately trained

personnel.

3.14. Resuscitation policies and related documents will be reviewed regularly and updated as required in line with guideline or operational changes.

3.15. The conduct and outcome of resuscitation events and adherence to resuscitation policies including DNACPR policy will be audited and resulting data reviewed by the Resuscitation Committee.

**Scope**

4. This document applies to all areas of the Trust, and all employees of the Trust, including individuals employed by a third party, by external contractors, as voluntary workers, as students, as locums or as agency staff. Arrangements to ensure that agency and third

party staff can act within the terms of this policy are the responsibility of the relevant employer.

## Aim

5. The aim of this policy is to ensure that all patients, visitors and staff for whom resuscitation is appropriate have access to the rapid and competent application of currently recognised best practice guidelines. It will do so by setting out an effective framework and guidance relating to the practice, organisational and training requirements and responsibilities of Trust staff.

### Definitions

6. The terms in use in this document are defined as follows:

6.1. **Cardiopulmonary Resuscitation (CPR)** – An emergency procedure which may include chest compressions and ventilations[1].

6.2. **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)** –Refers to not making efforts to restart breathing and/or the heart in cases of respiratory/ cardiac arrest. It does not refer to any other interventions, treatments and/or care such as fluid replacement, feeding, antibiotics etc[2].

6.3. **Advanced Decision to Refuse Treatment (ADRT)** – A decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding[3].

6.4. **Child and Young Person's Advance Care Plan (CYPACP)** – a document that records the advance wishes of a child or young person and/or those with parental responsibility for them. An ACP will include whether the child's resuscitation status has been discussed and the outcome of that discussion.

6.5. **S of E (C) SHA** – South of England (Central) Strategic Health Authority

6.6. **TNA –** Training needs analysis

6.7. **Defibrillator** – a medical device designed to deliver a therapeutic electrical current through the heart with the aim of terminating shockable cardiac arrest rhythms.

6.8. **Automated External Defibrillator (AED)** — a reliable, computerised medical device which analyses rhythms and uses visual and audible prompts to guide users to defibrillate if required.

## Responsibilities

7. The **Chief Executive** has overall responsibility for ensuring that the Trust complies with relevant legislation and has in place a policy relating to resuscitation practice. This responsibility is delegated to the Medical Director.

8. The **Medical Director** has delegated authority for overseeing the development and establishment of resuscitation policy and procedures.

9. The **Clinical Governance Committee** is responsible for:

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[1 -3] Definitions taken from the South of England (Central) Adult policy

9.1. Approving the Resuscitation Policy on behalf of the Trust Management Executive.

9.2. Reviewing reports from the Resuscitation Committee in relation to the implementation of this policy.

10. The **Resuscitation Services Department** is responsible for supporting resuscitation activities throughout the Trust by working with clinical and technical staff to:

10.1. Produce clinical guidelines and standards

10.2. Ensure availability of required resources

10.3. Provide training in basic and advanced life support

10.4. Conduct and report on audits of resuscitation events, resuscitation decisions, equipment provision and other relevant issues as agreed with the Resuscitation Committee.

11. **Clinical Directors** are responsible for ensuring that:

11.1. Resuscitation team members and other appropriate clinical staff in high-risk areas are trained in advanced life support techniques.

11.2. Proper rotas and systems are in place for the rapid deployment of resuscitation teams.

11.3. All clinical staff are appropriately trained and regularly updated in resuscitation skills.

12. **All Managers** are responsible for ensuring that staff are:

12.1. Aware of their responsibilities in relation to this policy

12.2. Supported to undertake training as relevant to role.

13. **Ward and other Clinical Managers** are responsible for ensuring that resuscitation trolleys and equipment located within their clinical areas are regularly checked, kept clean and well maintained, and are fully equipped at all times.

14. **Consultant medical staff** are responsible for:

14.1. Considering whether or not resuscitation is appropriate for their individual patients, taking into due consideration the perspectives of other relevant staff, the patient and family members as appropriate, in accordance with Trust polices (the Do Not Attempt Cardiopulmonary

Resuscitation Adult Policy and Child and Young Person's Advance Care Plan are available via the intranet)

14.2. Ensuring that a valid DNACPR order is in place for patients for whom cardiopulmonary resuscitation is inappropriate, that this is communicated to relevant clinical staff and discussed with the patient and their relatives unless such discussion would cause psychological or physical harm.

15. **Individual Staff** are responsible for:

15.1. Knowing, as a minimum, how to summon help in a medical emergency. This includes those in roles without direct patient contact.

15.2. Maintaining relevant clinical skills, complying with mandatory training requirements and for providing resuscitation as appropriate to their role.

15.3. Considering their own safety and that of other team members when involved in resuscitation. They must follow relevant health and safety guidance including *Manual Handling Policy.*.

16. The **Resuscitation Committee** is responsible for formulating Trust policy, setting standards, and monitoring resuscitation practice; reporting to the Medical Director via the Patient Safety and Clinical Risk Committee.

17. The **Paediatric Resuscitation sub-committee** is responsible to the Trust Resuscitation Committee for considering and advising on Resuscitation issues relating to the care of patients under sixteen years of age.

