

# **Cardiopulmonary Resuscitation Policy**

**V6.2**

**December 2025**

## Table of Contents

<b>1. Introduction</b>	4
<b>2. Purpose of this Policy</b>	4
<b>3. Scope</b>	4
<b>4. Definitions/Glossary</b>	4
<b>5. Ownership and Responsibilities</b>	6
5.1. The Trust Board	6
5.2. Chief Medical Officer	6
5.3. Role of the Resuscitation Committee	6
5.4. Role of Director of Medical Education	6
5.5. Role of Ward and Departmental Managers	6
5.6. Role of Individual Staff	7
5.7. Role of the Procurement Department	7
<b>6. Standards and Practice</b>	7
6.1. All Clinical Staff	7
6.2. Life Support Instructors – Roles, Responsibilities and Updating	8
6.3. Nursing, Midwifery and Allied Health Professional Staff - Roles and Responsibilities	9
6.4. Medical Staff - Roles and Responsibilities	10
6.5. Clinical Support Workers - Roles and Responsibilities	11
6.6. Pre-registration Health Care Students / Medical Students	11
6.7. Security Staff and Portering	11
6.8. Ancillary Staff	11
6.9. New Staff	11
6.10. Locums and Kernowflex workers	11
6.11. The Adult Cardiac Arrest Team	11
6.12. Responsibilities of the Adult Cardiac Arrest Team	14
6.13. Resuscitation in Trauma, Paediatrics, Newborn and Pregnancy	15
6.14. Trauma Team	15
6.15. Paediatric Emergency Response Team	16
6.16. Neonatal Team	17
6.17. Obstetric Emergencies	17
6.18. Anaesthetic Emergency	18
6.19. Non-Clinical Area Alert	18
6.20. Defibrillation	19
6.21. Resuscitation of the Patient with a Tracheostomy or Laryngectomy	19
6.22. Thrombolysis for Suspected PE during Adult Cardiac Arrest	20
6.23. Resuscitation Equipment	20

6.24. Procurement.....	22
6.25. Critical Care Outreach Service .....	22
6.26. Patient Transfer and Post-Resuscitation Care .....	23
6.27. Post Resuscitation Documentation and Reporting Arrangements.....	24
6.28. Manual Handling .....	24
6.29. Decisions Relating to Cardiopulmonary Resuscitation .....	25
6.30. Relatives Witnessing Resuscitation.....	25
<b>7. Dissemination and Implementation .....</b>	<b>25</b>
<b>8. Monitoring compliance and effectiveness .....</b>	<b>25</b>
<b>9. Updating and Review .....</b>	<b>27</b>
<b>10. Equality and Diversity .....</b>	<b>27</b>
<b>Appendix 1. Governance Information .....</b>	<b>28</b>
<b>Appendix 2. Equality Impact Assessment .....</b>	<b>32</b>
<b>Appendix 3. Basic Life Support Course Content .....</b>	<b>35</b>
<b>Appendix 4: 2222 RCHT response boundary .....</b>	<b>36</b>
<b>Appendix 5. Resuscitation Trolley – Daily Check Record.....</b>	<b>37</b>
Appendix 6. Thrombolysis for suspected pulmonary embolism in adult cardiac arrest .....	41

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## 1. Introduction

- 1.1. There is a requirement for all clinical staff to achieve a level of competence in cardiopulmonary resuscitation (CPR) skills appropriate to their employed role. This resuscitation policy fully supports the Quality Standards for Cardiopulmonary Resuscitation Practice and Training, published by the Resuscitation Council (UK) (2013) and the Care Quality Commission regulations.
- 1.2. This version supersedes any previous versions of this document.

## 2. Purpose of this Policy

- 2.1. The purpose of this policy is to provide guidance for the planning and implementation of a robust, high quality resuscitation service to the organisation. The strategy incorporates the current national guidelines for resuscitation (Resuscitation Council UK, 2021).
- 2.2. For guidance relating to situations where resuscitation may not be appropriate, please refer to: Treatment Escalation Plan (T.E.P.) and Resuscitation Decision Record (in relation to the adult patient) (2018) and Royal Cornwall Hospitals NHS Trust Treatment Escalation Plan and Resuscitation Decision Record (in relation to Children under 18 years) (2023). These documents are not the responsibility of the Resuscitation Committee.

## 3. Scope

This policy applies to all clinical staff working within Royal Cornwall Hospitals NHS Trust (including permanent, locum, secondee, students, Kernowflex, agency and voluntary).

## 4. Definitions/Glossary

- **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)** when completed as part of the Treatment Escalation Plan in the event of cardiopulmonary arrest; neither basic nor advanced resuscitation will be instigated.
- **Basic Life Support (BLS)** is the most basic certification of life support training for the initial management of patients in cardiac arrest, respiratory arrest and choking. BLS does not include the use of drugs or invasive skills.
- **Cardiac Arrest** is the cessation of cardiac output. There is abrupt loss of consciousness, no established breathing pattern, absence of a central pulse and /or no other signs of life.
- **Cardiopulmonary Resuscitation (CPR)** the manual application of chest compressions, with or without artificial ventilations, delivered to patients in cardiac arrest, with the aim of preventing irreversible brain damage and death.

- **Core Skills for Training Framework (CSTF)** is a document from Health Education England which provides guidance on mandatory training requirements in a variety of domains, including Resuscitation Training. It matches staff groups to three levels (Level 1 – 3) of training. This framework does not include Advanced-level courses. The minimum CSTF-equivalent training delivered by the Trust is Level 2.
- **National Early Warning Score 2 (NEWS2)** is a validated bedside “track and trigger” tool used to assess the severity of a patients’ physical condition by promoting early recognition of potential critical changes in vital signs.
- **Maternity Early Obstetric Warning Score (MEOWS)** is an essential tool for assessing a woman’s clinical condition. The MEOWS chart can highlight a deteriorating condition in the antenatal, intrapartum or post natal period.
- **Paediatric Basic Life Support (PBLs)** is the most basic certification of life support training for the initial management of paediatric patients in cardiac arrest, respiratory arrest and choking.
- **Paediatric Early Warning Score (PEWS)** is the paediatric version of the adult NEWS scoring system.
- **Paediatric Emergency Response Team (PERT)** A team of specialists (see 6.56) who respond to inter-hospital paediatric emergencies.
- **Respiratory Arrest** is the cessation of spontaneous breathing.
- **Resuscitation**, for the purposes of this document, is specifically limited to a definition of the coordinated efforts of a multidisciplinary healthcare team to deliver high-quality CPR to a patient in cardiac arrest (it does not extend to the broader medical use of ‘resuscitation’ to encompass treatment of a seriously unwell or deteriorating patient unless stated).
- **Resuscitation Committee** as the group of medical, nursing and allied health professionals who implement and recommend on matters relating to acute resuscitation care and CPR of patients of all ages and ensure compliance with regulatory frameworks.
- **Resuscitation Trainers (RTs)** are registered healthcare professionals working within the Resuscitation Training Team under the supervision of the Resuscitation Training Officers. They have a focussed role involving delivery of Level 2 life support courses, and a support role to the delivery of Level 3 and Advanced-level life support courses.
- **Resuscitation Training Officers (RTOs)** are senior members of the Resuscitation Training Team with a wide range of responsibilities including supervision of Resuscitation Trainers, compliance monitoring on behalf of the Resuscitation Committee, and delivery and management of Level 2, Level 3 and Advanced-level life support courses.
- **Treatment Escalation Plan (TEP)** an agreed plan of care guiding which treatments / ceilings of care the patient should receive if they deteriorate including the resuscitation status.

## **5. Ownership and Responsibilities**

### **5.1. The Trust Board**

The Trust Board and Chief Executive have a responsibility to ensure systems, policies and procedures are in place to provide an effective and appropriate resuscitation service. A suitable infrastructure is required to establish and continue support for these activities.

### **5.2. Chief Medical Officer**

- The Chief Medical Officer has executive responsibility for this policy. They are also responsible for ensuring that all medical staff (not in training) receive the appropriate resuscitation training, that it is recorded and that all non-attendees of CPR training are followed up (this may be delegated to Care Group Clinical Directors).
- The Chief Medical Officer is responsible for the appointment of a suitable Consultant as Chair of the Resuscitation Committee.

### **5.3. Role of the Resuscitation Committee**

- The Resuscitation Committee must act in accordance with the Resuscitation Council (UK) guidelines (2021) as a decision-making body for the development, distribution and implementation of policies governing resuscitation practices and training and is responsible for monitoring compliance throughout the Trust.
- The Chair of the Resuscitation Committee is accountable to the Chief Medical Officer. The Chair reports the activity of the Committee to the Trust Board via the Clinical Effectiveness Group.
- The Resuscitation Training Officers (RTOs) are responsible for delivery of the training as stipulated by the Committee, and for the collation of compliance information throughout the Trust, on behalf of the Committee.

