Document Control

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Resuscitation Policy			
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Directorate Corporate Nursing		**Department** Resuscitation	
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3.4	Sep 2008	Revision	Final amends to ensure corporate identity requirements
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3.6	Jan 2011	Revision	Amendments following Resuscitation Guideline changes. Approved at the Resuscitation Steering Group December 2010
3.7	Sep 2011	Revision	Harmonised policy as a result of the merging of Northern Devon Healthcare NHS Trust and NHS Devon community services. Following consultation offered for approval at the Resuscitation Steering Group in October 2011. A summary of key issues and differences is on page 3.
4.0	Oct 2011	Final	Approved by the Resuscitation Steering Group in October 2011.
4.1	Jan 2011	Revision	Minor amendments by Corporate Governance for NHSLA requirements to document control report, updating to latest template and formatting for document map navigation. The monitoring and training sections have been strengthened as a result of revised NHSLA requirements. NHSLA audit form added as Appendix E.
4.2	May 2014	Revision	Updated to meet organisational changes
5.0	Oct 2014	Final	Approved by PAR group In September 2014 and published on Bob

5.1	Oct 2017	Revision	
6.0	Feb 2018	Final	Approved by PAR group

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Superseded Documents NDHCT Resuscitation Policy v5.0	

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Consulted with the following stakeholders: (list all)

- Prevention and Resuscitation Group
- Workforce Development

Approval and Review Process

- Prevention and Resuscitation Group

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Resuscitation, All Staff, Nursing	Resuscitate, Resuscitation, CPR, Early Warning Score, TEP

CONTENTS

1. Purpose

1.1. The purpose of this document is to detail the process both for resuscitation and for meeting nationally recognised best practice for training of staff for all emergencies and cardiopulmonary resuscitation.

1.2. The policy applies to all Trust staff and staff from other organisations / trusts, who work within Northern Devon Healthcare Trust buildings.

1.3. Implementation of this policy will ensure that:

1.4. Staff are aware of their responsibilities for resuscitation

2. Definitions

2.1. Treatment Escalation Plan (TEP)

2.2. This is a written and signed order of treatment limitations. This is a Devon Wide document that is initiated by both GP's and Consultants in charge of patient's care. Some Registered nurses may now write these. List of roles to do this is in the appendices

2.3. Outreach and Resuscitation Officer

2.4. A registered individual who is responsible for ensuring resuscitation follows current guidelines. The individual will also work with staff on wards to recognise deterioration and reduce cardiac arrests.

2.5. Adult Cardiac Arrest Team

2.6. This team of qualified individuals responds to all adult emergencies when summoned via the bleep system on the NDHCT acute site. It consists of Medical F1, Medical F2, Anaesthetic Junior, Resuscitation Officer/ Senior on-call Nurse with ALS qualification and a porter.

2.7. Paediatric Cardiac Arrest Team

2.8. This team of qualified individuals responds to all paediatric emergencies when summoned via the bleep system on the NDHCT acute site. It consists of Paediatric Registrar, Paediatric Junior, Anaesthetic Junior Resuscitation Officer/ Senior on-call Nurse and a porter. Consultants in both Anaesthetics and Paediatrics are also called via the switchboard.

2.9. Neonatal Team

2.10. This small team respond to neonatal emergencies in the first instance. They can be summoned via the bleep system on the NDHCT acute site. It consists of one paediatric doctor + /- a SCBU nurse.

2.11. Paediatric

2.12. This refers to all children under the age of 18.

2.13. Newborn

2.14. This refers to a baby who has just or recently been born.

2.15. Medical F1 / F2 / ST1-4 or CT1-4

2.16. This refers to the junior medical staff who area in training.

2.17. Prevention and Resuscitation Steering Group

2.18. This multi-disciplinary team exists to ensure the quality and development of resuscitation practice across the Trust and it will include representation from areas within the trust.

2.19. Resuscitation Council (UK)

2.20. This is the national body whose objective is to facilitate education both of healthcare professionals and lay members of the population in the most effective methods of resuscitation appropriate to their needs. It encourages research into resuscitation, to study resuscitation teaching techniques, to establish appropriate guidelines and to promote the teaching of resuscitation in line with the guidelines.

2.21. The Resuscitation Council also establishes and maintains standards for resuscitation to foster good working relations between all organisations involved in resuscitation while producing and publishing training aids and other literature concerned with the organisation of resuscitation and its teaching.

2.22. **Early Warning Score (EWS)**

2.23. This is a track and trigger system used to recognise patients at risk of a cardio-pulmonary arrest. There are various types used in the trust EWS for adults, MEOWS for maternity, PEWS for paediatrics NEWS for neonates.

2.24. **Automated External Defibrillator (AED)**

2.25. This is a defibrillator which issues clear aural and visual instructions, by using in-built recognition of rhythm, which allow lay people to deliver defibrillation in an emergency situation.