**Organisational Arrangements**

18. All clinical staff must aim to prevent cardiopulmonary arrest by following the processes designed to recognise patients at risk, ensure effective communication and obtain a timely and appropriate response. These are outlined in the *Recognising and Responding to Acutely Ill Patients Policy* If a cardiopulmonary arrest or an immediately life-threatening medical emergency occurs the **appropriate** resuscitation team should be alerted by dialling 2222 without delay (see list of teams).

19. Staff should use the nearest internal telephone to ring 2222 and state:

20.1. The Team required

20.2. The building

20.3. Level

20.4. The ward / department

20. Posters should be clearly displayed in all clinical areas, patient reception areas and in appropriate non-clinical settings alongside readily accessible internal telephones setting out the above process as relevant to that location.

21. The switchboard operator will alert the Resuscitation team via the emergency bleeps, relaying the location details by speech message. This message will be followed by a text after approximately 10 seconds.

22. Resuscitation should be commenced by those staff present, without delay, following current guidelines and using available equipment in line with relevant training, knowledge and experience.

23. On arrival of the Resuscitation team those present should continue care under the direction of the team leader. Responsibilities of the resuscitation team are outlined in Appendix 2

24. Following resuscitation the team leader must make arrangements for continuity of care, including stabilisation and safe transfer as appropriate. Consideration should be given to the need for specialist and/ or critical care, including a period of targeted temperature management.

25. In the event that the team is called to a patient not in cardiopulmonary arrest or near arrest the team leader will ensure that the patient's own medical team (or the medical team carrying out care at the time, if different) are rapidly alerted and will if appropriate hand back care to that team or agree with them escalation to specialist or critical care teams.

26. Guidance on appropriate, and safe transfer arrangements can be found in the
*Recognising and Responding to Acutely Ill Patients Policy, Transfer and Escort Policy*

and other related documents available via the Trust intranet but as a minimum the team leader should ensure that suitable equipment and staff are assembled, that the route is planned and that the receiving location has been informed prior to any transfer.

27. Appropriate monitoring (including mandatory end-tidal carbon dioxide monitoring for intubated patients) will be carried out during transfer.

28. All clinical and public areas must have appropriate resuscitation equipment available which is checked regularly. See guidance on intranet side.

## Training

29. Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis as set out in Appendix 3 of this document. Management and monitoring of training will be in accordance with the Trust's *Learning and Development Policy.*

30. Defibrillation Training is managed and monitored in accordance with the *Medical Devices Training Procedure.*

## Monitoring Compliance

31. Compliance with the document will be monitored in the following ways.

| Aspect of compliance or effectiveness being monitored | Monitoring method | Responsibility for monitoring | Frequency of monitoring | Group or Committee that will review the findings and monitor completion of any resulting action plan |
|---|---|---|---|---|
| Requirement for a documented plan for vital signs monitoring that identifies which variables need to be measured, including the frequency of measurement | SEND (adults) | Ward manager | Monthly | RAID Committee |
| | PEWS audit - children | Paediatric outreach team/PDN | Monthly | Paediatric Resuscitation sub-committee |
| Use of an early warning system within the organisation to recognise patients at risk of deterioration | SEND | Ward manager | Monthly | RAID Committee |
| | PEWS audit - children | Paediatric outreach team/PDN | Monthly | Paediatric Resuscitation sub-committee |
| Actions to be taken to minimise or prevent | SEND | Ward manager | Monthly | RAID Committee |

| | | | | |
|---|---|---|---|---|
| further deterioration of patients | PEWS audit - children | Paediatric outreach team/PDN | Monthly | Paediatric Resuscitation sub-committee |
| Do not attempt resuscitation orders (DNACPR) (adults and paediatrics) | Audit, sample of completed DNACPR forms and/or associated | Resuscitation department | Annually | The Resuscitation Committee (delegated to the Paediatric |

| | | | | |
|---|---|---|---|---|
| | entries in the medical record using a standardised OUH tool in accordance with the framework set out within the SHA and CYPACP policies. | | | Resuscitation sub-committee for Paediatric aspects) |
| How the organisation documents that resuscitation equipment is checked, stored and fit for use | Periodic audit by clinical managers plus snap shot audit including compliance with daily (or exception) checking requirements using trolley audit tool. | Ward /department managers<br><br>Resuscitation Department | Annual plus as required in response to clinical incidents, or new areas. | Resuscitation Committee (delegated to Paediatric Resuscitation sub-committee for Paediatric areas). |
| Organisations expectations in relation to staff training as identified in the TNA | In accordance with the Trust's *Statutory and Mandatory Training Policy* available via the intranet. | | | |

32. In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this policy as a response to the identification of any gaps or as a result of the identification of risks arising from the policy prompted by incident review, external reviews, or other sources of information and advice. This monitoring could include:

- Commissioned audits and reviews
- Detailed data analysis
- Other focused studies

33. Resuscitation related incidents including anaphylactic reactions occurring in the hospitals will be reported and monitored via the incident reporting process. All such incidents reported to the Resuscitation Service will be investigated and incidents resulting in moderate or above harm, recurring risks and trends will reviewed by the Resuscitation Committee. Recommendations and learning will be shared via the divisional and corporate governance structure.

34. Resuscitation Events will be recorded and reported by clinical staff using the appropriate event record (adult, paediatric or newborn). This record will preferably be completed on the Electronic Patient Record but paper copies will be available until full implementation of EPR across the Trust. The Resuscitation

Department will collate and report on these events to the Resuscitation Committee at least annually.

