Sandwell and West Birmingham Hospitals NHS
NHS Trust

Emergency Medical Response Policy including Management of Resuscitation

Policy author	Lead Resuscitation Officer and Associate Deputy Chief Nurse MMUH
Accountable Executive Lead	Chelf Medical Officer
Approving body	EQG
Policy reference	[redacted]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

1: **All Group Triumvirates**
2: **On call Team Members**
3: **All Clinical Members of the Multidisciplinary Team – Medical and Non-Medical**

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:

1: **Senior Clinical Executives**
2: **Risk Management**
3: **Clinical Governance Teams**

POLICY APPROVAL DATE:
March 2025

POLICY IMPLEMENTATION DATE:
March 2025

DATE POLICY TO BE REVIEWED:
March 2027

DOCUMENT CONTROL AND HISTORY

Emergency Medical Response and the Management of Resuscitation	Review date: 2 yrs
Valid from: 1 March 2025	Expiry date: 3 yrs

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g., full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
V0.1				Reviewed by Deteriorating Patients and Resuscitation Group Members. Group Triumvirates

KEY POINTS

1. **Purpose of the Emergency Medical Response Team and Management of Resuscitation Policy**

This policy outlines the systems, processes, and structure in place to provide safe and effective care during resuscitation events to all individuals attending or working at Sandwell & West Birmingham NHS Trust. This policy should be viewed interactively in context with other organisational policies regarding the management of deteriorating patients or medical emergencies.

2. **Description of the Policy**

The policy aims to assure resuscitation services within the Organisation. It directs staff in their roles, responsibilities, and actions to provide care and summon assistance in clinical emergencies. The policy incorporates current guidelines for resuscitation (Resuscitation Council UK 2021) and provides standards for auditing the service and disseminating audit findings. Compliance with this policy is monitored by the DP&RT and the Resuscitation Group, reporting to the Executive Quality Group with support from the Enhanced Care Group.

3. **Who does this Policy affect?**

The policy applies to adult and paediatric emergency teams and cardiopulmonary resuscitation across all Sandwell and West Birmingham NHS Trust estates. All clinical and public areas where medical emergencies may occur must have adequate resources available and visible.

Key Points of the Policy

1. **Emergency Equipment**

- Emergency equipment must be checked daily and immediately after use, following the MyKitCheck SOP to ensure continual availability.
- All staff must be familiar with the resuscitation equipment in their workplace or know the location of the nearest equipment.

2. **Training Requirements**

- All clinical staff must be in date with the mandatory level 2 resuscitation training and attend annual BLS assessment. Staff working in areas dealing with children must also be trained in paediatric life support. The Trust will ensure adequate resources for relevant training specific to roles and specialties, including having an experienced Resuscitation Officer, designated training areas, and appropriate equipment.

3. **EMRT Composition and Response**

- The Emergency Medical Response Team(s) at MMUH, known as the 'emergency team', include skilled clinical professionals equipped to manage deteriorating patients and cardiac arrests. Core Teams consist of a Team Leader and clinical Team Members, described as:

    - Adult Emergency Team
    - Paediatric Emergency Team

- **Rapid Response Team in our Non-Acute (MMUH) Estates**

  The emergency team within our non-MMUH Estates, including Sandwell Treatment Centre, Birmingham Treatment Centre, BMEC, and the Sheldon Block, operates with a different team structure due to the lower acuity of these sites and the lower-risk patient population. Unlike the comprehensive emergency team response at MMUH, these Non-MMUH Estates will have:

    - **Team Composition:** The team at these sites will respond 'In Hours' led by a doctor within the Surgical Medical Team who holds an Advanced Life Support (ALS) qualification. This individual will serve as the team leader during emergencies.

    - **Supporting Team Members:** The remaining team members will be drawn from various departments and will include qualified staff with a combination of Immediate Life Support (ILS) and/or Basic Life Support (BLS) certifications.

A full breakdown of team compositions for each site can be found in **Annex 3** of this policy document. This annex provides detailed information on the specific roles and qualifications of team members across the different sites, ensuring clarity and preparedness.

Any person who needs to summon immediate, emergency, medical help on any site other than MMUH must call 2222 and ask for a 999 ambulance response.