### **5.4. Role of Director of Medical Education**

The Director of Medical Education is responsible for ensuring that all medical staff in training receive the appropriate training, that it is recorded and that all non-attendees of CPR training are followed up.

### **5.5. Role of Ward and Departmental Managers**

- Ward and Department managers are responsible for ensuring that staff members in their areas have access to this policy and adhere to it. Managers must also recognise the training needs of their staff by completing a Training Needs Analysis (TNA) and an annual Personal Development Review (PDR). Staff must then be provided access to training at the appropriate level agreed, being released from clinical duties to do so.

## 5.6. Role of Individual Staff

- Each individual clinical staff member is responsible for ensuring that they comply with this Trust policy and attend regular training identified on their electronic staff record to achieve the level agreed.

## 5.7. Role of the Procurement Department

- The Procurement Department have a responsibility to liaise with the RTOs regarding any plans to introduce new equipment in relation to resuscitation into the Trust. This may require the input of the Clinical Engineering Management Service in relation to any electrical equipment. The RTOs will exercise judgement as to which of these decisions require formal consultation with the Resuscitation Committee, or input from the Chair of the Committee.

# 6. Standards and Practice

## 6.1. All Clinical Staff

- 6.1.1. All clinical staff with direct patient contact should be fully competent in providing basic life support resuscitation to an adult.
- 6.1.2. All clinical staff with direct **paediatric** patient contact should be fully competent in providing basic life support resuscitation to both an adult and child.
- 6.1.3. The level of training required for all clinical staff will be dictated by their clinical role and agreed with their manager/clinical lead. An annual TNA is undertaken by the Learning and Development Team in consultation with line managers to review the education, core training and development needs of the organisation. Please refer to the Royal Cornwall Hospitals NHS Trust's 'Mandatory and Statutory Training Policy' (2017). The applicable national framework for this is the Core Skills Training Framework (CSTF) from Health Education England.
- 6.1.4. Adult Basic Life Support (ABLS) and Paediatric (PBLS) (CSTF Level 2)  
  
This is the minimum standard required for all clinical staff with patient contact. Although commonly referred to as BLS, specific variants of the training exist for adult and paediatric patients (see 6.1.1 and 6.1.2). This training encompasses recognition of cardiac arrest, age-appropriate CPR skills, foreign body airway obstruction (FBAO) and the use of airway adjuncts (Appendix 3). This should be updated ANNUALLY.
- 6.1.5. Immediate Life Support (ILS), Paediatric Life Support (PLS) and Newborn Life Support (NLS) (CSTF Level 3).

ILS, PLS and NLS are all recognised national training courses which provide clinical staff with the knowledge and skills needed to treat patients in cardiac arrest until arrival of the resuscitation team. These courses add extended skills such as defibrillation to those skills taught on BLS courses. It also prepares them to be members of that team.

This training should be updated ANNUALLY. An ILS certificate is only valid for one Year. Certificates for both PLS and NLS are valid for 4 years but staff must still update their BLS skills in years 2 and 3 (see 6.1.4).

6.1.6. Advanced Life Support (ALS) and Advanced Paediatric Life Support (APLS).

ALS and APLS are both recognised national training courses which provide clinical staff with the knowledge to lead a cardiac arrest team and to provide advanced skills as part of a team. These courses, whilst valid for 4 years requires a Basic Life Support (BLS) training update in year 3:

Year 1 – Advanced course certificate obtained.

Year 2 – No additional training required.

Year 3 – Basic Life Support training required.

Year 4 – Advanced course recertification or Basic Life Support minimum annually thereafter.

## 6.2. Life Support Instructors – Roles, Responsibilities and Updating

6.2.1. Resuscitation training may only be delivered by recognised life support instructors.

6.2.2. BLS instructors.

- BLS instructors may only train staff at that level.
- BLS instructors must have attended a Royal Cornwall Hospitals NHS Trust BLS Instructor course. If the Instructor already has the appropriate skills and knowledge, the Resuscitation Training Officer (RTO) team may waive this stipulation (subject to an assessment at their discretion).
- BLS instructors must successfully complete a BLS skills pack prior to attending the instructor course and can only instruct once they have attended the course and been assessed as competent in performing BLS and in teaching the skill to others.
- BLS instructors must teach twice a year to remain current in their role.
- BLS instructors must send a record of those trained to the Resuscitation Courses Administrator within the Postgraduate Department.
- It is the responsibilities of the Ward/Department Manager to ensure that their BLS Instructors are given adequate time in order to deliver training to their colleagues.

### 6.2.3. Advanced Instructors

- ALS/APLS instructors may deliver training to staff up to the level of their instructor certificate.
- Advanced instructors are developed and updated through a complex system of training overseen by the organisation validating their national course certificate e.g., Resuscitation Council (UK) or Advanced Life Support Group.
- These instructors are exempt from mandatory training (detailed in 6.1) as they are regularly assessed as part of their advanced instructor role; under strict rules and regulations overseen by the appropriate national organisation.
- All training delivered must be documented and a record of those trained sent to the Resuscitation Courses Administrator within the Postgraduate Department.
- Potential Advanced Instructors are selected from candidates on provider courses. Suitable candidates are objectively assessed by the instructor faculty. To be nominated for instructor training, candidates must consistently demonstrate excellence in their knowledge and skills of delivery of CPR and associated skills, as well as clear educational and interpersonal attributes which denote the likelihood of being an excellent teacher of these skills. Excellent knowledge and/or clinical seniority alone are not sufficient.

## 6.3. Nursing, Midwifery and Allied Health Professional Staff - Roles and Responsibilities

6.3.1. Registered nurses, midwives, and allied health professionals (clinical) must be fully competent to the level of BLS (minimum) irrespective of their area of work.

6.3.2. They may also undertake further advanced life support training as their role and job descriptions dictate, identified by the TNA agreed with their managers in conjunction with the RTOs.

### 6.3.3. Department Managers, Sisters/Charge Nurses

6.3.3.1. Those who take responsibility for a ward or department must demonstrate a clear understanding of the competencies their staff group collectively needs to hold in order to safely provide care for the patients in their area. They are responsible for ensuring that sufficient numbers of staff have adequate access to the training required to ensure patients cared for in their area can benefit from the delivery of high-quality resuscitation skills if required.

6.3.3.2. In addition they should:

- Ensure that a member of staff is available to assist the cardiac arrest team at each cardiac arrest within their clinical area.
- Establish a ward or departmental daily routine for the checking and documentation of resuscitation equipment checks.
- Risk-assess the need for non-clinical/clerical staff, e.g., Ward clerks working in their areas to undertake annual BLS training.

6.3.4. Matrons/Assistant Directors of Nursing

6.3.4.1. Those who take responsibility for a clinical area are expected to demonstrate an awareness of the required skills and competencies in respect of resuscitation required by the patient group served by their area. They have a strategic responsibility for ensuring training and maintenance of these skills is a protected activity for their staff.

6.3.4.2. They should establish systems to ensure that all non-attendees of CPR training are followed up.

6.3.4.3. Those responsible for devising new clinical areas e.g., as part of the Clinical Site Development Plan, or for changing the clinical purpose of an area must liaise with the RTOs at an early stage of the planning process. This is to ensure that the correct resuscitation equipment can be identified and redeployed or procured as necessary. Procurement for resuscitation equipment can take several months and advance notice is required to ensure minimum safe equipment is in place at the point of opening a new clinical area.

## **6.4. Medical Staff - Roles and Responsibilities**

6.4.1. All registered medical staff regardless of grade must be able to take an active role in a resuscitation attempt and should be fully competent to a minimum level of BLS, irrespective of their area of work. Further training is determined by the duties that these staff would be expected to undertake when in attendance at a cardiac arrest, medical / obstetric / neonatal emergency and identified through their personal development plan which is written in conjunction with their personal supervisor.

6.4.2. In addition:

### **6.4.2.1. Foundation Year One (F1)**

All F1s will receive as part of their induction to the Trust, information specific to the Trust arrest procedures and attend appropriate training. All F1s during their F1 year should undertake as a minimum a Resuscitation Council (UK) ILS and AIM course.

#### **6.4.2.2. Foundation Year 2 (F2)**

All F2s will receive as part of their induction to the Trust, information specific to the Trust arrest procedures and attend appropriate training. During their F2 year they should undertake as a minimum a Resuscitation Council (UK) ALS course.

### **6.5. Clinical Support Workers - Roles and Responsibilities**

Clinical support workers should be trained to minimum level of BLS in order to assist in resuscitation.

### **6.6. Pre-registration Health Care Students / Medical Students**

All pre-registration health care students working within the Trust should be able to perform BLS as a minimum and be appropriately trained and updated by their training establishment.

### **6.7. Security Staff and Portering**

Trust-appointed Site security and portering staff, must be trained on an annual basis in BLS (CSTF Level 2).