35. Results of this monitoring will be reported to the Resuscitation Committee.

## Review

36. This policy will be reviewed in 3 years in line with the *Policy for the Development and Implementation of Procedural Documents,* or earlier as necessary to reflect substantial

changes in European Resuscitation Council (ERC) and Resuscitation Council (UK) protocols or in response to examples of best practice or changes in legislation.

## References


37. Monsieurs K, G et al European Resuscitation Council Guidelines for Resuscitation 2015. Section 1. Executive Summary. Resuscitation 95 (2015) 1-80. Available from http://cprguidelines.eu/assets/downloads/guidelines/S0300-9572(15)00350-0_main.pdf Accessed 22 March 2016

38. Resuscitation Council (UK) Resuscitation Guidelines 2015. Available at https://www.resus.org.uk/resuscitation-guidelines/ Accessed 22 March 2016

39. Decisions relating to cardiopulmonary resuscitation (3rd Edition) Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (October 2014) *and* Decisions relating to cardiopulmonary resuscitation – new statement (November 2015) Available from https://www.resus.org.uk/dnacpr/decisions- relating-to-cpr-new-statement/ Accessed 22 March 2016

40. Resuscitation Council (UK) Quality standards for cardiopulmonary resuscitation practice and training: Acute care Available from https://www.resus.org.uk/quality- standards/acute-care-quality-standards-for-cpr/ Accessed 22 March 2016

41. Department of Health (2000) Resuscitation Policy Health Service Circular 2000/028

42. Intensive Care Society. Monitoring during transport, in: Guidelines for the transport of the critically ill patient, 3rd edition P.23. Intensive Care Society, 2011. Available at http://www.ics.ac.uk/ics-homepage/guidelines-and-standards/March 2012 Accessed 22 March 2016


## Equality Analysis

43. As part of its development, this policy and its impact on equality, diversity and human rights has been reviewed, an equality analysis undertaken (see appendix 1 attached) and no requirement for adjustments was identified.

## Document History

| Date of revision | Version number | Reason for review or update |
|---|---|---|
| January 1998 | 1 | Draft for consultation |

| | | |
|---|---|---|
| September 2002 | 2 | Review due |
| December 2003 | 3 | For consultation |
| June 2007 | 4 | Review due |
| September 2010 | 5 | Review due. submitted for approval to CRMG |
| August 2011 | 6 | To reflect changes in related policies. Policy template changes and for approval by Resuscitation Committee Approved by Clinical Governance Committee |
| June 2012 | 7 | Integrated policy to replace Policy and Procedures from ORH and NOC NHS Trusts. Minor amendments to draft. Policy revision then approved by Resuscitation Committee |

| | | |
|---|---|---|
| December 2012 | 8 | Following revision of associated Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy |
| July 2015 | 9 | Minor revisions to reflect update CYPACP and changes to regional bodies responsible for approval and dissemination of unified policy. |
| July 2015 | 9.1 | Draft to reflect changes in related policy, trust organisational arrangements and to produce more streamlined, shortened document. Preparation for review and amendments as required following publication of Guidelines 2015. |
| Sept 2015 | 9.2 | Revised draft for committee review |
| Dec 2015 | 9.3 | Draft for approval by Resus Committee |
| March 2016 | 9.4 | Final draft incorporating consultation feedback and using revised policy template. For submission for approval by Clinical Policy Group. |
| XX 2016 | 10 | Policy due for review. Amendments made to reflect operational and guideline changes and to provide more streamlined document. |

## Authors and Contributors

| Name | Title | Role |
|---|---|---|
| Jane Hatfield | Resuscitation Services Manager | Lead Author |
| Oliver Dyar | Resuscitation Clinical Lead and Chairman Resuscitation Committee | Author |

## Stakeholders – Who has Been Consulted?

| Who?<br>Individuals or Committees | Rationale and/or<br>Method of Involvement |
|---|---|

| | |
|---|---|
| Resuscitation Committee | Key group with responsibility for policy formulation. Members involved in reviewing all proposed changes. |
| RAID Committee | Group with responsibility for setting Cardiac Arrest Reduction Strategy – circulated to members for comment |
| PSCR Committee | Submitted to committee for feedback 24/02/16 |

| | |
|---|---|
| Medical and Nursing directors | Revised policy circulated for comment |
| Clinical staff | Revised policy circulated via divisional directors and nurses for comment |

## Appendix 1: Equality Analysis

***Please include this in the preparation to write a policy*** *and refer to the "Policy on Writing Policies." Full guidance is available:*
*http://ouh.oxnet.nhs.uk/Equality/Pages/EqualityImpactAssessment.aspx*

| **Equality Analysis** |
|---|
| Policy / Plan / proposal name: Resuscitation Policy |
| Date of Policy: Month 2016 |
| Date due for review: Month 2019 |
| Lead person for policy and equality analysis: Jane Hatfield, Resuscitation Services Manager |
| Does the policy /proposal relate to people? If yes please complete the whole form.<br>YES ~~/NO~~ |
| The only policies and proposals not relevant to equality considerations are those not involving people at all. (E.g Equipment such as fridge temperature) |
| **1. Identify the main aim and objectives and intended outcomes of the policy.**<br>Who will benefit from the policy? How is the policy likely to affect the promotion of equality and minimize discrimination considering: age, disability, sex/gender, gender re-assignment, race, religion or belief, sexual orientation, pregnancy and maternity, marriage or civil partnerships or human rights?<br><br>The aim of the policy is to ensure that all patients, visitors and staff for whom resuscitation is appropriate have access to the rapid and competent application of currently recognised best practice guidelines. |
| |