3. Responsibilities

Role of Line Managers

All Line Managers are responsible for:

- Ensuring that staff are aware of this policy
- Ensuring that staff are permitted to attend Resuscitation/ Life Support training
- Ensuring staff are trained appropriately, using the Training Matrix (see Appendix A) for determining the level of skill required for each member of staff, dependent on the individual's responsibilities – clinical or otherwise. The level should be identified on the job description, be evident on the departmental induction programme and training must be checked at annual appraisal.
- Ensuring that equipment is readily available for use in their areas. This will include the resuscitation trolley, any masks to assist in airway management or specialised equipment such as a resuscitaire for use with the newborn. Line Managers will delegate responsibility to ensure that all equipment in their area is checked daily and a record maintained.
- Report any adverse incidents that occur during or in connection with the above on a Trust Incident Reporting Form. This form will then be sent to the Governance Team for processing.

Role of the Prevention and Resuscitation Group

The Prevention and Resuscitation Group is responsible for:

- Overseeing policy and guideline development and reviewing on a regular basis.
- Ratifying any changes to any equipment or procedures for resuscitation.
- Receiving reports on training uptakes.
- Receiving data on all arrests and the investigations that have occurred
- Reviewing aggregated data on resuscitation audit activity.
- Advising on the appropriate resuscitation equipment and practice in line with national standards.
- Identifying Trust-wide and corporate risks.
- Monitoring compliance with National Standards.
- Implementing any audits that the group deem necessary and presenting the data to the group.
- Reviewing and monitoring incident trends relating to the work of the group.
- Ensuring that a replacement main contact is identified should the original author be re-deployed or leave the Trust.

Role of the Workforce Development Department

The Workforce Development Department are responsible for:

- Holding central records for all resuscitation training.
- Ensuring that quarterly reports are sent to the appropriate managers with a copy being sent to the Outreach and Resuscitation Officers.

Role of the Outreach and Resuscitation Officers

The Outreach and Resuscitation Officers are responsible for:

- Ensuring sufficient availability of life support/ resuscitation training programmes and deliver these programs.
- To ensure that only equipment approved by the prevention and resuscitation group is available for use within the trust. This is to ensure consistency and to minimise the level of clinical risk, which arises if a variety of equipment is in use throughout the Trust.
- Auditing the records of daily checks of equipment and sending the results to the line managers and the Prevention and Resuscitation Group.
- Ensuring that the Workforce Development Department receive copies of the attendance records of training sessions.

- Ensuring that key stakeholders are consulted with and involved in the development of the policy. In cases where there is more than one author, all contributors should be recorded and a main contact identified on the Document Control Report

- Auditing survival of patients following Resuscitation using the same questions as used by the National Cardiac Arrest Audit (NCAA).

- Escalate any risks related to trust resuscitation and complete risk assessments

Role of All Staff

All staff are responsible for:

- Ensuring that they remain appropriately trained under Trust mandatory training requirements by booking onto the appropriate resuscitation/ life support course. Bookings must be made via the Workforce Development department.

- Ensuring that they attend in a timely manner or inform the Learning and Development department if they cannot attend a booked training session.

- Ensuring that if they attend any emergency, the arrest trolley is re-stocked from the emergency stocks as per their hospital protocol. If they are unable to do this then the senior nurse for the hospital must be informed.

- Ensuring that after any emergency call at any site which necessitates a call to either the Arrest Team, a trust resuscitation data collection form is completed, one copy filed in the patient's notes and the other sent to the Outreach and Resuscitation officer.

- Reporting any adverse incidents that occur during or in connection with an emergency procedure, on the Trust Datix system.

- Complying with this policy.

4. Cardiac Arrest Procedures

Adults

4.1. On discovering a medical emergency or cardiac arrest, staff must start basic life support on all people unless it is categorically known and documented that they are not for resuscitation. If the incident occurs in the North Devon District Hospital, they must dial 2222 from any telephone, as appropriate.

4.2. Staff must speak clearly and inform the operator of the location of where the 'cardiac arrest team' is required. The North Devon District Hospital switchboard operator will then activate the bleep of the appropriate team.

4.3. If in a community hospital, staff must dial 999, speaking clearly and inform ambulance control of the location. Staff may have to first dial 9 to get an outside line.

4.4. Staff must follow the Resuscitation Council (UK) guidelines for resuscitation and can administer adrenaline as per the Trust's Patient Group Direction.

4.5. Defibrillation using an Automated External Defibrillator (AED) can be used by all staff. This is in line with the recommendations by the Resuscitation Council (UK)

4.6. However, staff may perform manual defibrillation only if they have received the appropriate training and they are competent to do so within their area of practice. They must ensure the safety of all those around them at all times. Staff are responsible for updating their own skills by attending an annual update. If the skill is not used regularly in practice, more frequent training should be sought by staff. The healthcare worker must ensure that either the Cardiac Arrest Team or the paramedics have been alerted and that they follow the Resuscitation Council (UK) guidelines at all times whilst performing defibrillation.