### **6.8. Ancillary Staff**

This range of staff includes all non-clinical patient support staff, such as maintenance, clerical staff, Central Sterile Services Department, domestic and catering staff. Resuscitation training should meet the relevant competencies outlined in The Health and Safety (First-Aid) Regulations (1981). However, it is acknowledged that in some clinical areas administrative and clerical staff may initially be the only other person available to assist in the resuscitation attempt. Therefore, for these staff it is recommended that BLS be taught at the discretion of the Ward/Clinical area manager.

### **6.9. New Staff**

Attendance at Corporate Induction is mandatory to ensure that all newly appointed staff receive mandatory training as appropriate for their role. This includes BLS for all new clinical staff. Please also refer to the Royal Cornwall Hospitals NHS Trust Policy 'Management of Corporate and Local Induction' (2017).

### **6.10. Locums and Kernowflex workers**

Locums and Kernowflex staff should be as competent as the replacement role they are providing cover for and attend the local induction. Therefore, BLS is the minimum requirement.

### **6.11. The Adult Cardiac Arrest Team**

6.11.1. All members of the Adult Cardiac Arrest Team should hold as a minimum a current ILS certificate. The Team Leader and at least one other member of the cardiac arrest team should have a current ALS certificate.

6.11.2. The Cardiac Arrest Team should be summoned to all suspected cardiac arrests by dialling '2222' stating, for example, "Cardiac Arrest, Roskear Ward, 1st Floor, Trelawney Wing". All members of the cardiac arrest team will carry 'emergency bleeps'. These bleeps will be alerted simultaneously by the switchboard operator via a speech channel. This speech channel will be tested each day to ensure the system and individual bleeps are in working order.

6.11.3. The Cardiac Arrest Team will attend all 2222 calls to all areas in and around the Trust. Some outlying areas within the geographical constraints of the site represent areas of special risk and are deliberately excluded from the area of cover. These include areas which would require the team to cross roads or enter hazardous areas, such as the Estates maintenance complex. A diagrammatical area of the exact limits of team attendance is in [Appendix 4](#). For areas outside, staff should be aware that they summon help via the 999 Ambulance system.

6.11.4. The RCHT Cardiac Arrest Team:

- Medical SpR – Team Leader.
- ICU Speciality Trainee/Core Trainee/F2 – Airway management (advanced airway support available via 4444 Bleep Senior Anaesthetic Trainee).
- Medical Core CCU Trainee/F2 – Manual defibrillation.
- Medical F1 – Peripheral intravenous access and drug delivery.
- Two ward nurses – Automated defibrillation, basic airway management, airway assist, drug delivery, chest compressions, equipment preparation and documentation.
- Critical Care Outreach practitioner – Assist with airway management.
- Resuscitation Training Officer – Supervisory, educational, and supportive role and if the clinical situation dictates, lead the team (within working hours).
- Hospital at night (within working hours) – to support the team as needed.

6.11.5. The West Cornwall Hospital Cardiac Arrest Team:

**09.00 hours-22.00 hours**

- Urgent Treatment Centre Doctor/ST2 (ED Middle Grade/GP) – Team Leader.
- Urgent Treatment Centre Nurse/Medical ST1/2 –Airway management.
- Ward Nurse – Cardiac monitoring and defibrillation.

- Ward Nurse - Peripheral intravenous access and drug delivery.
- Ward Nurses – Automated defibrillation, basic airway management, airway assistance, drug delivery, chest compressions, equipment preparation and documentation.

**22.00 hours-09.00 hours**

- Medical ST1/2– Team Leader.
- Ward Nurse / Urgent Treatment Nurse Centre – Airway management.
- Ward Nurse – Cardiac monitoring and defibrillation.
- Ward Nurse – Automated defibrillation, basic airway management, airway assistance, drug delivery, chest compressions, equipment preparation and documentation.

6.11.6. The St. Michael’s Hospital Cardiac Arrest Team:

**09.00 hours-21.00 hours**

- RMO – Team Leader.
- Higher Level Care Medic/ Ward Nurse - Airway management.
- Ward Nurse – Peripheral intravenous access and drug delivery.
- Ward Nurse – Automated external defibrillation, basic airway management, airway assistance, drug delivery, chest compressions, equipment preparation and documentation.
- The Duty Floor Anaesthetist will also attend if they are on site and available.

**21.00 hours-09.00 hours**

- RMO – Team Leader.
- Ward Nurse – Airway management.
- Ward Nurse – Cardiac monitoring and defibrillation.
- Ward Nurse – Airway assistance. Drug delivery. Chest compressions, equipment preparation and documentation.

6.11.7. Individual cardiac arrest situations may dictate that roles are shared within the Cardiac Arrest Team.

## 6.12. Responsibilities of the Adult Cardiac Arrest Team

- 6.12.1. Core personnel of the Adult Cardiac Arrest Team are responsible for ensuring that they are familiar with the emergency equipment available and how to use any piece of the equipment relevant to their role. All members of the team are expected to be familiar with the contents of the standardised cardiac arrest trolley.
- 6.12.2. All team members must attend the 9am and 9pm daily Cardiac Arrest Team meetings. Baton arrest bleeps are handed over, teams introduce themselves, roles are allocated, and any skills deficiencies can be identified.
- 6.12.3. All team members must respond to the daily test by ringing switchboard (this call may be delegated). If a test call has not been received by the time of the 9 am cardiac arrest team meeting, then it is the responsibility of the bleep holder to recognise this and take appropriate steps to check their bleep is working and call switchboard. If there is no response to the test, bleep holders will be tested a second time and failure to respond will be investigated by the Resuscitation Training Officers.
- 6.12.4. All team members must attend any call they receive with all possible haste while maintaining their own and others' safety. Once they arrive, they should make themselves known to the Team Leader and only leave with the Team Leader's agreement.
- 6.12.5. The Team Leader has a specific role directing the resuscitation attempt and ensuring it continues in a co-ordinated manner. This person is responsible for patient assessment throughout, ensuring that adequate BLS is being performed and that defibrillation is delivered swiftly when indicated.
- 6.12.6. If the resuscitation is successful, it is the Team Leader's responsibility to communicate with those responsible for the further care of the patient. It is the Team Leader's responsibility to make the final decision to stop the resuscitation attempt. Ideally this should be done after discussion with all the members of the team and may include the relatives where appropriate. In all cases, Team Leaders should feel able to call for a senior opinion, particularly with a decision to cease resuscitation efforts. High-quality CPR must be continued until all discussions have been completed about the appropriateness of ceasing resuscitation.
- 6.12.7. It is the Team Leader's responsibility to ensure that all the necessary documentation is completed as soon as possible after the resuscitation attempt, including the cardiac arrest event form. The ITU doctor is then responsible for ensuring the carbon copy of the event form is brought back to ITU and left in the red resuscitation folder for collection by the Resuscitation Team (the original form forms part of the patient's notes).

- 6.12.8. In the event of a 'false alarm', it is the responsibility of the Team Leader to assess the patient using an A-E structured approach as recommended by the Resuscitation Council (UK).
- 6.12.9. For deceased patients, the ward team are responsible for verification and confirmation of death, and for informing the next of kin.
- 6.12.10. Where a return of circulation is achieved but the patient is expected to die shortly (and not for escalation), pro-active consideration should be given to End of Life care. This process should follow the Trust End of Life plan (CHA3739 – see red priority actions, and CHA4214). This should include clear communication with the next of kin, and their involvement to establish priorities of care, including symptom assessment and management, and spiritual care where appropriate.

### **6.13. Resuscitation in Trauma, Paediatrics, Newborn and Pregnancy**

Special conditions apply when resuscitating victims of trauma, children, newborns, and pregnant women, both in the aetiology of cardiopulmonary arrest and in the techniques of resuscitation. It is imperative that experienced personnel who are aware of these special needs are present at the resuscitation attempt. The Royal Cornwall Hospitals NHS Trust has specialist teams, namely the 'Trauma Team', the 'Paediatric Emergency Response Team', 'Neonatal Emergency' and the 'Obstetric Emergency' Teams, all of which are contacted directly via switchboard on 2222.

### **6.14. Trauma Team**

- 6.14.1. The Trauma Team should be summoned by dialling '**2222**' stating, for example, "Trauma Team to ED Resus". All members of the team will carry 'emergency bleeps'. These bleeps will be alerted simultaneously by the switchboard operator via a speech channel. This speech channel will be tested weekly to ensure the system and individual bleeps are in working order.
- 6.14.2. At least two members of the Trauma Team should have a current Advanced Trauma Life Support (ATLS) qualification (or equivalent).
- 6.14.3. The RCHT Hospital Trauma Team comprises of:
- ED Consultant/Staff Grade/SpR/Speciality Trainee - Team leader.
  - Trauma Transfer Consultant (TTC) – support team leader, facilitate timely intervention/imaging, support transfer as required.
  - Anaesthetist/ICU/SpR/Speciality Trainee - Advanced airway management.
  - ED F2 – IV access and circulation.
  - General Surgical SpR/Speciality Trainee - Team members.
  - Orthopaedic SpR/ Speciality Trainee - Team members.