4. **Emergency Telephone Call**

- Regardless of location, the emergency telephone call number is 2222. There are several pathways where intervention may be required, for example:
    - Cardiac Arrest
    - Deteriorating Patients
    - Immediate Clinical Physical Review and Intervention
    - 999 via 2222

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1: INTRODUCTION

1.1 This Emergency Medical Response and the Management of Resuscitation Policy, is based on the recommendations for clinical practice and training in cardiopulmonary resuscitation and management of anaphylaxis published by the Resuscitation Council UK. This policy describes the process for managing and mitigating risks associated with resuscitation and deteriorating patients.

1.2 Sandwell and West Birmingham NHS Trust (the Organisation) must provide a resuscitation service for patients, visitors, and staff on all its sites. The aim is that all relevant staff with direct patient contact must be able to provide cardiopulmonary resuscitation at a level appropriate to their role and healthcare environment, with a minimum of Basic Life Support. **Defibrillation is now considered part of basic life support, and all resuscitation attempts are expected to include a defibrillator if available**.

1.3 Some staff may require additional training to provide elements of Intermediate or Advanced Life Support. This will be defined by their job role and where they actively see patients.

1.4 The purpose of this Policy is to:

- Ensure that safe, early, and appropriate management of a medical emergency, including cardiopulmonary resuscitation, occurs in our Organisation.
- Detail the duties and training requirements for all staff in our Organisation relating to the management of a medical emergency, including cardiopulmonary resuscitation.
- Detail the process and tools in the recognition, identification, and response to patients/clients at risk from cardiac arrest within our Organisation.
- Standardise the management of medical emergencies and cardiac arrests within our Organisation in accordance with the current Resuscitation Council UK guidelines.

2: SCOPE

2.1 This policy applies to all directly and indirectly employed staff, including other people working within the Trust in line with the Organisation.

2.2 Any person (staff, patient, or visitor) who collapses within any area of the Organisation must be rendered assistance up to, and including, cardiopulmonary resuscitation according to the skills and ability of the individual staff member.

2.3 Staff who work within the community and are employed by the Trust (such as community midwives) retain this responsibility for the patients in their care away from Trust areas, wherever they may be with their patient.

3: POLICIES TO WHICH THIS POLICY RELATES

3.1 The list of policies below is not inclusive but references the main related policies any clinical staff member is likely to refer to. The Trust's policies are all kept on the Trust's intranet and are accessible to all staff.

- Acute Life-Threatening Events (ALTE) in Children (SWBH/PAED/170)
- Fire Safety Management Policy (SWBH/ORG/043)
- Immediate Care of the Newborn, Including Thermal Care (SWBH/MAT/079)
- Infection Prevention and Control Policy (SWBH/COI/001)
- Management of the Acutely Ill Obstetric Woman (SWBH/MAT/059)
- Medicines Reconciliation Policy (SEBH/Pt Care/027)
- Maternity Escalation Guideline (SWBH/MAT/095)
- Moving and Handling Policy (SWBH/HR/057)
- Neonatal Resuscitation Network Guidelines
- Observation and Monitoring Policy for Children and Young People (SWBH/Paed/167)
- Paediatric Clinical Guidelines for Managing Acute Life-Threatening Events (ALTE) in Children (SWBH/Paed/170)
- Physiological Observation, Monitoring, and Escalation Policy (SWBH/Pt Care/132)
- Policy for Assessing Mental Capacity and Complying with the Mental Capacity Act 2005 (SWBH/Pt Care/02)
- Policy for the Reporting, Management, and Investigation of Incidents (SWBH/ORG/050)
- Policy Regarding Advance Care Plan (ACP) for Children and Young Persons with Palliative and Continuing Care Needs (SWBH/Pt Care/012)
- Resuscitation of the Collapsed Obstetric Woman (SWBH/MAT/039)
- Resuscitation Status and Treatment Escalation Policy (SWBH/Pt Care/062)
- Statutory, Mandatory, and Risk Management Training Policy (SWBH/HR/016)
- Supportive Care Plan - A Guide for Clinicians (SWBH/Pt Care/100)
- Major Incident Plan (SWBH/ORG/01)

4: GLOSSARY AND DEFINITIONS

4.1 Advanced Life Support (ALS)

- The term ALS describes temporary measures aimed at restoring ventilation and a perfusing cardiac rhythm; this is necessary to improve the chance of long-term survival.