4.7. Staff working in any area which is locked should ensure that access, for the arrest team or the paramedics, is available by unlocking the doors.

4.8. Staff working in the patient's own home must ensure their own safety and follow basic life support algorithm where possible. They must dial 999 for assistance, before commencing CPR. If the patient has a TEP stating not for resuscitation or an advanced decision to refuse treatment the GP must be contacted

Paediatric

4.9. In the event of a cardiac arrest involving a child (age 1-18 years) or an infant (age 0-1 year excluding newborn) staff must start paediatric life support unless it is category known and documented that they are not for resuscitation.

4.10. Staff in North Devon District Hospital should then activate the cardiac arrest team using the 2222 number and asking for the Paediatric Cardiac Arrest team. Staff must speak clearly and inform the operator of the location for the team to attend. Switchboard will then alert the team along with the consultants on call for Intensive Care and Paediatrics.

4.11. Staff in a community hospital should dial 999 and inform the ambulance control of the nature of the emergency. They may need to dial 9 first for an outside line.

4.12. All other aspects of the resuscitation should be as the Resuscitation Council (UK) guidelines as taught in resuscitation training.

4.13. Recommendations from the Resuscitation Council (UK) state that any child post puberty can be resuscitated as per the adult algorithm, however, you would still need to call both adult and paediatric teams for these individuals.

4.14. Staff working in any area which is locked should ensure that access, for the arrest team or the paramedics, is available by unlocking the doors.

Newborn

4.15. Emergencies involving newborns will be dealt with by midwives in the first instance. These staff will need to immediately call the neonatal team. Staff should put out a neonatal call by dialling 2333 and asking for the neonatal team to attend. The doctor on this team should hold a valid Resuscitation Council accredited Newborn Life Support (NLS) course.

4.16. However, if anyone feels that further support and help is needed the paediatric arrest team should be called using 2222 and ask for the Paediatric Cardiac Arrest Team to attend.

4.17. In the event of a cardiac arrest involving a newborn staff must start basic life support unless it is categorically known and documented that they are not for resuscitation.

4.18. Staff must follow the Resuscitation Council (UK) guidelines for resuscitation as per their resuscitation training.

4.19. If resuscitation for a newborn is required in the patient's own home then help should be summoned using 999. The resuscitation Council (UK) guidelines should be followed.

Relatives / Next of Kin Who Wish to Watch Resuscitation Attempts

4.20. Relatives / Next of Kin should be offered the opportunity to stay during the resuscitation attempts. This may be uncomfortable for medical and nursing teams, but allows the relatives to see, that if the patient died, then all the appropriate treatment was carried out. For some relatives the fact that they were with the patient when they died is of help in the bereavement process. They may feel distressed if they are excluded; others will find resuscitation scenes distressing.

4.21. When relatives are present during resuscitation, ideally a nurse should be dedicated to looking after them who will be able to explain the procedures. The relatives should be given the opportunity to leave at any time.

4.22. The Resuscitation Team should perform cardiac arrest procedures as normal.

4.23. If the Cardiac Arrest Team leader finds the situation difficult, senior help should be sought.

4.24. Each clinical area should plan how this situation would be handled if/ when it occurs.

4.25. If relatives request Last Rites to be delivered, consideration will be given to continuing resuscitation until a priest is present.

Recognition of Patients at Risk of Cardio-Pulmonary Arrest

4.26. Staff on wards, throughout the Trust, must calculate the Modified Early Warning Score (EWS) every time a set of observations is recorded. This does not include Intensive Care, Paediatric Wards and Labour Ward.

4.27. Staff must escalate to either senior staff or medical staff, as per the flow diagram for further management. This can be found in the Patient at Risk Policy.

4.28. If staff are sufficiently worried about a patient's condition (even if the EWS is low) then the Cardiac Arrest Team may be initiated to ensure medical help arrives quickly. In the community the GP can be called and if staff are sufficiently worried they can dial 999.

4.29. All staff who attend for training and who work on the wards, will be given annual refresher training on recognition of patients at risk of arrest. This will be done as part of their resuscitation training.

Post Resuscitation Care

4.30. If the Adult Cardiac Arrest Team have been activated, the Medical F2 / ST1-4 on the team is responsible for the patient until he/ she is handed over back to their team.

4.31. It will be the responsibility of the Medical F2/ ST1-4on the team to ensure that the events and treatments are accurately documented in the patient's medical notes. This will include when the team have been called to a non-arrest situation/ medical emergency.

4.32. If the Paediatric Cardiac Arrest Team has been activated, the most senior paediatrician on the team is responsible for the patient until he/ she is handed over back to their team.

4.33. It will be the responsibility of the most senior paediatrician to ensure that the events and treatments are accurately documented in the patient's medical notes. This will include when the team have been called to a non-arrest situation/ medical emergency

4.34. Staff in the community are responsible for recording events in the patient's notes before the paramedics take the patient away.

4.35. Following survival from a cardiac arrest then a decision will be made as to the most appropriate place for further treatment.