- Two ED Nurses - Documentation, drug preparation/ administration.
  - Critical Care Outreach Team (CCOT) Practitioner - Assist in airway management.
- 6.14.4. In the scenario of a patient with a shock index of  $<0.9$ , at the request of a pre-hospital critical care (HEMS) team, or the discretion of the ED consultant, a CODE RED Trauma Response may be requested. In addition to the Hospital Trauma Team response, switchboard will individually contact the on-call consultants for ICU, anaesthesia, interventional radiology, and general, vascular and orthopaedic surgery. These consultants may elect to telephone ED resus or their respective registrars, or attend in person, depending on the circumstances.

## **6.15. Paediatric Emergency Response Team**

- 6.15.1. The Paediatric Emergency Response Team should be summoned by dialling '2222' stating, for example, "Paediatric Emergency response Team to Polkerris Ward, 5th Floor, Tower Block". The term, 'Paediatric Emergency Response Team' must always be requested in full form when contacting switchboard; abbreviating to "PERT" leads to confusion with other non-approved abbreviations i.e., "NERT". All members of the team will carry 'emergency bleeps'. These bleeps will be alerted simultaneously by the switchboard operator via a speech channel. This speech channel will be tested each day to ensure the system and individual bleeps are in working order.
- 6.15.2. At least two members of the Paediatric Emergency Response team should have a current APLS qualification.
- 6.15.3. The RCHT Paediatric Emergency Response Team comprises of:
- Paediatric SpR/ Speciality Trainee - Team leader.
  - Anaesthetist/ICU SpR/Speciality Trainee - Advanced airway management.
  - Paediatric F2 - IV access and circulation.
  - Senior Nurse Child Health- basic airway management, airway assist, drug delivery, chest compressions, equipment preparation and documentation.
  - Critical Care Outreach Practitioner/Resuscitation Officer – Team support.
- 6.15.4. If the patient is managed within the Emergency Department, the team also involves the following staff
- ED Consultant – Team leader.
  - Staff Grade/ SpR/Speciality Trainee – Assist team leader, IV access.

- Two ED Nurses, basic airway management, airway assist, drug delivery, chest compressions, equipment preparation and documentation.
  - Senior Nurse Child health- To support ED Nurses/ family.
- 6.15.5. Within West Cornwall Hospital and St Michaels Hospital there is no dedicated paediatric cardiac arrest team. In the event of a paediatric emergency, the adult Cardiac Arrest Team should be called and 999 dialled for an ambulance to transfer the child to Royal Cornwall Hospital.

## 6.16. Neonatal Team

- 6.16.1. The Neonatal Team should be summoned by dialling '2222' stating, for example, "Neonatal Emergency' to Wheal Rose, PAMW". The abbreviation 'NERT' must not be used. All members of the team will carry 'emergency bleeps'. These bleeps will be alerted simultaneously by the switchboard operator via a speech channel. This speech channel will be tested each day to ensure the system and individual bleeps are in working order.
- 6.16.2. At least 2 members of the team should hold a current NLS (or ARNI) qualification.
- 6.16.3. The RCHT Neonatal Team comprises of:
- Neonatal Registrar.
  - Advanced Neonatal Nurse Practitioner.
  - Neonatal Core Trainee/F2.
  - Neonatal Nurse.
- 6.16.4. Medical and nursing staff working on the Neonatal Intensive Care Unit should hold a current NLS certificate.
- 6.16.5. Medical and Midwifery staff who attend the delivery of newborns must attend the Practical Obstetric Multi Professional Training (PROMPT) course and should hold an NLS certificate.

## 6.17. Obstetric Emergencies

- 6.17.1. The Obstetric Emergency Team should be summoned by dialling '2222' stating, for example, "Obstetric Emergency to Delivery, 1st floor PAMW". All members of the team will carry 'emergency bleeps'. These bleeps will be alerted simultaneously by the switchboard operator via a speech channel. This speech channel will be tested weekly to ensure the system and individual bleeps are in working order.
- 6.17.2. The RCHT obstetric emergency team comprises of:
- Obstetric Anaesthetist.

- Obstetric Registrar.
- Obstetric Core Trainee/ F2.
- Scrub nurse.
- ODP.

6.17.3. Obstetric Recovery Nurse.

## **6.18. Anaesthetic Emergency**

6.18.1. The Anaesthetic Emergency response is activated via switchboard, the caller dialling 4444, and stating the Anaesthetic Emergency response is required, and the exact location. The bleep will be alerted by the switchboard operator via a speech channel. This speech channel will be tested weekly to ensure the system and bleep is in working order.

6.18.2. This baton bleep is carried from 08:00hrs – 20:00hrs by the emergency floor anaesthetist and handed to the night anaesthetic senior resident from 20:00hrs – 08:00hrs.

## **6.19. Non-Clinical Area Alert**

6.19.1. On occasion, staff, patients or visitors may suffer some form of clinical event outside a clinical area e.g., in a carpark or stairwell. Activation of the Cardiac Arrest response may not be appropriate, but equally, assistance of a small group of clinical staff may be required to ensure the safety of the individual concerned.

6.19.2. The Non-Clinical Area response is activated via switchboard, the caller dialling 4444, and stating the Non-Clinical Area response is required, and the exact location.

6.19.3. The response consists of Critical Care Outreach Practitioner, the Medical Registrar, the Resuscitation Officer (if on duty) and portering staff.

6.19.4. Depending on the location of the incident and its nature, additional assistance and equipment may be required. If this is clearly beyond the capability of an on-foot team, a low threshold should be adopted for calling the Ambulance Service and/or Fire and Rescue Service via 999 to provide assistance.

6.19.5. Between 1700-0800 (approximating to hours of darkness year-round), team members will meet at an agreed rendezvous point announced by switchboard, prior to exiting the hospital to attend any calls. This is to ensure the safety of all staff when operating outside the confines of the buildings. High visibility jackets and head torches should be worn as appropriate.

## 6.20. Defibrillation

6.20.1. Manual defibrillation of adult patients in the treatment of ventricular fibrillation (VF) and pulseless ventricular tachycardia (PVT) may be performed by Registered Health Professionals who have been trained and deemed competent, if all the following criteria are fulfilled:

- The patient is confirmed to be in a collapsed state, with no cardiac output, determined by the absence of a major pulse and /or no signs of life.
- They hold a current Resuscitation Council (UK) ALS certificate, or Resuscitation Council (UK) ILS certificate.

6.20.2. Automated/semi-automated defibrillation in adult patients to treat pulseless VT and VF may be performed by Registered Health Professionals who have been trained and deemed competent, if all of the following criteria are fulfilled:

- The patient is confirmed to be in a collapsed state, with no cardiac output, determined by the absence of a major pulse and /or no signs of life.
- They hold a current Resuscitation Council (UK) ALS certificate or Resuscitation Council (UK) ILS certificate or have attended a Trust 'Automated External Defibrillation (AED) session'.

6.20.3. Synchronised cardioversion of adult patients may be performed by nursing staff that have been trained and assessed, if the following criteria are fulfilled:

- It is an elective prescribed treatment for the patient.
- As an emergency treatment for tachyarrhythmia (Resuscitation Council (UK), 2021).
- They hold a current Resuscitation Council (UK) ALS certificate, or they have attended a Trust synchronised cardioversion session.

## 6.21. Resuscitation of the Patient with a Tracheostomy or Laryngectomy

6.21.1. Patients with a tracheostomy or laryngectomy are at increased risk of death or harm if their specific needs are not recognised and catered for by professionals familiar with caring for such individuals. All staff involved in the care of patients with a laryngectomy or tracheostomy should be appropriately trained. Patients should be cared for in areas with appropriately trained staff in attendance throughout their stay. Tracheostomy routine care trolleys and Tracheostomy emergency boxes must be immediately available, and appropriate tracheostomy/laryngectomy information signage placed at the bedside of the patient for immediate access by staff using the National Tracheostomy Safety project posters.

6.21.2. Please refer to the [RCHT Care of the Adult patient with a Tracheostomy Policy 2021](#).

## **6.22. Thrombolysis for Suspected PE during Adult Cardiac Arrest**

A laminated, two-sided algorithm for guidance is available in the documentation (top) drawer of all standardised resuscitation trolleys throughout RCHT. This details the treatment options and drug doses. It also lists areas that stock thrombolysis drugs and the location of the Autopulse devices which can provide mechanical chest compressions.

## **6.23. Resuscitation Equipment**

6.23.1. Emergency equipment must be available in all clinical areas of the hospital. The majority of these areas will have a dedicated cardiac arrest trolley which should be sealed with a unique numbered tag and contains standardised equipment. The equipment trolley contents list for checking purposes will be kept on each trolley (copies can be found on the Resuscitation intranet website). An electronic checking system is likely to be introduced before the next revision of this document. Checking via this system will be via an online portal available through any Trust computer, or via a dedicated iPad in each clinical area.