**2. Involvement of stakeholders.**
List who has been involved in the policy/proposal development?

This policy revision reflects changes in organisational arrangements, revised guidelines (Guidelines 2015) and changes to provide clarity and assurance following feedback from stakeholders.
The Resuscitation Committee has reviewed all proposed amendments to the policy prior to consultation with key stakeholders identified via the divisional structure and via the

membership of the RAID and PSCR Committees.
Previous versions have undergone wide consultation.
This policy includes operational guidance for the implementation of the unified SCSHA policy on Do Not Attempt Cardiopulmonary Resuscitation for adults and the Child and Young Person's Advanced Care Plan Collaborative policy on the Child and Young Person's Advance Care Plan within this Trust. Clinicians and patient representatives from across the SCSHA were involved in formulation of the DNACPR policy including recent amendments to produce v2 of the adult policy. Similarly, Clinicians and patient/parent representatives from eighteen organisations nation-wide collaborated to update the Child and Young Person's Advance Care Plan.

**3. Evidence.**

Population information on www.healthprofiles.info search for Oxfordshire.
This policy applies to all patients, visitors and staff.

It is based on best practice guidelines and recommendations, particularly

Resuscitation Council (UK) Quality standards for cardiopulmonary resuscitation practice and training: Acute care and current European Resuscitation Council and Resuscitation Council (UK) guidelines (see references in policy document), applicable NICE, NPSA and NHSLA requirements and recommendations.

It is a Health Service requirement that appropriate resuscitation policies which respect patient's rights are in place.

**Disability** Have you consulted with people who has a physical or sensory impairment? How will this policy affect people who have a disability?
The policy sets out guidance and expectations in relation to clinical staff with temporary or permanent disabilities that are likely to prevent them carrying out resuscitation procedures relevant to their role, to ensure they can demonstrate applicable competence during training and ensure safe arrangements for patients in their care.
This policy does not have any other impact on this area.

**Disability: learning disability**
See above.

**Sex** How will the policy affect people of different gender?
This policy will not have an impact on this area

**Age:** How will the policy affect people of different ages – the young and very old?

This policy will not have an impact on this area

**Race:** How will the policy affect people who have different racial heritage?

This policy will not have an impact on this area

**Sexual orientation:** How will the policy affect people of different sexual orientation- gay, straight, lesbian, bi-sexual?
This policy will not have an impact on this area

**Pregnancy and maternity:** How will the policy affect people who are pregnant or with maternity rights?

This policy will not have an impact on this area

| |
|---|
| **Religion or belief.** How will the policy affect people of different religions or belief – or no faith?<br><br>This policy will not have an impact on this area |
| **Gender re-assignment.** How will the policy affect people who are going through transition or have transitioned?<br>This policy will not have an impact on this area |
| **Marriage or civil partnerships:** How will the policy affect people of different marital or partnership status?<br>This policy will not have an impact on this area |
| **Carers** Remember to ensure carers are fully involved, informed, supported and they can express their concerns. Consider the need for flexible working. How will carers be affected by the policy?<br>This policy will not have an impact on this area |
| **Safeguarding people who are vulnerable:** How has this policy plan or proposal ensured that the organisation is safeguarding vulnerable people? (E.g. by providing communication aids or assistance in any other way.)<br>This policy will not have an impact on this area |
| **Other potential impacts e.g. culture, human rights, socio economic e.g. homeless people**<br>This policy will not have an impact on this area |
| |
| **Section 4 Summary of Analysis**<br>Does the evidence show any potential to discriminate? If your answer is no – you need to give the evidence for this decision.<br>No – this policy applies to all staff, visitors and patients. |
| How does the policy **advance equality of opportunity?**<br>This policy is positive as it applies to all patients, visitors and staff. |
| How does the policy **promote good relations between groups?** (Promoting understanding)<br>This policy promotes equality as it applies to all including members of the public who may need and may benefit from resuscitation interventions whilst on Trust premises. |
| |

## Appendix 2: Roles and responsibilities of Resuscitation Teams Policy Statement

1. It is the policy of the Trust to identify resuscitation teams for each main hospital site and maintain procedures for their swift deployment.

### Scope

2. There are one or more core Resuscitation teams available on each site at all times.

2.1 The core teams are

| | |
|---|---|
| **Churchill** | Resuscitation Team |

| | | | |
|---|---|---|---|
| **Horton** | Adult Team | Paediatric Team | Newborn Team |
| **John Radcliffe** | Adult Team | Paediatric Team | Newborn Team |
| **NOC** | Resuscitation Team | | |

2.2 In addition there are some specialist resuscitation and emergency teams on the John Radcliffe and Horton sites. See appendix 5 for link for further details.