4.36. The Trust must make provisions for safe continuity of care and where necessary, safe transfer following resuscitation of the patient. This may involve the following steps:

- Referral to a specialist.
- Full and complete hand-over of care.
- Preparation of equipment, oxygen, drugs and monitoring systems.
- Intra or inter hospital transfer.
- Liaison with other trusts or organisations.
- Use of staff who are experienced in patient transfer.
- Informing relatives.

Manual Handling

4.37. In situations where the collapsed patient is on the floor, in a chair or in a restricted/ confined space, the Trust guidelines for the movement of the patient must be followed to minimise the risks of manual handling and related injuries to both staff and the patient.

Please also refer to the Resuscitation Council (UK) Statement which can be found at https://www.resus.org.uk

5. Ceiling of care decisions including do not attempt Cardio-pulmonary resuscitation. (TEP)

5.1. If in doubt, staff must **always** start resuscitation.

5.2. When cardiac arrest is the result of a progressive deterioration in a patient's condition or underlying illness resuscitation is unlikely to succeed. In this situation it may be appropriate to discuss future treatment including attempted resuscitation with the patient and/ or relatives. Any decision to withhold resuscitation must be sanctioned by a senior doctor, GP or senior specialist nurse who has undergone the appropriate training. This will be reviewed as dictated by changes in clinical condition.

5.3. A Treatment Escalation Plan (TEP) should be initiated and communicated with the team. It should be documented in the medical notes that a form has been completed. This enables positive discussions with patients, families and within teams about treatments that would or would not be of overall benefit, including Cardiopulmonary resuscitation (CPR). This will ensure that all staff, patients (as they wish) and family members (with patient consent) are aware of the ceiling of care that will be given for that patient. It must be signed by the professional completing the form and include their GMC or NMC number. If that is not the senior responsible medical clinician they should be consulted around the forms completion, and at the earliest practicable opportunity they should review and endorse the recommendations by adding their signature to the form or recording their agreement within the person's medical record.

5.4. Any member of the team who has concerns with any Do Not Attempt Resuscitation order, must discuss it with the senior doctor, GP or nurse. If this person is not available or the team member feels unable to talk to these individuals, then the matter should be discussed with one of the Outreach and Resuscitation Officers or the Lead Clinician for Resuscitation.

5.5. Full guidance on making Treatment Escalation Plans (TEP) are provided at Appendix B.

5.6. A Do Not Attempt Resuscitation order does not change the patient's clinical care in any other way.

5.7. A TEP form review is at the discretion of the doctor in charge of the patient's care, however, if the condition of the patient changes drastically it should be done.

5.8. If the patient has a TEP this is considered valid by all healthcare providers across Devon. The original must go with the patient, as long as the patient is aware it is in place and then a photocopy should be taken and kept in the notes for reference.

5.9. Senior specialist nurses, who have undergone the appropriate training and therefore, can complete TEPs are listed in Appendices.

6. Advanced Directives

A patient's valid and applicable advance decision to refuse treatment (living will) must be adhered to when the patient lacks capacity to participate in decisions themselves. Please refer to the Advance Decision to Refuse Treatment (ADRT) Clinical Tool and Guidance.

7. Training

7.1. Resuscitation training is viewed as essential and further Continuous Professional Development may not be supported unless evidence of essential training is given.

7.2. The level of training required for each group of staff is as defined in the Resuscitation Training Matrix. (see Appendix A) This is subject to annual review. This responds to guidance from the Resuscitation Council (UK), the Royal Colleges, British Medical Association, and the National Service Frameworks. All staff identified as required to undertake an annual update of resuscitation skills will receive training if requested.

7.3. Booking for all resuscitation training will be undertaken through Workforce Development via the Electronic Staff Record. Signed records must be kept of all training undertaken in the Trust. These records will be held centrally and reported Trust wide through ESR records. Individuals are encouraged to keep a copy of this in their portfolio.

7.4. On updating the Electronic Staff Record, line managers will be notified of all non-attenders, further detail on booking and reporting processes are contained within Risk Management (Statutory and Mandatory) Training Policy.

7.5. All courses offered by the Resuscitation Department will be designed to meet the needs of the individuals and their departments. (see Appendix A)

7.6. Staff required to hold any Advanced Life Support qualifications will be supported to attend these courses within the time scale identified on the training matrix and will be required to update skills to retain qualification within the limits set by the Resuscitation Council (UK) or the Advanced Life Support Group. In the intervening years, access to in house updates will be required on an annual basis.

7.7. Mock-simulated cardiopulmonary arrests may be initiated by the Resuscitation Officers, in the clinical area, and will be used to assess the competence and training needs of the staff.

7.8. Staff will receive training on their responsibilities in respect of maintaining and checking ward/ department level equipment and in audit requirements for monitoring the quality of resuscitation.