6.23.2. The Resuscitation Committee determines the contents of the standardised emergency equipment sets. There are four types of equipment set available within the Trust, as determined by the Committee. The requirements of any given area will depend on geographical location on the site, clinical activity undertaken, and ages of patients typically cared for in these areas. The RTOs are responsible for agreeing with Ward/Department Managers which equipment set is appropriate in each case. The four equipment sets are:

- Full adult cardiac arrest trolley.
- Full combined paediatric/adult trolley.
- Adult “plus” trolley.
- Resuscitation grab bag.

6.23.3. In a few patient areas where a dedicated cardiac arrest trolley is not required, basic emergency equipment should be available for staff to use until further help arrives. The list of equipment to be stocked and checked must be agreed with the RTOs.

6.23.4. Portable oxygen and suction devices should always be available on all resuscitation trolleys. Where piped or wall oxygen and suction are available, these should be used in preference.

- 6.23.5. Defibrillators are available on most (but not all) cardiac arrest trollies. The RTOs are responsible for deciding the location and type (manual and/or automated) of defibrillator if required. Defibrillators with external pacing are located strategically, (both in terms of need and accessibility) i.e. Coronary Care, Emergency Department, Critical Care Unit, Cath Lab, Tower block etc.
- 6.23.6. The resuscitation trolley, defibrillator, oxygen and suction equipment must be kept clean and free from dust.
- 6.23.7. Every seven days since the last full check or after use, all cardiac arrest equipment should be checked against the standardised checklist and the trolley resealed. Daily, this seal number must be checked along with defibrillator, oxygen and LSU daily checks. It is the responsibility of the department manager to ensure that a trained member of staff carries out these checks and signs the 'Resuscitation Trolley: Daily Check Record' (Appendix 5). These books are updated, published and distributed annually by the Resuscitation Team.
- 6.23.8. There is a spare adult cardiac arrest trolley, suction unit and defibrillator available to loan out of hours from the Clinical Site Co-ordinators. This is for use in situations where another trolley has been exhausted in a resuscitation attempt while the original trolley is restocked, where there is a device failure e.g., defibrillator fault, or to manage an acute surge e.g., major incident. It must not be used to facilitate planned opening of new clinical areas; new equipment should be ordered as part of the planning process to open the new area.
- 6.23.9. After use, staff must ensure that all items are either safely disposed of or cleaned as per the instructions on the equipment trolley checklist.
- 6.23.10. All items for both adult and paediatric trollies (except for defibrillator batteries which are kept in Medical Physics) are available either via ward stock or from the Inventory Management Store (IMS). This is located in the basement of the Tower Block and is accessible out of hours for equipment to restock the clinical areas. A list of the equipment available from the IMS should be found in the top drawer of the cardiac arrest trolley or via the Resuscitation intranet website.
- 6.23.11. Please also refer to the Royal Cornwall Hospitals NHS Trust Policy 'Medical Device and Equipment Management Policy' (2023).
- 6.23.12. Additional, specialised equipment is brought to every cardiac arrest by the ICU bleep holder. This includes, amongst other things, intubation and surgical airway equipment, pericardiocentesis equipment, and intra-osseous access equipment. This is checked and maintained by the Critical Care Outreach Team.
- 6.23.13. Equipment for emergency surgical procedures can be located in Trelawney emergency theatre (Theatre 7), Obstetric theatre (hysterotomy equipment), or ED resus (hysterotomy and thoracotomy equipment). Those areas are responsible for maintaining that equipment and ensuring it is easily accessible when called for.

- 6.23.14. An algorithm for managing cardiac arrest with pulmonary embolus is attached as Appendix 6. This includes locations from which thrombolytic therapy (Alteplase) can be sourced. For this and other cardiac arrest scenarios (e.g. some toxicological cardiac arrests) where CPR efforts should be extended, the Autopulse mechanical CPR device should be obtained from the cardiac cath lab (CCU staff can provide access to this if the lab is not staffed at the time) or ED resus.

## **6.24. Procurement**

All resuscitation equipment purchased should be subject to the Trust's standardisation strategy. There is an approved purchase list for resuscitation equipment. Any items not on this list but proposed for purchase should be discussed with the RTOs prior to ordering. The RTOs should generally seek input from the Resuscitation Committee or the Committee Chair before sanctioning procurement of off-list items. As appropriate, a one-off procurement may be recommended, an addition made to the approved purchase list, or else an alternative proposed.

## **6.25. Critical Care Outreach Service**

- 6.25.1. The Critical Care Outreach Team (CCOT) are available seven days a week and can be contacted by bleep or via switchboard.
- 6.25.2. The Trust uses situation-appropriate physiological early warning systems: the National early warning scoring system (NEWS2) for adults, the modified early obstetric warning scoring system (MEOWS) for obstetric patients and the paediatric early warning scoring system (PEWS) for children. These have been adopted in all clinical areas for the recognition of the deteriorating patient and prevention of cardiopulmonary arrest. All clinical staff should be trained in the identification of critically ill patients and the use of physiological observation charts (E-obs) to enhance decision making and care escalation. Appropriate EWS triggers exist which automatically flag a deteriorating patient to the attention of CCOT, but staff should feel empowered to contact the team before that threshold is met if they judge it appropriate.
- 6.25.3. Opinions on a patient's suitability or requirement for admission to the High Dependency Unit or Intensive Care Unit must be directed to the Senior Anaesthetic Trainee (Bleep 3513) or direct to the duty ICU consultant. This should typically follow registrar-level review by the team responsible for the patient's care where time allows. Providing opinions of this nature are not within the remit of CCOT.
- 6.25.4. Further to 6.23.3, decisions regarding escalation and DNACPR status for a patient are not within the remit of CCOT. These decisions must be made by the senior members of the medical team responsible for the patient's care, in line with Trust policy on TEP. Where an opinion regarding escalation to HDU/ICU is required as part of that process, it should be sought by consultant-to-consultant discussion with the duty ICU consultant.

6.25.5. Please refer to the following documents:

- Royal Cornwall Hospitals NHS Trust '[Policy For Recording Physiological Observations and NEWS2 in Adults](#)'.
- Royal Cornwall Hospitals NHS Trust '[Patient Observation and Monitoring Paediatric Policy](#)'.
- Royal Cornwall Hospitals NHS Trust '[Maternity Early Warning Score \(MEWS\) in Detecting the Seriously Ill and Deteriorating Woman Clinical Guideline](#)'.
- Royal Cornwall Hospitals [Treatment Escalation Plan and Resuscitation Decision Record / Allow Natural Death Policy \(In relation to adult patients over 18 years\)](#).
- NHS Trust '[Escalation and Non Clinical Management of Critically Ill Children Clinical Guideline](#)'.

## 6.26. Patient Transfer and Post-Resuscitation Care

- 6.26.1. The immediate post-resuscitation phase is often characterised by a stepwise increase in the patient's requirement for invasive support and monitoring. Most patients require either admission to Coronary Care or Intensive Care and it will then become necessary to undertake an intra-hospital transfer of what is likely to be a critically-unwell and unstable patient.
- 6.26.2. It is the responsibility of the Team Leader at the resuscitation to ensure that appropriately skilled staff are available to facilitate the transfer (this may be devolved to the ICU clinician attending the resuscitation). The Team Leader remains responsible for a comprehensive handover of the patient to a senior clinician (typically an ICU registrar or consultant, or a consultant cardiologist). This process may occur at the bedside e.g., if the patient is going to the cath lab or CT scan. However, where a patient is going directly to ICU or CCU a handover from the Team Leader and nurse looking after the patient, to the receiving senior medical staff and nurse in CCU/ICU should be undertaken. This should take the form of a single, joint-handover, rather than as two parallel nursing and medical discussions.
- 6.26.3. The RTOs and CCOT Lead are jointly responsible for ensuring there are appropriate emergency/transfer equipment caches maintained strategically around the site. The CCOT team are responsible for requisitioning drugs as required to support safe transfer.
- 6.26.4. A patient being transferred should be accompanied by a doctor and an appropriately trained nurse. Relatives should be informed of the transfer.
- 6.26.5. For deceased patients, the ward team are responsible for undertaking the process of confirmation of death. Both tasks should follow as soon as is reasonably possible following cessation of resuscitation attempts.