## Definitions

3. ALS – Advanced Life Support, Resuscitation Council (UK) accredited course

4. EPALS – European Paediatric Advanced Life Support, Resuscitation Council (UK) accredited course

5. APLS- Advanced Paediatric Life Support, Advanced Life Support Group (ALSG) accredited course.

## Roles and responsibilities of the resuscitation team

6. Team members are identified by carrying the "Resuscitation" bleep. At the end of shift, duty period, etc, it is the Team Member's responsibility to pass the bleep to the incoming member of staff.

7. Emergency bleep holders should make every effort to ensure their bleep is fully functioning and report any problems immediately to switchboard.

8. Emergency bleep holders must listen to all test messages to the end of message and respond as requested, unless urgent clinical commitments intervene.

9. Clinical Directors covering the relevant Clinical Units (e.g. anaesthetics, general medicine) are responsible for ensuring that the individuals undertaking these duties are appropriately trained.

10. An appropriately trained clinician will provide leadership for the team providing advanced life support. For adult patients this is normally the Medical trainee. For children it is normally the Paediatric Intensive Care Unit (PICU) registrar at the John Radcliffe or Paediatric Consultant at the Horton. If appropriate it may be another doctor, resuscitation officer or senior nurse. The senior specialist will normally lead the other specialist resuscitation teams.

11. In the absence of the above team leader any ALS (Adult teams) or EPALS / APLS (Paediatric teams) qualified member of the team can and should act as

"Team Leader". If appropriate and acceptable to the other team members this role may continue throughout the event

12. The Team Leader must ensure that CPR is effectively performed and any personnel are delegated appropriately to assist in advanced life support procedures.

13. The Team Leader should delegate specific tasks to the appropriately trained team members and other available personnel and ensure that they remain available to oversee the team, make decisions and plan interventions in line with the current guidelines. If they deem it essential that they step aside from the leadership and coordination role to directly intervene in carrying out procedures or to leave the area to

speak to family members or other colleagues then they must handover the team leader role at least for the duration of that activity.

14. The porters will attend the scene and bring a defibrillator and any other equipment not available in the area as requested by the team. A porter will remain available to assist as required.

15. The medical team currently responsible for the patient's care should be informed as soon as practicable.

16. Any medical history or social history of relevance must be made available by ward staff to assist the team to arrive at medically and ethically sound decisions.

17. The Team Leader is responsible for completing (or delegating the completion) of the Resuscitation Event Record within EPR. A fuller entry must be made in the patient's record (electronic and/or paper medical record) describing the event and outcome.

18. Any training, equipment or other deficiencies should be reported to a Resuscitation Officer, at the earliest opportunity and as appropriate via the incident reporting system.

19. At the completion of the resuscitation episode the team leader should debrief the team members appropriately.

20. The Team Leader must ensure that the relatives are informed of the outcome of the event and document this.

21. At the end of a resuscitation event, including calls to patients who are not in cardiopulmonary arrest, near arrest or suffering other immediately life threatening illness the team leader needs to agree, with relevant medical clinicians (the patient's primary team and/or critical or specialist teams) a plan for ongoing management and hand over care to the relevant team.

22. Where the agreed management plan for post resuscitation care includes transfer to high dependency or critical care the Team Leader will make any necessary arrangements for admission and transfer in agreement with the relevant medical lead for the receiving area involved.

23. They will ensure that safe transfer arrangements are in place in line with Transfer Policy and other related trust documents including as a minimum that suitable equipment and staff are assembled, that the route is planned and that the receiving location has been informed prior to any transfer.

24. In the event that transfer routes may involve transfer outside and between buildings, busy public thoroughfares or may put the patient at risk due to the time required, the team leader should discuss the best option with the

Operational Managers who will advise and assist with arrangements including arranging time critical ambulance transfer. Transfer should be deferred until all arrangements are in place unless the team leader, in consultation with the team, judges that further delay will put the patient at unacceptable risk.

25. Patients should not be transferred until a return of spontaneous circulation is achieved unless the team leader judges that transfer is essential to the continuation of the resuscitation process. In this event the nearest available Compression Assist Device should be obtained and attached to provide continuing CPR during transfer. Staff must not put themselves or others at risk by attempting to provide compressions whilst the patient trolley is being moved from one location to another.

## Appendix 3: Training Requirements and Provision

### Introduction

1. Resuscitation training is necessary in order that all staff in direct contact with patients can carry out resuscitation to a level appropriate for their expected clinical responsibilities. Training should ensure that clinical staff are able to recognise patients at risk of cardiopulmonary arrest and provide them with knowledge and skills to help them prevent or treat such events. In addition, in the event of the patient collapsing in a shockable rhythm, defibrillation should be attempted by competent staff within three minutes.

### Policy statement

2. It is the policy of the Trust to carry out resuscitation to appropriate standards (current European Council protocols) by appropriately trained personnel.

3. Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trust's *Statutory and Mandatory Training Policy*, which can be accessed via the Learning and Development pages on the Trust intranet. This appendix provides guidance on the implementation of that policy as specific to Resuscitation training.

### Scope

4. This Policy applies to all Trust staff including temporary and agency staff who have direct patient contact. Arrangements to ensure agency and third party staff can act within the terms of this policy are the responsibility of the relevant employer. This appendix concentrates on the training requirements and provision necessary to support the Resuscitation Policy.