4.2 Advanced Paediatric Life Support (APLS)

- Advanced Life Support Group (ALSG) course

4.3 Agonal Breathing

- Occasional gasps, slow, laboured, or noisy breathing associated with the initial stages of cardiac arrest and evident in up to 40% of cardiac arrest victims. This is not a sign of life, and resuscitation should be commenced unless resuscitation is not appropriate (i.e., a current and valid DNACPR decision is in place).

4.4 Ambulance

- Emergency ambulance following 2222 call to alert for a 999 call.

4.5 Anaphylaxis

- An acute, life-threatening hypersensitivity reaction which should be considered when there is an acute onset of life-threatening airway and/or breathing and/or circulation problems, especially if skin/mucosal changes are present.

4.6 Automated External Defibrillator (AED)

- The AED analyses cardiac rhythms and advises whether a shock is indicated or not. It has preset energy levels according to the Resuscitation Council (UK) guidelines. AEDs allow appropriately trained staff to defibrillate a person in cardiac arrest before more expert help arrives. AEDs can be used on paediatric patients ideally with the use of attenuated pads that reduce the energy delivered to children weighing less than 25 kg. In the event these pads are not available, adult pads should be used. It is not recommended to use AEDs on the under-one-year-old age group due to potential problems with rhythm recognition.

4.7 **Basic Life Support (BLS)**

- BLS is the maintenance of airway patency and supporting breathing and circulation without the use of equipment other than a protective device. This is carried out by artificial ventilations using a pocket mask or bag valve mask (not a face shield) with or without supplemental oxygen and the provision of chest compressions.

4.8 **Baton Bleep**

- The emergency team baton bleep notifies the individual members of the emergency teams and gets passed over at the end of each shift to the covering emergency team staff member.

4.9 **Cardiac Arrest**

- The sudden cessation of mechanical cardiac activity, confirmed by the absence of any obvious sign of life (or pulse for those appropriately trained to carry out pulse checks), unresponsiveness, and agonal/complete cessation of normal breathing.

4.10 **Cardiopulmonary Resuscitation (CPR)**

- A combination of airway management, artificial ventilation and chest compressions

4.11 **Clinical Staff**

- A member of Trust staff whose job description includes direct patient care.

4.12 **Defibrillation**

- The definitive treatment for shockable cardiac arrest rhythms, such as ventricular fibrillation (VF) and pulseless ventricular tachycardia (VT), is defibrillation. This involves delivering a DC electric shock to the myocardium at energy levels recommended by the Resuscitation Council (UK).

4.13 **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)**

- A DNACPR order indicates that in case of cardiac arrest, CPR will not be started. It is emphasised that a DNACPR decision does not prevent other forms of treatment being provided, including other types of emergencies such as anaphylaxis or choking.

4.14 **Immediate Life Support (ILS)**

- Resuscitation Council UK accredited medical emergency and resuscitation course.

4.15 **National Early Warning Scoring System (NEWS)**

- A standardised track and trigger system for acute illness in patients presenting to or within inpatient areas is also used in the community. Based on a simple scoring system in which a score is allocated to physiological measurements including respiratory rate, pulse rate, blood pressure, oxygen saturation level, temperature, and conscious level (using AVPU: Alert, Voice, Pain/pressure, Unresponsive). An appropriate response is triggered according to the resulting score.

4.16 **Non-Clinical Staff**

- A member of Trust staff whose job description does not include direct patient care.

4.17 **Seizure**

- When the oxygen level to the brain drops following a cardiac arrest, the casualty may have a seizure-like episode. Anyone suffering a seizure should be suspected of being in cardiac arrest, and breathing should be carefully assessed.

4.18 **Situation, Background, Assessment, Recommendation (SBAR)**

- Communication tool to facilitate the comprehensive handover of patient information in a structured format, e.g., shift handover, nurse to doctor over the telephone, etc.

5: PRINCIPLES

5.1 The Trust is a complex Organisation offering services to individuals (both adults and children) with a wide range of needs on many different sites, including health centres, hospital inpatient and outpatient services, community services, and patients' own homes. As a result, the Trust cannot offer the same medical emergency or resuscitation response across all its services.

5.2 This policy seeks to establish the principles and standards by which more site-specific procedures will operate. Where care is being provided by our Organisation's employed staff on non-SWB NHS Trust sites, the resuscitation/emergency procedure for that setting should be followed. Staff are responsible for ensuring they are familiar with the local emergency procedures. However, in all situations, basic life support will be started without delay.