- 6.26.6. For patients who have a Do Not Resuscitate decision documented and who are discovered in a state of cardiac arrest, it is preferable to await formal confirmation of death by a competent clinician before advising the next of kin. If confirmation is unavoidably delayed due to other clinical pressures, it may be necessary to advise the next of kin in the interim. In this situation, a senior member of the nursing team should usually undertake the communication where possible.
- 6.26.7. Where a patient is expected to die shortly following a resuscitation attempt, the ward should commence the standard End of life care planning supported by the trust End of life care plan ([CHA3739](#) – see red priority actions, and [CHA4214](#)). This should include clear communication and involvement of the patient’s next of kin to establish priorities of care, including symptom assessment and management, and spiritual care.
- 6.26.8. All the staff involved in a resuscitation attempt must be given the opportunity to debrief. This will usually be facilitated by the RTO (if present) and/or Team Leader. For particularly challenging circumstances, a low threshold should be adopted for contacting a consultant, if not already present, to facilitate this process.
- 6.26.9. Please refer to the following document:

RCHT ‘Safe Transfer of Patients Between Care Areas or Hospitals Policy’ internally, between sites and out of the Trust

## **6.27. Post Resuscitation Documentation and Reporting Arrangements**

- 6.27.1. Accurate data from all resuscitation attempts must be kept, for audit, training, and medico-legal purposes. During resuscitation, one team member should document events. The Team Leader should ensure that an accurate record of the resuscitation attempt has been recorded on the cardiac arrest event form. The original copy forms part of the patient’s notes and the carbon copy can be taken back to Critical Care by the Critical Care doctor, where it is collected by a member of the Resuscitation Team for local and national audit purposes.
- 6.27.2. It is essential that any issues noted in the course of the resuscitation attempt e.g., delays, equipment issues, team member absence, etc are recorded on the arrest event form and a Datix is completed.

## **6.28. Manual Handling**

In situations where the collapsed patient is on the floor, in a chair or in a confined space, the Trust guidelines for the movement of the patient must be followed to minimise the risks of manual handling related injuries to both the rescuer and the patient. Please also refer to the Resuscitation Council UK (2020) Guidance for safer handling during cardiopulmonary resuscitation in hospital settings.

## 6.29. Decisions Relating to Cardiopulmonary Resuscitation

It is essential to identify patients where it is inappropriate to attempt resuscitation or where a patient is refusing or has refused resuscitation in advance. For further information please refer to Royal Cornwall Hospitals [Treatment Escalation Plan and Resuscitation Decision Record / Allow Natural Death Policy \(In relation to adult patients over 18 years\)](#) and NHS Trust [Escalation and Non Clinical Management of Critically Ill Children Clinical Guideline](#).

## 6.30. Relatives Witnessing Resuscitation

The Trust support relatives should they wish to be present during a resuscitation attempt. There will be occasions where the cardiac arrest Team Leader deems it inappropriate for relatives to be present. The overall decision remains with the cardiac arrest Team Leader, and the decision, either way, should be documented in the cardiac arrest record. Wherever possible, a member of staff should be delegated to stay with the relatives and liaise with the Cardiac Arrest Team on their behalf.

## 7. Dissemination and Implementation

- 7.1. This policy document will be held in the public section of the Documents Library with unrestricted access, replacing the previous version which will be archived in accordance with the Trust information Lifecycle and Corporate Records Management Policy.
- 7.2. Staff will be alerted to changes from previous versions using established communication channels to distribute information.
- 7.3. This guidance will be held on the Documents Library on the Trust.

## 8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Daily/weekly resuscitation trolley and equipment checks.
Lead	Ward/Department managers.
Tool	A standardised daily record check book for every resuscitation trolley (see Appendix 5).
Frequency	Ongoing monitoring.
Reporting arrangements	Ward managers will report back to their staff and highlight any ongoing issues to their clinical line managers.
Acting on recommendations and Lead(s)	Care Group "Triumvirates" are responsible for designating a named lead where appropriate to action recommendations.

<b>Information Category</b>	<b>Detail of process and methodology for monitoring compliance</b>
<b>Change in practice and lessons to be shared</b>	The Resuscitation Officers to take any necessary changes to practice forward where appropriate. Lessons will be shared with all the relevant stakeholders.
<b>Element to be monitored</b>	<b>Equipment availability in all clinical areas.</b>
<b>Lead</b>	Resuscitation Officers
<b>Tool</b>	Annual cardiac arrest trolley audit carried out by the resuscitation officers.
<b>Frequency</b>	Annual
<b>Reporting arrangements</b>	Will be reported to the ward managers, matrons and Resuscitation Committee. All reports presented and discussed by the Resuscitation committee are minuted. Proceedings of the Resuscitation committee are fed via exception report to the Clinical Effectiveness Group. Matters requiring more urgent response are fed directly to the Chief Medical Officer (or their deputy) by the Chair of the Committee.
<b>Acting on recommendations and Lead(s)</b>	Care Group "Triumvirates" are responsible for designating a named lead where appropriate to action recommendations.
<b>Change in practice and lessons to be shared</b>	The Resuscitation Officers to take any necessary changes to practice forward where appropriate. Lessons will be shared with all the relevant stakeholders.
<b>Element to be monitored</b>	<b>All cardiac arrest calls within the Trust.</b>
<b>Lead</b>	Resuscitation officers
<b>Tool</b>	Cardiac arrest event form and National Cardiac Arrest Audit.
<b>Frequency</b>	Ongoing collection of cardiac arrest event forms.
<b>Reporting arrangements</b>	Will be reported back to the Resuscitation Committee. All reports presented and discussed by the Resuscitation committee are minuted. Proceedings of the Resuscitation committee are fed via exception report to the Clinical Effectiveness Group. Matters requiring more urgent response are fed directly to the Chief Medical Officer (or their deputy) by the Chair of the Committee.
<b>Acting on recommendations and Lead(s)</b>	Care Group "Triumvirates" are responsible for designating a named lead where appropriate to action recommendations.
<b>Change in practice and lessons to be shared</b>	The Resuscitation Officers to take any necessary changes to practice forward where appropriate. Lessons will be shared with all the relevant stakeholders.

<b>Information Category</b>	<b>Detail of process and methodology for monitoring compliance</b>
<b>Element to be monitored</b>	<b>All incidents involving Resuscitation and Resuscitation equipment.</b>
<b>Lead</b>	Resuscitation Officers
<b>Tool</b>	Datix, the electronic system used for reporting incidents/non-compliance.
<b>Frequency</b>	Whenever an alert occurs
<b>Reporting arrangements</b>	Will be reported back to the Resuscitation Committee. All reports presented and discussed by the Resuscitation committee are minuted. Proceedings of the Resuscitation committee are fed via exception report to the Clinical Effectiveness Group. Matters requiring more urgent response are fed directly to the Chief Medical Officer (or their deputy) by the Chair of the Committee.
<b>Acting on recommendations and Lead(s)</b>	Care Group "Triumvirates" are responsible for designating a named lead where appropriate to action recommendations.
<b>Change in practice and lessons to be shared</b>	The Resuscitation Officers to take any necessary changes to practice forward where appropriate. Lessons will be shared with all the relevant stakeholders.

## 9. Updating and Review

- 9.1. The document review process is managed via the document library. Document review will be every three years unless best practice dictates otherwise. The author remains responsible for the policy document review. Should they no longer work in the organisation or in the relevant practice area then an appropriate practitioner will be nominated to undertake the document review by the designed director.
- 9.2. Revision activity will be recorded in the versions control table to ensure robust document control measures are maintained.

## 10. Equality and Diversity

- 10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).
- 10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

## Appendix 1. Governance Information

Information Category	Detailed Information
<b>Document Title:</b>	Cardiopulmonary Resuscitation Policy V6.2
<b>This document replaces (exact title of previous version):</b>	Cardiopulmonary resuscitation Policy V6.1
<b>Date Issued / Approved:</b>	November 2025
<b>Date Valid From:</b>	December 2025
<b>Date Valid To:</b>	October 2026
<b>Author / Owner:</b>	Ella Leuzzi, Resuscitation Officer. Resuscitation Department, Postgraduate Education Centre.
<b>Contact details:</b>	01872 252124
<b>Brief summary of contents:</b>	Guidance for staff regarding all aspects of in-hospital Cardiopulmonary resuscitation, including roles and responsibilities, training and equipment.
<b>Suggested Keywords:</b>	Resuscitation, cardiopulmonary.
<b>Target Audience:</b>	<b>RCHT:</b> Yes <b>CFT:</b> No <b>CIOS ICB:</b> No
<b>Executive Director responsible for Policy:</b>	Chief Medical Officer
<b>Approval route for consultation and ratification:</b>	Resuscitation Committee
<b>Manager confirming approval processes:</b>	Doug Riley
<b>Name of Governance Lead confirming consultation and ratification:</b>	Suzanne Barber
<b>Links to key external standards:</b>	Care Quality Commission
<b>Related Documents:</b>	First aid at work: Approved code of practice and guidance, The Health and Safety (First-Aid) Regulations (1981). Health and Safety Commission. Resuscitation Council UK (2021) 'Guidance for safer handling during resuscitation in healthcare settings.' Resuscitation Council UK (2013) Quality Standards