4.1 Further detail in support of this policy including key training options available for differing staff groups to meet learning outcome requirements, supporting arrangements for staff who fail to demonstrate the required standard and specific information in relation to defibrillator training is available via *(insert link).*

### Responsibilities

5. **Clinical staff and others directly involved in the delivery of care:**

5.1 Staff should undergo regular resuscitation training to a level appropriate for their expected clinical responsibilities, and relevant to their patient caseload (adults, children newborn). See table below for the relevant courses for different staff groups.

5.2 All clinical staff should be able to demonstrate competence in carrying out basic life support during simulated training on manikins. See additional information via link if such competence is not achieved.

5.3 Clinical staff with temporary or permanent physical impairment which is likely to prevent them being able to perform basic life support or other resuscitation procedures relevant to their role should discuss with their clinical leads what arrangements are in place should a clinical emergency arise with a patient under their care. They should also be able to guide others to carry out basic life support procedures on their behalf if necessary.

5.4 All newly appointed registered clinical staff with direct involvement in patient care should during an induction period, as a minimum, have training / information on:

5.4.1 Getting help in a medical emergency

5.4.2 Basic Life Support

5.5 Newly appointed registered clinical staff should complete the on-line induction package.
They should then attend hospital life support or higher level training, as applicable, within 3 months of commencement or provide evidence of competency for equivalent level training in the previous 15 months.

5.6 Clinical staff and others in regular direct contact with patients should attend an appropriate level and type of resuscitation training every 15 months.

5.6.1 Staff with responsibilities for adults and children or other groups with special resuscitation requirements should normally undertake alternate training to maintain competence in one or more areas. (Example for illustration only: January Year 1 complete adult HLS including paediatric modifiers, March Year 2 complete paediatric HLS including adult modifiers, May Year 3 repeat adult session).

5.7 Staff must be aware of the location, type and correct use of resuscitation equipment within their own ward or department.

5.8 All staff must be aware of the level of training required for their role and responsibilities. (See link for relevant sessions or contact the Resuscitation Services department for further advice.)

6. **Clinical Directors** are responsible for ensuring that:

6.1 Resuscitation team members and other appropriate clinical staff in high-risk areas are trained in advanced life support techniques.

6.2 All clinical staff are appropriately trained and regularly updated in resuscitation skills.

6.3 A Resuscitation training needs analysis return is completed for staff in their area of responsibility annually, to support planning and organisation of relevant training.

## 7. Clinical Managers and Supervisors:

7.1 Managers should review the need for extended skills relevant to their staff group e.g., advanced airway adjuncts, intravenous or intraosseous cannulation, rhythm recognition, manual defibrillation and medicine administration and plan for staff training as appropriate.

7.2 Managers should recognise and make provision for staff to have time to train in resuscitation skills.

7.3 Managers should ensure that their staff complete the appropriate training as per the Resuscitation Training Needs Analysis. (available on the Resuscitation intranet site or follow link at appendix 5).

## 8. Resuscitation Services Department

8.1 The Resuscitation Services department and Resuscitation Officers (ROs) should organise, co-ordinate and deliver resuscitation training for staff.

8.2 In order to maintain standards and clinical credibility, the ROs will respond to 2222 calls regularly and provide feedback to team members as part of their continuing training in resuscitation.

8.3 The ROs have a responsibility to maintain their own education in resuscitation. This will include obtaining and maintaining Resuscitation Council (UK) Instructor certification in relevant disciplines.

8.4 Specific training for cardiopulmonary arrests in special circumstances (e.g. paediatrics, newborn, pregnancy, cardiothoracics and trauma) will be provided for clinical staff in the relevant specialities.

8.5 All training will be recorded in a central database.

8.6 The ROs will work with the Resuscitation Committee and others to identify resuscitation equipment that requires specific training, such as defibrillators and incorporate this training into the overall training provision.

## Learning outcomes – guide to levels

9. See table below for general competencies associated with each level of training. For detailed competencies for each type of training session refer to the session lesson plan or course outline (accessible via the Resuscitation intranet site or e LMS intranet site).

<table>
<tr><th>Level</th><th>General competencies</th><th colspan="2">Maps to OUH session/s</th></tr>
<tr><td>1</td><td>Describe how to summon immediate emergency help to a collapsed person on Trust premises</td><td colspan="2">OUH Resuscitation Induction programme</td></tr>
<tr><td rowspan="4">2</td><td rowspan="4">As Level One plus:<br>2.1 Demonstrate an awareness of current legislation and local Resuscitation policies and procedures.<br>2.2 Demonstrate an awareness of a structured approach to recognition of a seriously ill person.<br>2.3 Initiate an appropriate emergency response.<br>2.4 Initiate and maintain effective Basic Life Support in accordance with Resuscitation Council (UK) guidelines which may include management of choking, and the lateral/recovery position.</td><td colspan="2">Porters role in resuscitation</td></tr>
<tr><td rowspan="3">Basic Life Support</td><td>Adult</td></tr>
<tr><td>Paediatric</td></tr>
<tr><td>Newborn</td></tr>
<tr><td>2 with AED</td><td>As Level Two plus:<br>2.5 Initiate the operation of an Automated External Defibrillator (AED) in a safe manner, in accordance with Resuscitation Council (UK) guidelines</td><td colspan="2">Adult basic life support and AED</td></tr>
<tr><td>3</td><td>As Level Two plus:<br>3.1 Recognise a clinically deteriorating patient using the ABCDE approach and initiate appropriate treatment as per current Resuscitation Council (UK) guidelines.<br>3.2 Demonstrate an awareness of individual responsibilities to accurately report and record details of emergency</td><td rowspan="2">Hospital Life Support</td><td>Paediatric</td></tr>
<tr><td>Newborn</td></tr>
</table>