5.3 Recognition of the Deteriorating Patient ‘A deteriorating patient refers to an individual whose medical condition is worsening or declining. This can occur in a variety of healthcare settings and manifests through worsening vital signs, increasing symptoms, or a decline in overall health’.

A. The recognition of the deteriorating patient is essential in the chain of survival and for the prevention of cardiac arrest.

B. The assessment of the deteriorating patient will depend on the knowledge and skills of the rescuer and the equipment available to them.

C. The Trust uses a National Early Warning Scoring (NEWS) system for adults and a Paediatric Early Warning Score (PEWS) system for the recognition of patients at risk and, as such, the prevention of cardiac arrest, primarily in inpatient areas. During an inpatient acute episode, the patient’s observations are recorded and scored as per NEWS or PEWS.

D. To ensure the appropriate action is taken because of a calculated NEWS or PEWS score, the process is supported by an escalation procedure.

5.4 **Response to a Medical Emergency**

A. All staff should have the means to obtain immediate local assistance. This will depend on the site but may include shouting for help and activating the emergency response using the internal phone number 2222. If you are away from the buildings and alone and there is no local help, assess the patient and ring 999 for an emergency ambulance or as per local site procedure.

B. Begin appropriate initial treatment according to patient needs and the skill level of the rescuer and continue until directed by the responding emergency

team or responding ambulance crew.

C. Once local help has arrived, send someone to summon the site emergency team to the appropriate hospital sites and/or the ambulance service in other Trust locations, giving the exact location and brief details of the incident.

D. Ensure the available emergency resuscitation equipment is brought to the victim. If there is no defibrillator on site, for example in the community, the emergency call handler may direct staff to the nearest defibrillator.

E. Co-operate and assist the site emergency team/ambulance crew with the resuscitation attempt using the current Resuscitation Council (UK) guidelines according to the responding staff's level of ability.

F. Consider "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) orders. However, if there is any doubt as to the patient having a valid DNACPR order, resuscitation should continue until one is located and verified.

Even with a DNACPR in place, THE PATIENT WILL STILL REMAIN SUITABLE TO CALL 2222/EMRT IN THE EVENT OF AN IMMEDIATELY REVERSIBLE CONDITION INCLUDING:

· Anaphylaxis

· Choking or blocked tracheostomy tube

· New event unrelated to current clinical condition e.g fracture following a fall

G. Support relatives, other patients, visitors, and staff who are involved in or witness a resuscitation attempt.

H. Ensure appropriate documentation is completed (e.g., medical notes, nursing notes on the Electronic Patient Record (Unity) of the emergency) and the DP&RT will be informed.

I. In the event of a sudden unexpected death, local procedures should be followed.

J. In the event of a death, an appropriate member of staff should inform the deceased's next of kin as soon as practicable.

6: ROLES AND RESPONSIBILITIES

6.1 The Trust Board including Chief Medical Officer/Chief Nursing Officer.

The Trust Board and Chief Executive have a responsibility to ensure that 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.

The Chief Medical Officer (CMO) has executive responsibility for this policy. The CMO has responsibility for ensuring that all medical staff (not in training) receive the appropriate resuscitation training, that it is recorded, and that all non-attendees of resuscitation training are followed up (this may be delegated to Clinical Group Directors).

The Chief Nursing Officer (CNO) has responsibility for ensuring that all non-medical staff (not in training) receive the appropriate resuscitation training, that it is recorded, and that all non-attendees of resuscitation training are followed up (this may be delegated to Clinical Group Directors).

6.2 The Deteriorating Patient and Resuscitation Group and Resuscitation Team

The Deteriorating Patient and Resuscitation Group and Team are responsible for policy implementation, distribution, and monitoring compliance throughout the Trust, as well as advising the Trust on matters relating to the deteriorating patient and the patient in need of cardiopulmonary resuscitation.

The Group and Team are responsible for providing sufficient training courses and places in accordance with the training matrix. This will also include the maintenance of the resuscitation learning modules and equipment.

6.3 Procurement Department

The Procurement Department has a responsibility to liaise with the Deteriorating Patient and Resuscitation Group and Team about any plans to introduce new equipment in relation to resuscitation within the Trust. This will require the input of Medical Engineering and/or Medical Physics in relation to any electrical equipment.

All resuscitation equipment purchased should be subject to the Trust's standardisation strategy. Therefore, all resuscitation equipment placed upon the approved purchase list should be agreed by the DP&RG, and any other equipment purchased outside of this should be sanctioned by the DP&RT prior to ordering.