Information Category	Detailed Information
	<p>for Cardiopulmonary Resuscitation Practice and Training.</p> <p>Resuscitation Council UK (2021) Resuscitation Guidelines.</p> <p>Resuscitation policy. Health Services Circular (HSC) 2000/028. (2000) London. Department of Health.</p> <p>Royal Cornwall Hospitals NHS Trust 'Clinical Guideline for the use of Modified Early Obstetric Warning Score (MEOWS) in Detecting the Seriously Ill and Deteriorating Woman' (2021).</p> <p>Royal Cornwall Hospitals NHS Trust's 'Mandatory and Statutory Training Policy' (2017).</p> <p>Royal Cornwall Hospitals NHS Trust Policy 'Management of Corporate and Local Induction Policy' (2017).</p> <p>Royal Cornwall Hospitals NHS Trust 'Policy for the Physiological Observations and NEWS2 in Adults' (2022).</p> <p>Royal Cornwall Hospitals NHS Trust 'Patient Observation and Monitoring Child Health Policy' (2021).</p> <p>Royal Cornwall Hospitals NHS Trust Policy 'Medical Devices Training Policy' (2023).</p> <p>Royal Cornwall Hospitals NHS Trust.</p> <p>Clinical policy for safe transfer of patients between care areas or between hospitals' (2023).</p> <p>Royal Cornwall Hospitals NHS Trust Care of the Adult patient with a Tracheostomy Policy (2020).</p> <p>Royal Cornwall Hospitals NHS Trust Policy 'Treatment Escalation Plan (T.E.P) and Resuscitation Decision Record (2018).</p> <p>Royal Cornwall Hospitals NHS Trust Policy Treatment Escalation Plan (T.E.P) and Resuscitation Decision Record: Children under 16 years (2023).</p>
<b>Training Need Identified:</b>	Care Quality Commission
<b>Publication Location (refer to Policy on Policies – Approvals and Ratification):</b>	Internet and Intranet
<b>Document Library Folder/Sub Folder:</b>	Clinical / Critical Care and Resuscitation

## Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
June 2009	V1.0	Original document produced	Ella Leuzzi, Resuscitation Officer
June 2009	V2.0	Full review of document and changes made to content.	Ella Leuzzi, Resuscitation Officer
June 2012	V3.0	Full document review. Changes made to wording, new appendices.	Ella Leuzzi, Gemma Ashton-Cleary, Jay Over, Resuscitation Officers
November 2012	V3.1	Review of West Cornwall Hospital Cardiac Arrest Team	Gemma Ashton-Cleary, Resuscitation Officer
June 2015	V4.0	Full review of document and changes made to content	Ella Leuzzi , Resuscitation Officer
January 2016	V4.1	Minor additions to the role of the cardiac arrest team	Ella Leuzzi , Resuscitation Officer
January 2018	V4.2	Minor additions to the roles of the cardiac arrest team and emergency teams, updating of policy references	Ella Leuzzi , Resuscitation Officer
February 2020	V5.0	Thrombolysis algorithm added	Ella Leuzzi , Resuscitation Officer
September 2023	V6.0	Full review of document and changes made to content. Transposed onto latest Trust template.	Dr David Ashton-Cleary, Chair of Resuscitation Committee, and Ella Leuzzi, Gemma Ashton-Cleary, Resuscitation Officers
November 2024	V6.1	Minor amendments to terminology and formatting	Dr David Ashton-Cleary, Chair of Resuscitation Committee
April 2025	V6.2	Minor amendments to non-clinical area alert and addition of anaesthetic emergency response	Ella Leuzzi, Resuscitation Officer

**All or part of this document can be released under the Freedom of Information Act 2000.**

**All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.**

**This document is only valid on the day of printing.**

**Controlled Document.**

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

## Appendix 2. Equality Impact Assessment

### Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team  
[rcht.inclusion@nhs.net](mailto:rcht.inclusion@nhs.net)

Information Category	Detailed Information
<b>Name of the strategy / policy / proposal / service function to be assessed:</b>	Cardiopulmonary Resuscitation Policy V6.2
<b>Department and Service Area:</b>	Critical Care and Resuscitation
<b>Is this a new or existing document?</b>	Existing
<b>Name of individual completing EIA</b> (Should be completed by an individual with a good understanding of the Service/Policy):	Ella Leuzzi, Resuscitation Officers
<b>Contact details:</b>	01872 252124

Information Category	Detailed Information
<b>1. Policy Aim - Who is the Policy aimed at?</b> (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide guidance for the planning and implementation of a robust, high- quality resuscitation service to the organisation.
<b>2. Policy Objectives</b>	To ensure that all clinical staff are fully competent in CPR skills appropriate to their role. To ensure that all clinical areas have fully stocked, working and in date resuscitation equipment available.
<b>3. Policy Intended Outcomes</b>	Effective management of all patients in the event of a cardiopulmonary or respiratory arrest occurring.
<b>4. How will you measure each outcome?</b>	Audit of every arrest call. Annual Trolley Audit.
<b>5. Who is intended to benefit from the policy?</b>	All Patients. Clinical Staff.

Information Category	Detailed Information
<b>6a. Who did you consult with?</b> (Please select Yes or No for each category)	<ul style="list-style-type: none"> <li>• Workforce: Yes</li> <li>• Patients/ visitors: No</li> <li>• Local groups/ system partners: No</li> <li>• External organisations: No</li> <li>• Other: No</li> </ul>
<b>6c. What was the outcome of the consultation?</b>	Agreed.
<b>6d. Have you used any of the following to assist your assessment?</b>	<b>National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:</b> No.

## 7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
<b>Age</b>	No	
<b>Sex</b> (male or female)	No	
<b>Gender reassignment</b> (Transgender, non-binary, gender fluid etc.)	No	
<b>Race</b>	No	
<b>Disability</b> (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
<b>Religion or belief</b>	No	
<b>Marriage and civil partnership</b>	No	
<b>Pregnancy and maternity</b>	No	

Protected Characteristic	(Yes or No)	Rationale
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

**A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.**

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Ella Leuzzi, Resuscitation Officers.

**If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:**  
[Section 2. Full Equality Analysis](#)

## Appendix 3. Basic Life Support Course Content

Staff are trained to act in the immediate resuscitation of a patient, including the use of oxygen, pocket mask or bag valve mask and suction. As such they should be competent in the management of Airway, Breathing and Circulation until the arrival of the hospital Cardiac Arrest Team. This training must be updated annually.

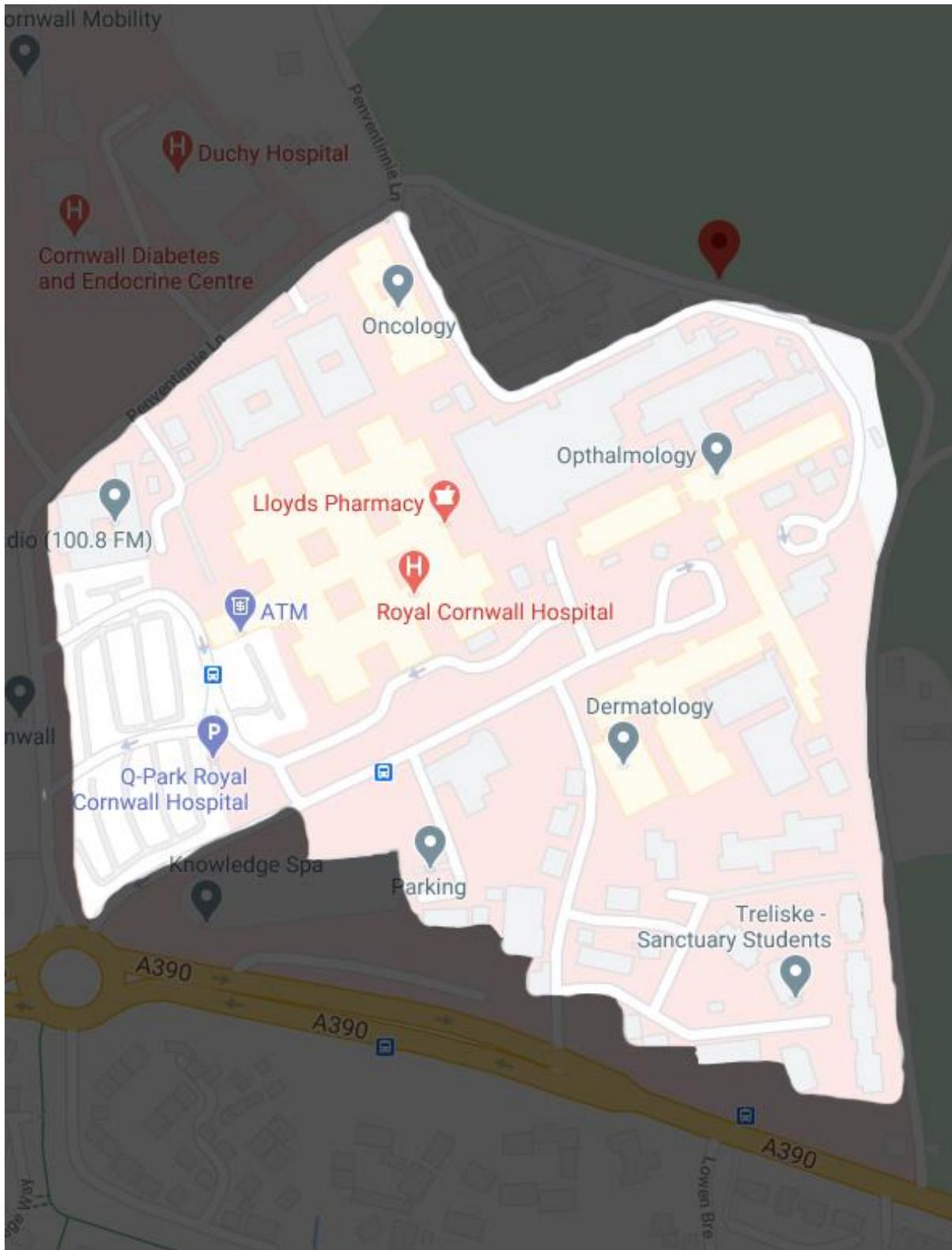
### Basic Life Support and associated CORE skills:-