| | | | |
|---|---|---|---|
| | events.<br>3.3 Articulate their individual role and responsibilities within the team in responding to persons in emergency situations.<br>3.4 Articulate their individual role and responsibilities with regards to end of life decisions. | Paediatric Immediate Life Support and PILS Recertification | Paediatric Life Support (PILS) |

| | | | | |
|---|---|---|---|---|
| 3 with Defibrillator | As Level Three plus:<br>3.5 Initiate the operation of an Automated External Defibrillator (AED), in a safe manner, in line with Resuscitation Council (UK) guidelines<br>OR<br>As Level Three including 3.5 plus: | Hospital Life Support | Adult<br>Maternal | |
| | Resuscitation Council (UK) guidelines for performing this procedure during cardiac arrest. | Support (ILS) and ILS recertification | Adult | |
| | | MOET | Maternal | |
| 4 | As Level Three plus:<br>4.1 Demonstrate competence in participating in and leading a resuscitation/medical emergency team.<br>4.2 Demonstrate an ability to make appropriate decisions and initiate actions in relation to:<br>a) Management of reversible causes<br>b) The patient's resuscitation status<br>c) Cardiac Arrest management and post resuscitation care<br>d) Continuing or ceasing CPR<br>4.3 Initiate the safe operation of a manual external defibrillator, in accordance with | Advanced Skills Updates | Adult<br>Paediatric<br>Newborn (not 4.3 or 4.4) | |
| | Resuscitation Council (UK) guidelines<br>4.4 Safely initiate specialist defibrillator functions e.g. pacing, cardioversion and internal defibrillation, (if applicable to role) in line with local policies and procedures<br>4.5 Initiate post resuscitation care, including stabilisation and transfer to an appropriate level of care | Accredited advanced courses | Adult<br>Paed<br>Newborn | ALS<br>EPALS<br>APLS<br>NLS<br>ARNI<br>(not 4.3 or 4.4) |

10. All of the above courses/ assessment only sessions are provided and available through the Resuscitation Services department.

11. For further advice about appropriateness, eligibility and application for specific courses, staff should contact the Resuscitation Services department.

12. Almost all courses comprise e-learning and instructor led elements, the e-learning element forms part one of the session and **must** be completed prior to attendance at the instructor led session. Both parts are required for statutory and mandatory training compliance. In addition

staff are encouraged to use the available on-line elements for personal revision in the intervals between attendance for training

**Accreditation of prior learning**

13. Nationally accredited courses.

13.1 Evidence of current provider or instructor certification in an applicable nationally accredited resuscitation course will be accepted as meeting the requirement for OUH statutory and mandatory resuscitation training and will be recorded on LMS as long as the following conditions are met.

13.1.1 The course is relevant to the clinical responsibilities for the staff member concerned

13.1.2 The relevant course was held within the previous 15 months. The record on LMS will be updated to record the course date and will be valid for the normal 15 month interval. Courses that are still within the course certification dates (normally 4 years from completion) but which were attended more than 15 months previously will be added to the LMS on request but will not count for the purpose of maintaining current compliance.

13.1.3 It is the responsibility of the staff member concerned to provide evidence of current certification and this will normally be a copy of the approved course certificate.

13.1.4 Applicable courses will normally only be current Resuscitation Council (UK) or ALSG accredited courses which must include teaching and assessment in recognition of the deteriorating patient, recognition and immediate management of a patient in cardiopulmonary arrest and defibrillation[1]

14. 'In-house' training from other organisations

14.1 Evidence of successful completion of an applicable resuscitation course will be accepted as meeting the requirement for OUH statutory and mandatory resuscitation training and will be recorded on LMS as long as the following conditions are met.

14.1.1 The training is relevant to the clinical responsibilities for the staff member concerned.

14.1.2 The training was held within the previous 15 months. The record on LMS will be updated to record the training date and will be valid for the normal 15 month interval.

14.1.3 It is the responsibility of the staff member concerned to provide evidence of the training concerned and this must include evidence of the learning outcomes.

14.1.4 Mapping to the UK Core Skills for Health and the locally agreed framework will provide the basis for accreditation.

15. Staff newly employed within the OUH and those attending applicable courses elsewhere who believe that they meet the relevant criteria as outlined above should submit requests for accreditation of their prior learning following the process outlined in the induction package (or via link).

16. Further information and advice is available from the Resuscitation Service.

## Responsibilities when staff fail to demonstrate the required standard during training

[1] Defibrillation requirement excludes newborn specific courses as not included in syllabus.

17. Instructors, individual members of staff and line managers all have a responsibility to recognise and take appropriate action and to cooperate together to maintain patient safety and plan for any necessary retraining / reassessment in the event that staff fail to meet the required standard during training.

## 18. Instructors

18.1 If a health care worker (this may include course candidates who are not OUH employees as well as those who are) fails to meet the required standard on a course but that standard is not necessary for their area of work then it may not be necessary for instructors to take further action. If however, they fail to achieve the required standard in a skill that is deemed essential/necessary to their job then the Instructor has a duty to take action to ensure patient and/or staff safety.