6.4 Medical Engineering

Medical Engineering is responsible for servicing medical equipment and liaising with the Deteriorating Patient and Resuscitation Group and Team regarding product changes, alerts, or recalls.

Medical Engineering must have a maintenance schedule and an ongoing replacement plan.

6.5 Switchboard

Switchboard responsibilities include ensuring the working order of telecom devices such as speech paging and answering emergency calls promptly to immediately alert the emergency team as per the procedure.

The Organisation's Switchboard is to keep a record of all emergency calls.

Test Calls will perform daily test calls to the emergency team members at pre-arranged times. If a team member does not reply within 5 minutes, switchboard staff will send a second test bleep for that bleep holder only.

If again there is no reply within 5 minutes, or it has been established the bleep is not being covered appropriately, the switchboard will inform the emergency team registrar-tier doctor to arrange cover.

If the registrar is the bleep holder who is not responding, the Medical Consultant on call must be informed to arrange cover.

Test calls must be conducted and escalated appropriately.

6.6 Ward and Departmental Managers

Ward and Department managers are responsible for ensuring staff members have access to and adhere to this policy.

Ward and Departmental Managers must recognize the training needs of their staff by completing a Training Needs Analysis (TNA) and an annual appraisal, ensuring that staff are provided with access to training at the appropriate level.

Details of the training requirements are contained within the departmental Training Needs Analysis. Staff need to complete the e-Learning for health BLS module (valid for two years) before their BLS practical can be assessed by a BLS assessor.

6.7 Clinical Staff

Clinical Staff are responsible for recording patients' physiological parameters, escalating variance according to the Trust's escalation plan (Policies identified above) Clinical staff are responsible for accurately recording patients' physiological parameters and ensuring any abnormalities are escalated according to the Trust's full escalation plan, which must be referenced in clinical documentation. This includes not only documenting actions taken but also any omissions, ensuring accountability and transparency. Staff must adhere strictly to the escalation protocol, which outlines specific thresholds for when and how to report patient deterioration, ensuring timely interventions. Being explicit in carrying out these duties can improve patient outcomes by

promoting rapid response to critical changes in a patient's condition.

Clinical Staff are responsible for immediately alerting for an emergency team or 999 Ambulance if emergency assistance is needed.

Staff will attend training related to deteriorating patients. The type and level of skill will vary and depend on the role of each staff member.

While it is the responsibility of each practitioner to maintain the appropriate level of skill, it is also the Trust's responsibility to ensure that adequate training is available, and systems are in place to remind staff of their training responsibilities.

Take account of Patients' Resuscitation Status.

Cooperate with the emergency team or West Midlands Ambulance Service Emergency crew.

Support relatives, other patients, and staff who are involved in, or witness, a resuscitation attempt.

Attend Debrief Sessions as required.

Each staff member is responsible for ensuring that they comply with the Trust policy and attend designated training courses as dictated by their training needs and PDR (Personal Development Review) to achieve the level agreed.

6.8 Non-Clinical Staff

Non-clinical staff have a responsibility to respond immediately to all situations where there is a suspicion of resuscitation being required and to cooperate with the emergency team or West Midlands Ambulance Service Emergency crew if required.

Each staff member is responsible for ensuring that they comply with this trust policy and attend training as dictated by their TNA and PDR to achieve the level agreed.

6.9 Instructors

Life support instructors must work within the limitations of the Council they are registered with. Instructors' role is to carry out life support training and are responsible for ensuring competency, documentation, and logging training sessions.

6.10 Basic Life Support Assessors

Basic Life Support Assessors (BLS Assessors) are responsible for assessing BLS within their clinical area as part of the Trust's mandatory training. Their role is to ensure that assessments are per current National and Trust resuscitation guidelines/policies, ensuring that candidates have completed the BLS e-learning module or other Trust-agreed learning before the assessment.

To stay current and in date for BLS, BLS Assessors are responsible for booking their own 'BLS Assessors update' to be both updated and assessed by the DP&RT annually.

Where BLS assessors are available, the manager must allow an opportunity for assessments to be completed.

6.11 New Staff and Students

All new staff must complete the appropriate training indicated in the Statutory, Mandatory, and Risk Management Training Policy (SW BH/HR/016).