8. Monitoring Compliance with and the Effectiveness of the Policy

Standards/ Key Performance Indicators

8.1. Key performance indicators comprise:

- Percentage of 72 hour investigations completed following a Cardiac Arrest in hospital – target 100% from January 2017
- Percentage of attendance at training – target 85% from January 2017

Process for Implementation and Monitoring Compliance and Effectiveness

8.2. The policy will be on BOB for all staff to access.

8.3. Information will also be included in the weekly Chief Executive's Bulletin which is circulated electronically to all staff.

8.4. An email will be sent to senior management to make them aware of the policy and they will be responsible for cascading the information to their staff.

- Monitoring compliance with this policy will be the responsibility of the Resuscitation Service Manager and workforce development. This will be undertaken by auditing the uptake of training quarterly. Where non-compliance is identified, feedback will be given to the Resuscitation Steering Group and line managers for action.
- 72 hour reports and SEA's will be presented to the Prevention and Resuscitation Group at allocated meetings. This may be as causal analysis. Any themes identified will be escalated to the appropriate division for action

9. Equality Impact Assessment

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age	X			
Disability	X			
Gender	X			
Gender Reassignment	X			
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership	X			
Pregnancy	X			
Maternity and Breastfeeding	X			
Race (ethnic origin)	X			
Religion (or belief)	X			
Sexual Orientation	X			

10. References

- Resuscitation Council (UK) (2010), **Resuscitation Guidelines.** Available at www.resus.org.uk This site also provides further information and guidance on many topics relating to resuscitation
- Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Capacity Act 2005
- International Liaison Committee on Resuscitation. (2010) **International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations.**
- Department of Health **National Service Framework for Children.**
- NHS Litigation Authority (2007) **Risk Management Standards for Acute Trusts**
- National Patient Safety Agency. (2004) **Establishing a Standard Crash Call Telephone Number in Hospitals.** Available at: http://www.npsa.nhs.uk/
- Department of Health. (2000). **Resuscitation Policy Health Circular 2000/028.** Available at: https://www.gov.uk/government/organisations/department-of-health-and-social-care
- Royal College of Anaesthetists; Royal College of Physicians of London; Intensive Care Society; Resuscitation Council (UK) (2008) **Cardiopulmonary Resuscitation Standards for Clinical Practice and Training in the UK.**
- British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. (2007). **Decisions relating to cardiopulmonary resuscitation.** Available at: https://www.bma.org.uk/
- General Medical Council (2010). Treatment and care towards the end of life: good practice in decision making. Available at https://www.gmc-uk.org/

- **Disability Discrimination Act 1995 amended 2005**. London: The Stationery Office
- End of Life Care for Adults **National Institute Clinical Excellence (NICE)**

11. Associated Documentation

- Advance Decision to Refuse Treatment (ADRT) Clinical Tool and Guidance
- Assessment and Maintenance of Clinical Competence in Nurses, Midwives and Support Workers Policy
- Consent Policy
- Patient at Risk of Deterioration Policy
- Mental Capacity – Deprivation of Liberty (DoL) Safeguards Policy
- Moving and handling Policy
- Risk Management Policy
- Risk Management (Statutory and Mandatory) Training Policy

Appendix A: Resuscitation Training Matrix by Staff Group

Coding

Essential / Mandatory within 6 months of starting	=	1
Essential within 6 – 12 months	=	2
Optional	=	3

Definition of Terms

ILS Course – The Immediate Life Support (ILS) course has been developed in order to standardise much of the in-hospital training undertaken already by Resuscitation Officers. Its aim is to train healthcare personnel in cardiopulmonary resuscitation, simple airway management and safe defibrillation (manual and/or AED), enabling them to manage patients in cardiac arrest until arrival of a cardiac arrest team and to participate as members of that team.

PILS Course - The Paediatric Immediate Life Support (PILS) course aims to provide healthcare staff with the requisite knowledge and skills needed to:

- recognise the seriously ill child and initiate appropriate interventions to prevent cardiorespiratory arrest treat the child in respiratory or cardiorespiratory arrest for the short time before the arrival of a resuscitation team or more experienced assistance
- become members of the resuscitation team

ALS Course - The Advanced Life Support (ALS) course aims to teach the theory and practical skills to effectively manage cardiorespiratory arrest, peri-arrest situations and special circumstances, and to prepare senior members of a multidisciplinary team to treat the patient until transfer to a critical care area is possible.

This course is designed for healthcare professionals who would be expected to apply the skills taught as part of their clinical duties, or to teach them on a regular basis. Appropriate participants include doctors and nurses working in critical care areas (e.g. A&E, CCU, ICU, HDU, operating theatres, medical admissions units) or on the cardiac arrest / medical emergency team and paramedics. All applicants should hold a current clinical appointment and professional healthcare qualification.