- Chain of survival (inc. brief overview of NEWS2/PEWS/MEOWS).
- In-hospital BLS.
- Airway opening manoeuvres (head tilt/chin lift).
- Choking manoeuvres.
- Recovery position.
- Basic airway management, inc. use of 2-person bag-valve-mask technique.
- Calling the Adult Cardiac Arrest Team.
- Equipment:-
  - Position of Cardiac Arrest Trolley.
  - Contents of Cardiac Arrest Trolley.
- Other Issues :-
  - Cardiac Arrest Audit.
  - CPR and TEP policies.

### Role Specific skills:-

- Placement of defibrillator pads.
- Use of pharyngeal airways.
- Jaw thrust technique.
- Checking of trolley, oxygen and suction.
- Cardiac arrest drugs.

## Appendix 4: 2222 RCHT response boundary



## Appendix 5. Resuscitation Trolley – Daily Check Record



Royal Cornwall Hospitals  
NHS Trust

# Resuscitation Trolley: Daily Check Record

Ward/Department:

**YYYY**

## Crash Trolley and Emergency Equipment Daily Checklist

DAILY Checks Week Commencing		26/01/21	02/02/21	09/02/21	16/02/21	23/02/21
Day	Item	Signature	Signature	Signature	Signature	Signature
Monday	Crash trolley external check					
	Ensure seal number is correct (sign)					
	Defibrillator					
	Portable suction and oxygen					
Tuesday	Crash trolley external check					
	Ensure seal number is correct (sign)					
	Defibrillator					
	Portable suction and oxygen					
Wednesday	Crash trolley external check					
	Ensure seal number is correct (sign)					
	Defibrillator					
	Portable suction and oxygen					
Thursday	Crash trolley external check					
	Ensure seal number is correct (sign)					
	Defibrillator					
	Portable suction and oxygen					

<b>DAILY Checks Week Commencing</b>		26/01/21	02/02/21	09/02/21	16/02/21	23/02/21
<b>Day</b>	<b>Item</b>	<b>Signature</b>	<b>Signature</b>	<b>Signature</b>	<b>Signature</b>	<b>Signature</b>
Friday	Crash trolley external check					
	Ensure seal number is correct (sign)					
	Defibrillator					
	Portable suction and oxygen					
Saturday	Crash trolley external check					
	Ensure seal number is correct (sign)					
	Defibrillator					
	Portable suction and oxygen					
Sunday	Crash trolley external check					
	Ensure seal number is correct (sign)					
	Defibrillator					
	Portable suction and oxygen					

<b>WEEKLY Crash trolley full contents check</b>	<b>Week Commencing</b> 02/02/21	<b>Week Commencing</b> 09/02/21	<b>Week Commencing</b> 16/02/21	<b>Week Commencing</b> 23/02/21	<b>Week Commencing</b>
<b>Date</b>					
<b>Time</b>					
<b>Seal number</b>					
<b>Signature</b>					

## Specimen Signatures

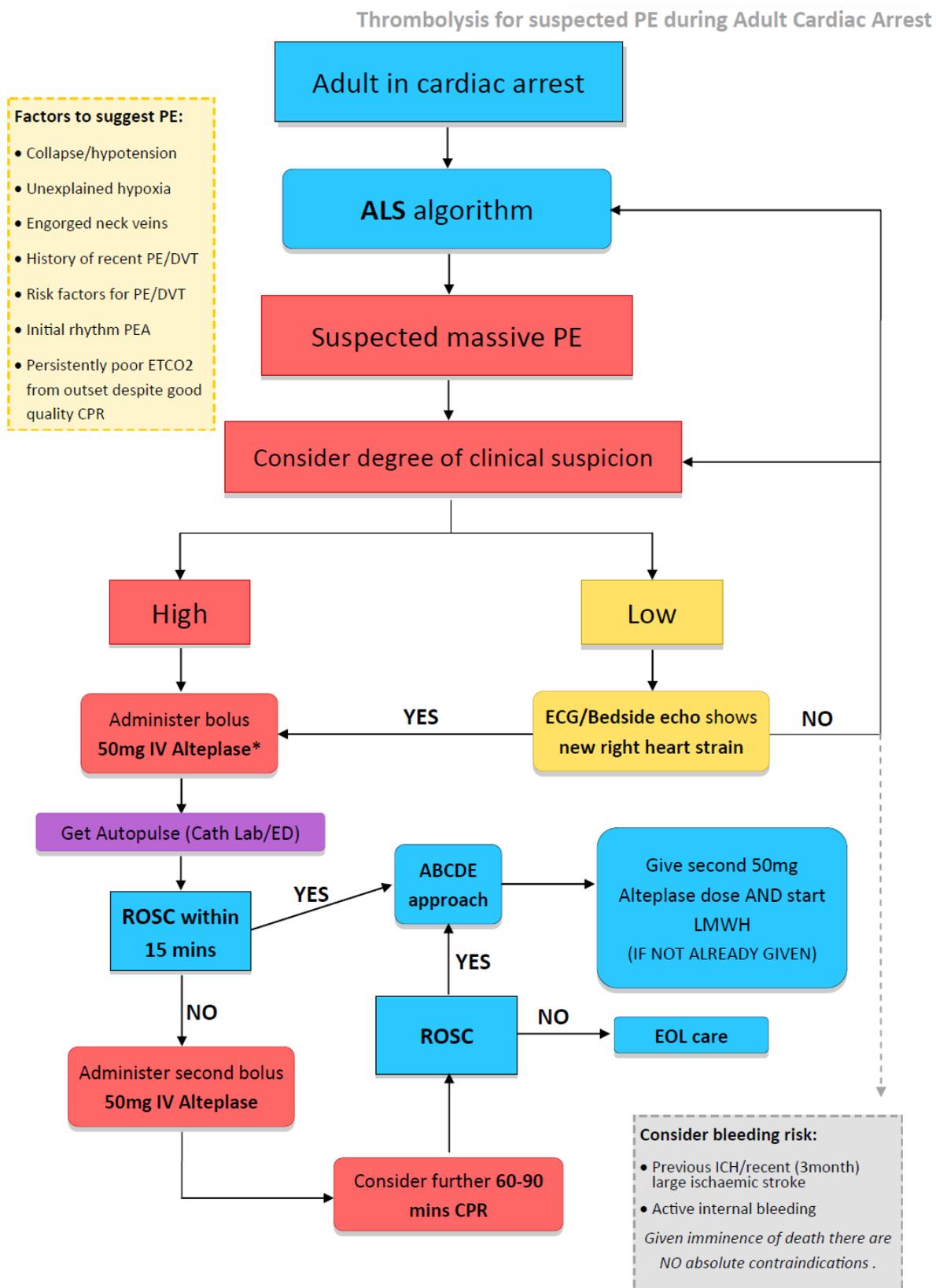
Before signing this please make sure you have read the general points and helpful information at the beginning of this book . Please also ensure you know the correct procedures for checking your defibrillator and suction unit.

Full Name (in capitals)	Initials	Job Title	Signature
E.g. MARGARET BROWN	MB	Staff Nurse	

Please try to ensure that two members of staff do not enter the same initials. Either do not include a middle name or use small.

(The ' Resuscitation Trolley – Daily Check Record' are updated, published and distributed annually by the Resuscitation Team).

# Appendix 6. Thrombolysis for suspected pulmonary embolism in adult cardiac arrest



Alteplase drug, reconstitution and administration details are in the following areas:

- Coronary Care
- Critical Care
- Acute Medical Unit 1&2
- Wellington
- ED Resus & ED Majors
- Eden
- Tower Theatre
- Trelawney Theatre
- St Michaels Hospital - Emergency drug cupboard
- West Cornwall Hospital - Emergency drug cupboard
- RCHT Pharmacy Emergency drug cupboard

Autopulse locations :

Cath Lab 2 anteroom cupboard and ED Resus