6.12 EMRT Core Members

All emergency team Leaders must hold a current Advanced Life Support Provider certificate and use the up-to-date skills recommended by the Resuscitation Council (UK) or Advanced Life Support Group. Practicing members have a responsibility to keep this certificate in date.

Core members of the emergency team are responsible for ensuring that they are familiar with the emergency equipment available and how to use any piece of equipment relevant to their role. All members of the team are expected to be familiar with the contents of the standardised Adult and Paediatric Emergency Equipment trolley and out-of-hospital emergency bag.

Core members of the emergency team must log in for their duty and complete their details using the appropriate system (see Annex 3).

It is the responsibility of each emergency team member to familiarise themselves with relevant information before commencing their duty and act within the terms of this Policy or best practice.

All team members must attend to any call they receive with appropriate haste while maintaining their own and others' safety.

Special conditions apply when resuscitating children, newborns, and pregnant women, both in the aetiology of cardiopulmonary arrest and in the techniques of resuscitation. It is imperative that experienced personnel are present at the resuscitation attempt and that the appropriate 2222 call for the speciality is made.

Core members are to attend the emergency team briefing for the shift they are covering. When team members change mid-shift, the baton bleep must be exchanged, and they must register their role on the emergency team sign-in. A face-to-face handover must be attended by all core members. For meeting locations, please see Annex 03.

Core members will attend 2222 Emergency calls to areas in and around the Organisation. The perimeter line surrounding the hospital is considered the boundary, and outside these areas, i.e., on footpath, staff should dial 999. If the emergency team is not available to attend incidents in the outside areas of the hospital site, a 999-ambulance response is expected.

Core membership of the Adult and Paediatric emergency teams within the Trust is detailed in annex 3 of this policy.

7: PROCEDURE (including by site)

7.1 Early Warning Scores

Staff will record patient physiological observations, escalate according to the Trust's Physiological Observations, Monitoring and Escalation Policy and plan, and document their acts and omissions accordingly.

All clinical staff must be trained in the identification of the deteriorating patient and the use of physiological observation charts/systems to enhance decision-making and care escalation.

The Trust has Early Warning/Patient at Risk Systems for adults (NEWS) and paediatrics (PEWS), established for the detection of the deterioration or change in patient condition. All clinical staff will be trained in the identification of ill/deteriorating patients and the use of the Trust physiological observation tool to enhance decision-making and care escalation as indicated in the Physiological Observation, Monitoring and Escalation policy (SWBH/Pt Care/132).

NB: Parameters (triggers) for escalation may be reset for patients on the Supportive Care Path in the terminal phase of their illness and patients with chronic long-term conditions (Ref to the Supportive care plan). Parameters can be re-set by a registrar tier member of medical staff in an emergency and confirmed with the responsible Consultant within 24 hours at MMUH and 96 hours at Rowley Regis Hospital.

There is a Paediatric escalation policy relating to what to do if there are concerns regarding a child's condition. Escalation of concerns regarding patient condition (Paediatrics) can be found in the Observation and Monitoring Policy for Children and Young People (SWBH/Paed/167).

Paediatric clinical guidelines for managing Acute Life-Threatening Events

(ALTE) In Children can be found here: (SWBH/Paed/170).

NEWS2 and SpO2 Scale: Patients must be scored using SpO2 scale 1 unless there is a documented amendment by an appropriately skilled clinician on the recommendation of arterial blood gases.

7.2 CALLS FOR EMERGENCY INTERVENTION

Immediately contact the emergency team or 999 Ambulance by calling the switchboard by dialling 2222 ('double two - double two') if a patient or other person requires emergency medical help. Indicate the category of the patient, for example, an adult emergency, a paediatric emergency, etc., and give the exact location of the incident.

Do not differentiate between a Cardiac Arrest or a deteriorating patient, as all calls will be placed as emergency call. For example: "Adult Emergency, A6 Side Room 3".

Upon receiving an emergency intervention call, the switchboard operator will immediately relay the call details to the appropriate response team using the current voice bleep system. The operator will ensure that all pertinent information, including the location and any specific instructions, is communicated over the voice bleep. Each team member will then receive these details through their assigned bleeps.

Critical Care and the Cardiac Cath Lab may not initially activate a 2222 call due to the appropriate skills mix of staff available. If the emergency team is prolonged or extra assistance is required, a 2222 call is available. Cardiac arrests occurring within these areas must be recorded on Unity (EMRT power chart), and the DP&RT will be informed.