APLS Course – (Advanced Paediatric Life Support) This is a paediatric emergency medicine and resuscitation course. It is designed for more senior doctors and nurses who will be actively leading teams involved in the emergency management of seriously ill children i.e. SpRs and Consultants, senior sisters and clinical nurse specialists. It teaches the recognition of serious illness and injury, respiratory and cardiovascular compromise and decreased conscious level. It contains the knowledge and skills as in the EPLS and in addition also teaches the emergency management of individual conditions including Asthma, Croup and Bronchiolitis. In addition APLS describes support for rapid sequence induction of anaesthesia, intubation and teaches central venous access to enable providers to manage a child until retrieval.

EPALS Course - The European Paediatric Advanced Life Support (EPALS) provider course is intended to provide training for multi-disciplinary healthcare professionals in the early recognition of the child in respiratory or circulatory failure and the development of the knowledge and core skills required to intervene to prevent further deterioration towards respiratory or cardiac arrest. This course is designed for healthcare professionals who would be expected to apply the skills taught as part of their clinical duties, or to teach them on a regular basis. Appropriate participants include doctors, nurses and paramedics working in direct contact with children. All applicants should hold a current clinical appointment and professional healthcare qualification. Medical students in their final year of training can be accepted as candidates provided they do not exceed 10% of the total number of candidates.

NLS Course - The Newborn Life Support (NLS) course has been developed under the auspices of the Resuscitation Council (UK) to provide clear practical instruction in airway support and the theoretical background to illustrate its importance in resuscitation of the newborn. It is designed for any healthcare professional, regardless of discipline or status, who may be called upon to resuscitate a newborn baby. The aim of the course is to give those responsible for initiating resuscitation at birth the background knowledge and skills to approach the management of a newborn infant during the first 10-20 minutes in a competent manner. The course concentrates on the importance of temperature control, practical airway management and ventilatory support.

ALSO Course - The ALSO® (Advanced Life Support in Obstetrics) Provider Course is an educational program designed to assist healthcare professionals in developing and maintaining the knowledge and procedural skills needed to manage emergencies that can arise in obstetrical care. The ALSO Provider Course is geared to all maternity care providers including family physicians, obstetricians, midwives, nurses, paramedics and trainees.

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Consultant Anesthetists ICU Side	1	N/A	N/A	N/A	N/A	N/A	Or Equivalent 2	3	Or Equivalent 2	3	N/A
Consultant Anesthetists General Side	1	N/A	N/A	N/A	N/A	N/A	Or Equivalent 2	N/A	3	Or Equivalent 2	3
A&E Consultants	1	N/A	N/A	N/A	N/A	N/A	1	1	3	N/A	N/A
ENT Consultants	1	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Haematologist	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Histo - pathologists	3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maxillofacial Consultants	1	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Micro - biologists	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Consultants in O&G	N/A	N/A	N/A	1	N/A	N/A	N/A	N/A	N/A	3	2

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Oncologists	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ophthalmologists	2	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthopaedic Consultants	2	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paediatric Consultants	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3	1	1	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Consultant Physicians	N/A	1	N/A	N/A	3	N/A	3	N/A	N/A	N/A	N/A
Consultant Psychiatrists	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Radiologists	2	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Consultant Surgeons	2	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Middle Grades in A&E	N/A	N/A	N/A	N/A	N/A	N/A	1	1	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Middle Grades in Paediatrics	1	N/A	N/A	N/A	N/A	N/A	N/A	3	1	1	N/A
Middle Grades in Anaesthetics	1	N/A	1	N/A	N/A	N/A	3	3	3	3	N/A
Specialist Trainees appropriate to area	1	1	1	N/A	3	3	3	3	3	3	3
F2 Doctors appropriate to their area	N/A	1	N/A	N/A	N/A	3	2	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
F1 Doctors appropriate to their area	N/A	N/A	3	N/A	1	3	N/A	N/A	N/A	N/A	N/A
Medical Students appropriate to their area	1	1	N/A	N/A	3	N/A	N/A	N/A	N/A	N/A	N/A
Clinical Site Management Team.	N/A	N/A	1	N/A	3	3	2	N/A	N/A	3	N/A
Registered Nursing Staff on Surgical Wards	N/A	1	N/A	N/A	3	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Non-Registered staff on Surgical Wards	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Registered Nursing Staff on Medical Ward	N/A	1	N/A	N/A	3	N/A	N/A	N/A	N/A	N/A	N/A
Non-Registered Staff on Medical Wards	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Critical Care Nursing Team Leaders A&E, and ICU	N/A	N/A	N/A	N/A	2	2	3	N/A	3	N/A	N/A
Critical Care Nursing Staff; A&E, and ICU	N/A	N/A	N/A	N/A	2	2	3	N/A	3	N/A	N/A
Registered Paediatric Ward Staff	1	N/A	N/A	N/A	N/A	1	N/A	N/A	3	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Non-Registered Paediatric Ward Staff	2	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Theatres Staff Nurses and ODP's including DSU & Endoscopy	1	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SCBU Staff	3	N/A	N/A	2 intervening years	N/A	N/A	N/A	N/A	N/A	2	N/A
Midwives and MCA's	N/A	N/A	N/A	1	N/A	N/A	N/A	N/A	N/A	3	3