18.2 Further information on the responsibilities of instructors should be accessed *via link*.

## 19. Candidates

Candidates who are unable to meet the required standard during training have a responsibility to co-operate with recommendations / requirements for further training and assessment and to refrain from carrying out any skills in their clinical practice if they have been told they are not safe to do so.

## 20. Clinical Managers

Managers have a responsibility to support staff who require additional training and/or assessment to meet that requirement and to take appropriate management action in the event that staff are deemed incompetent to carry out skills that are essential for their role. This will include liaising with the Resuscitation Services department to arrange urgent support and retraining and may include ensuring alternative arrangements for covering staff responsibilities such as carrying a Resuscitation team bleep.

**Defibrillation training**

## *21. This section is an appendix to the Medical Devices Training Procedure and must be read in conjunction with that procedure.*

**Types of defibrillators**

22. Within the OUH NHS Trust defibrillators fall into two main categories

22.1. Automated External Defibrillators (AEDs)

22.1.1 These are widely available in clinical areas across the Trust and are also at main receptions to provide support for non-clinical areas.

22.1.2 Usage in children: In specified areas the AEDs also contain a packet of attenuated paediatric AED (Teddy Bear) pads. These pads allow the AED to be safely used on children under 8 years by reducing the shock energy to 50 joules. AEDs can be safely used in children over 8 years with standard multifunction pads (labelled Adult).

22.1.3 If a manual defibrillator or trained operator is not readily available an AED can be used; including on infants. Attenuated pads should be used if available for children under 8 years but if they are not available standard pads can be used.

22.2. Manual defibrillators

22.2.1 All manual defibrillators are standardised biphasic models with or without pacing.

These defibrillators have an AED function but this is not currently in use in this Trust so

**only staff trained in manual defibrillation can use these defibrillators.**

22.3. Special functions

22.3.1 The manual defibrillators have varying energy levels enabling them to be used for adults and children and have a synchronised mode to enable cardioversion.

22.3.2 Some of the manual defibrillators on each site have an external pacing function.

22.3.3 Accessories for carrying out internal defibrillation will be available in certain specialist areas.

22.3.4 The appropriate energy levels for manual defibrillators must always be set by the operator.

## Training

23. In line with the *Medical Devices Training Policy* all staff must have received appropriate training and been deemed competent by a qualified instructor to use the functions relevant to their practice.

24. Different users require different levels of training. See the table at paragraph 9 above for OUH training including defibrillation.

25. For full information relating to training for defibrillation see the supporting documentation accessible via link.

## Responsibilities

26. All **clinical staff**

26.1 All staff **must** ensure that they receive appropriate training before operating AEDs or manual defibrillators

26.2 All staff must be aware of the type of defibrillator, its location and any extra specialist functions (e.g. Pacing) in or closest to their practice area.

26.3 They must be aware of the nearest location of other defibrillators that can provide those functions, which are not available on their own machine.

26.4 They must be aware of the routine checking procedures relevant to their machine and the location and function of required accessories e.g. pads and test

load.

26.5 They must be aware of the actions to be taken in the event of a fault being noted during checking procedures or during clinical use.

26.6 All clinical staff working in areas without a defibrillator must be aware of the nearest location of both AED and manual defibrillators and how these are obtained in an emergency.

26.7 All clinical staff and their line managers should refer to the supporting documentation accessible via link for further information in relation to their responsibilities for defibrillation including training.

26.8 Staff providing specialist defibrillator functions including cardioversion, external pacing and/ or internal defibrillation must ensure that they are aware of how to carry out the relevant procedures using the particular defibrillator in their location.

26.9 All staff carrying out elective cardioversion **must** ensure that they are trained and competent to carry out emergency defibrillation and to provide advanced life support following current RC (UK) protocols.

## Internal defibrillation

27. All staff required to assist during procedures where internal defibrillation is liable to be required must ensure that they are aware of the procedures for summoning appropriate support; where the internal paddles and paddle connecting cables are kept and how these are connected to the machine in use.

28. All medical staff who may be required to perform internal defibrillation must ensure they have received appropriate training and been deemed competent. Such training will include appropriate energy levels for these procedures.

## Monitoring

29. The Resuscitation Services department will record resuscitation training attendance and competency on the Trust Learning Management System or any alternate system in use by the Trust at the time and will report compliance (including attendance and non attendance) through the processes maintained by the Trust's Learning and Development Department.

30. The primary monitoring of attendance and non attendance will occur in accordance with the
*Statutory and Mandatory Training Policy*.

31. Issues relating to non compliance will also be reported to the Resuscitation Committee and action plans will be agreed and monitored by them.

## References

32. Royal College of Anaesthetists; Royal College of Physicians of London; Intensive Care Society; Resuscitation Council (UK) (October 2004, updated June 2008). Cardiopulmonary Resuscitation Standards for Clinical Practice and Training

## Appendix 4: Further information

***(This document forms part of the Resuscitation Policy)***

### Introduction

1. See related documents for further information to support this policy. This appendix will be updated as required during the life of this policy and can be located as a separate folder via the Resuscitation pages on the Trust intranet site or follow link below:

Link to Related Documents