Community staff must call 999 for West Midlands Ambulance Service. They will require the address of your location and, where possible, the full postcode.

Appropriately trained staff are expected to provide initial support, begin first aid (including BLS if required) according to the needs of the patient, and continue until advised to stop by the emergency team or West Midlands Ambulance Service Emergency crew. In areas where patients requiring resuscitation may be treated without alerting the emergency team (e.g., Intensive Care Unit, Emergency Department), Advanced Life Support (ALS) should begin as soon as possible, according to the patient's needs and the individual staff member's abilities. Staff who are suitably trained should initiate secondary, advanced resuscitation interventions depending on the patient's needs.

CALLS FOR EMERGENCY INTERVENTION in non-MMUH Estates

If a patient deteriorates significantly, including cardiac arrest, and is for treatment,

2222 will be called and a 999-ambulance requested.

a. In hours 0700 - 1900h the emergency team will come from the on-site Team as described in Annex 3
b. An additional emergency response from the ambulance service will be activated, as necessary
c. Out of Hours, 2222 call will be made with a request for 999-ambulance

7.3 SITE-SPECIFIC RESPONSE: (SEE ANNEX 3)

7.3.1 Sandwell Health Campus

In Hours Sandwell will have an emergency team Monday – Friday, 0700 - 1900h. All emergency medical response bleeps are alerted. Each member of the site response team must respond at the earliest opportunity if it is safe to leave their area.

On receiving a 2222 call, switchboard will confirm the need for a 999-ambulance call and activate this response, if necessary, as well as dispatching the SWB emergency team.

If in **cardiac arrest,** BLS with AED will be commenced by the local team, and a call will be put out for the attendance of the emergency team via switchboard **2222.**

Advanced Life Support will be provided by appropriately trained team members as necessary when they arrive.

If the patient is **acutely unwell and deteriorating** and immediate emergency **medical attention** is required, a call will be put out for the attendance of the emergency team via switchboard **2222.**

The emergency team staff will assess and treat the patient and determine what ongoing management strategy is necessary. The expected pathways will include:

a. **Remain in the same clinical environment** at the retained estates (ie event has resolved or does not need interventions beyond those available at the retained estate). This includes patients who did not survive.
b. **Urgent transfer** (e.g. within the next several hours, not blue light) to MMUH for ongoing care
    i. The emergency team will contact the relevant on-call doctor at MMUH and refer the patient to their care
    ii. The emergency team will call 2222 to request an urgent ambulance transfer
    iii. Ongoing care needs before the transfer will be determined and continued as needed
c. **Immediate transfer** (e.g. 999-ambulance, blue light) to MMUH for emergency treatment
    i. The emergency team will contact the relevant on-call doctor at MMUH and refer the patient to their care
    ii. The emergency team will call 2222 to request an immediate 999-ambulance transfer (by a paramedic-led crew)
    iii. Ongoing care needs before the transfer will be determined and continued as needed

d. **Complex immediate transfer** to MMUH is rare and are patients with critical illness that would prevent safe transfer by a standard paramedic-led crew (eg respiratory failure requiring enhanced support, such as anaesthesia or ventilation, severe agitation or abnormal consciousness requiring anaesthesia)
    i. The emergency team will call the relevant theatre complex to request critical care support from onsite anaesthesia staff (if available)
    ii. The emergency team will call 2222 to initiate critical care support from MMUH.
    iii. Critical care transfer from the retained estates to MMUH will be undertaken by the Adult Critical Care Co-Ordination & Transfer Service (ACCOTS) with relevant assistance from the MMUH critical care staff

Outside of the specified hours, there is no SWB emergency team. In an emergency, call 2222 (for a 999-ambulance) or directly call 999. Local staff, as available, will provide first aid or life support.

City Health Campus

City Health Campus will have an emergency team at all times. All emergency medical response bleeps are alerted. Each member of the site response team must respond at the earliest opportunity if it is safe to leave their area.

On receiving a 2222 call, switchboard will confirm the need for a 999-ambulance call and activate this response, if necessary, as well as dispatching the SWB emergency team.