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Clinical Nurse Specialists appropriate to their area	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Registered Staff in Support services i.e. OPD	1	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Clinical Nurse Specialists appropriate to their area	1	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Non-Registered Staff in Support Services	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Registered Staff in Minor Injury Units / Walk in centres in community areas	N/A	N/A	N/A	N/A	2	2	N/A	N/A	N/A	N/A	N/A
Non-Registered Staff in Minor Injury Units / Walk in centres in community areas	1	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Registered Nurses in Community Hospitals	N/A	1	N/A	N/A	3	N/A	N/A	N/A	N/A	N/A	N/A
Non-Registered Staff in Community Hospitals	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
District Nurses inc OOH nurses	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Non-Registered Staff in Community	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Community Paediatric Team	N/A	N/A	2	N/A	N/A	3	N/A	N/A	N/A	N/A	N/A
Family Planning Staff	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Radiology Staff	2	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pharmacy staff if patient public contact	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Cardiac Physiologists	1	N/A	N/A	N/A	2 For staff performing exercise testing only	N/A	N/A	N/A	N/A	N/A	N/A
Occupational Therapists	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Physio-therapists appropriate to their area	1	3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Physician Associate Surgery	N/A	1	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Nursing Associates	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Physician Associate Medicine	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dieticians	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Podiatry	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Speech and Language Therapy Staff (appropriate to area)	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dentists who give sedation	N/A	N/A	N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A
All other Dental Staff	1	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Clinical Managers (appropriate to area)	2	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Non Clinical Managers (appropriate to area)	3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Support Staff Admin and Clerical & other non clinical Departments if any face to face patient or public contact	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Staff Group	Adult Practical session / BLS 1 Hour plus e-learning Annually	In Patient Life Support 3.5 hours plus e-learning Annually	Paediatric Basic Life Support 1.5 hours Annually	Obstetric and neonatal life support 3.5 hours Annually	Adult Immediate Life Support (Resus Council UK) (1 day) Annually	Paediatric Immediate Life Support (Resus Council UK) (1 day) Annually	Advanced Life Support ALS (Resus Council UK) (2 days) 4 yearly with an update annually	Advanced Paediatric Life Support APLS (2.5 Days) 4 Yearly with an annual update	European Paediatric Advanced Life Support EPALS (Resus Council UK) (2 Days) 4 Yearly with an annual update	Neonatal Life Support NLS (Resus Council UK) (1 day) 4 Yearly with an annual update	Advanced Life Support for Obstetric ALSO (2 Days) With an annual update
Sodexho Porters who have patient contact	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Staff who do not have regular face to face patient or public contact	3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix B: Guidance on Treatment Escalation Plans (TEP)

This Appendix is intended to be used as a guide only and should be read along with the document from the Royal College of Nursing, Resuscitation Council (UK) and BMA October 2007 and GMC 2010

The doctor's responsibilities include:

- Looking after the patient as an individual and providing treatment in their best interests.
- Using resuscitation as a procedure or treatment as indicated in some patients but not in others. This should be decided using appropriate clinical decision making based upon professional guidance documents. This reasoning should be clear, transparent and justifiable.
- Discussing resuscitation decisions whenever patients wish to do so – this may form part of a general discussion about the underlying illness, treatment and prognosis. Discussion regarding resuscitation should never be forced on a patient, but it should not be avoided due to clinician discomfort.
- Communicating decisions regarding resuscitation in an open and honest way.
- Doctors cannot be required to give treatment contrary to their clinical judgement, however if patients are adamant then a second opinion should be offered.
- TEP is not legally binding and does not preclude clinical judgement. If there is an obviously reversible cause of their condition, full consideration of treatment options should be made. If treatment contrary to the TEP form is deemed clinically appropriate and not against patient wishes, it should be given

The patent's rights as stated in the Human Rights Act 1998 include:

- Right to refuse treatment provided they are competent to do so. Under Freedom of expression Article 10
- Right to life and to be free from degrading treatment; Article 2 and 3.
- Right to privacy; Article 8.
- Right to freedom from discriminatory practice; Article 14.

For whom should a TEP Order be made?

- Patients who have made an appropriate advance directive (written or verbal) that can be verified.
- Patients dying from a severe underlying, irreversible illness during the current hospital admission for whom attempts at resuscitation would be ineffective and inappropriate.
- In other circumstances when resuscitation would be ineffective, or when attempts would result in more harm than good.

Who should make the decision and with whom should it be discussed?

- The Consultant or GP in charge of the patient's care is responsible for any decision made

- TEP's should be made by a Senior Doctor of Specialist Registrar status or above who has experience and training in this area. F1's and SHO's/F2's not able to make TEP decisions

- This **always** needs to be discussed with or explained to **patients** except in the following situations:

    - The patient is unconscious
    - Patient lacks capacity to the extent that this conversation would confuse and distress them, causing harm
    - It is considered, after MDT discussion, that this conversation would cause distress to the point of harm **and** the intervention is deemed to be futile
    - The patient makes it clear they do not wish to have this conversation

  Document – the reason for not having the conversation

  Review – reconsider discussion if any of the above circumstances change.

- In most cases this should be discussed with the relatives (respecting confidentiality). Family or friends may be present at the time of cardiac arrest or death and consideration should be given to their need to be aware of what may or may not happen at that time.

- If discharging a patient home with a TEP form, **patient and close family** need to be aware of its contents. They will be responsible for ensuring it is available to emergency services. It should also be recorded on the discharge summary

Relatives:

- Many relatives believe that they have the right to consent or refuse treatments on behalf of the patient. This is not true – medical decisions are the responsibility of the doctor and the patient, unless the patient lacks capacity. See separate paragraph

- Their views on the patient's wishes regarding end of life care and resuscitation should be sought when patients lack the capacity to participate in the decision themselves (see below).

- In most cases they will need to be informed of any decision made providing this does not breach confidentiality.

- They should not feel responsible for any decision that is made.

Reviewing the decision:

- TEP decisions are seen as indefinite. They should, however, be reviewed when the Consultant / GP feels it necessary.

- This review needs to include the decisions made and the discussions held with patient and family

- As a minimum:

    - They should be reviewed if the patient's condition changes

    - They should be reviewed prior to and after transfer between healthcare settings

- Reviews should be documented appropriately

- The frequency of the review should be determined by the health professional in charge and will be influenced by the clinical circumstances of the patient. A minimum of annual review is recommended.

Other treatments:

- A TEP does not change any other aspect of the patient's care. Full care should continue to be given in every other way.

- In some patients a TEP is a part of a planned limitation of treatment. In certain patients it may be decided that it is not in their best interests to undergo treatments such as admission to Intensive Care, or dialysis. The process for making these decisions is similar to DNAR Orders, but is not subject to these guidelines.

Adults who lack capacity (please refer to the MCA 2005 and local guidance and documentation):

- A patient is presumed to have capacity unless proven otherwise by an appropriately documented mental capacity assessment (MCA 2005)

- The purpose of the mental capacity act is to ensure that decisions are made with respect given to patient views even when they are unable to express them themselves. In this situation we need to look for evidence of previously expressed views in the form of:

    - A valid and applicable written advance decision to refuse treatment

    - An appointed Lasting Power of Attorney for health and welfare registered with the office of the public guardian

    - Consultation with family or friends

    - Consulting an independent mental capacity advocate if un-befriended

- In an emergency situation, if the patient lacks capacity and we are unable to elicit what their views may have been from any of the above sources, a decision should be made in the best interests of the patient based upon clinical judgement while attempts are made to gain information from the above sources.

- If patients lack capacity and have a valid and applicable advance decision to refuse treatment this must be respected.

- If patients lack capacity and have a welfare attorney or guardian, this person must be consulted about CPR decisions. These LPA's cannot demand treatment that is clinically inappropriate. Their views, however, must be sought (for details of their roles and responsibilities see MCA 2005 and local MCA guidance)

Adults who lack capacity without an advance directive or LPA but have family or friends:

- The decision for CPR and treatment rests with the most senior clinician in charge of the patient's care.

- The views of those close to the patient should be sought in order to gain an understanding of what the patient's wishes on end of life care and resuscitation would be unless this is impossible.

- It should be clear that we are asking them about what they believe the wishes of the patient would be and in most cases informing them of the decision we have made.

We are not asking for their personal opinions. We are not asking for their consent. They are not responsible for the decision made.

- Under the Mental Capacity Act all healthcare personnel must act in the best interests of the patient who lacks capacity.

Adults who lack capacity without an advance directive an attorney and have no family or friends:

- The Mental Capacity Act 2005 requires an independent mental capacity advocate (IMCA) to be consulted about all decisions about 'serious medical treatment' where patients lack capacity and have nobody to speak on their behalf and the decision is made by an NHS body or Local Authority.

- This includes TEP/CPR decisions

Children:

Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, their families and their healthcare team.

- Parents have the right to consent to treatment for children up to the age of 16 years. Whenever possible, decisions taken by competent children (of any age) should be respected.

When parents or children refuse a treatment that is felt to be necessary by the medical team, the Consultant / GP should be contacted immediately and where necessary legal advice should be sought via the Duty Manager. Consent Policy. This is also the case when a child or parents insist on an inappropriate treatment

Ref: A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. October 2007

GMC Treatment and Care towards the end of life: good practice in decision making (2010)

MCA 2005

Resuscitation Council response to Janet Tracey ruling—July 2014

Appendix C: Nurse Written TEP

Nurse Written TEP

Nurse roles that can complete and sign for TEP following training

Job title			
Lung Cancer CNS			
Heart Failure CNS			
Respiratory Nurse CNS			
Breast Cancer CNS			
Colorectal Cancer CNS			
Stroke CNS			
Gynae Cancer CNS			
Parkinsons CNS			
MS CNS			
Urology CNS			