If in **cardiac arrest,** BLS with AED will be commenced by the local team, and a call will be put out for the attendance of the emergency team via switchboard **2222.**

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i. The emergency team will contact the relevant on-call doctor at MMUH and refer the patient to their care
ii. The emergency team will call 2222 to request an urgent ambulance transfer
iii. Ongoing care needs before the transfer will be determined and continued as needed

Immediate transfer (e.g. 999-ambulance, blue light) to MMUH for emergency treatment

iv. The emergency team will contact the relevant on-call doctor at MMUH and refer the patient to their care
v. The emergency team will call 2222 to request an immediate 999-ambulance transfer (by a paramedic-led crew)
vi. Ongoing care needs before the transfer will be determined and continued as needed

Complex immediate transfer to MMUH is rare and are patients with critical illness that would prevent safe transfer by a standard paramedic-led crew (eg respiratory failure requiring enhanced support, such as anaesthesia or ventilation, severe agitation or abnormal consciousness requiring anaesthesia)

vii. The emergency team will call the relevant theatre complex to request critical care support from onsite anaesthesia staff (if available)
viii. The emergency team will call 2222 to initiate critical care support from MMUH
ix. Critical care transfer from the retained estates to MMUH will be undertaken by the Adult Critical Care Co-Ordination & Transfer Service (ACCOTS) with relevant assistance from the MMUH critical care staff

7.3.2 Other Community Sites include Rowley, Leasowes, GP Surgeries, Health Centres, Patients' Homes, etc.

The response on these sites is BLS (and AED where available), which will be carried out by appropriately trained staff.

An ambulance service response is initiated by calling (Hospital Site) 2222 for a 999 call or 999 where an ambulance is required for all other sites. Advanced Life Support will be provided by the ambulance service.

7.3.3 Shared Public Areas within Main Buildings (e.g., corridors, restaurants, etc.)

In most instances, the nearest member of staff to the incident should summon local help and emergency calls via 2222 or 999 (as above) for ambulance service assistance as per site response.

If there is a nearby clinical area, they could be contacted to provide clinical expertise and equipment to patients, visitors, and staff suffering a medical emergency.

7.3.4 Other Areas Outside Main Buildings (e.g., grounds, car parks)

If a person has become unwell outside any site of the main building, the staff who find them should summon help as per site response.

If access to an internal phone is not possible, such as in the event the person is in an isolated place, then staff should call for an ambulance as they would in a public setting, i.e., 999, from a mobile phone.

7.4 Resuscitation Equipment, Defibrillators, and Defibrillation

Emergency equipment will be available for clinical areas of the hospital. Most of these areas will have a dedicated emergency equipment trolley, which will contain standardised equipment recommended by the RC(UK). The standardised equipment cannot be changed without authorisation from the DP&RT.

There are defibrillators on top of the Trust emergency equipment trolleys. Some are dedicated to specific wards/areas; others may share equipment with other departments. It is the ward/unit's responsibility to check and make available the defibrillators and trolleys. The ward/unit does not own them and must not remove them from the area or make them inaccessible without consulting the DP&RT, as doing so may leave the area unsafe.

Manual defibrillation in patients for the treatment of a shockable cardiac arrest may be performed by a Registered Health Professional who has been trained and deemed competent. Automated External Defibrillation (AED) in patients to treat shockable cardiac arrests may be performed by a person who feels competent and confident in its use. Where areas do not have access to emergency equipment, an out-of-area emergency equipment bag will be provided with the EMERGENCY TEAM.

7.5 Treatment Escalation Plans and Do Not Attempt 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 the Treatment Escalation Plan policy (SWBH/Pt Care

062).

Having an altered resuscitation status is a positive decision not to attempt resuscitation in the event of cardiorespiratory arrest. It is used when clinicians consider that attempting to resuscitate would be medically inappropriate (i.e., CPR would be unsuccessful) or it has been determined not to be in the patient's best interest.

A Treatment Escalation Plan may have variables and omissions. Whenever there is doubt about a patient's status, the decision must always be in favour of starting resuscitation until the status is confirmed.

Even with a DNACPR/TEP in place, THE PATIENT WILL STILL REMAIN SUITABLE TO CALL 2222/EMRT IN THE EVENT OF AN IMMEDIATELY REVERSIBLE CONDITION INCLUDING:

· Anaphylaxis

· Choking or blocked tracheostomy tube

· New event unrelated to current clinical condition e.g fracture following a fall

7.6 Not for EMRT

There may be some patients who have reached a ceiling of medical care for whom an emergency team call may not be appropriate; in fact, it may be distressing for the patient, family, and carers if the emergency team were to be called. In these circumstances, the team caring for the patient may decide that the emergency team should not be called.

All such patients must have this decision annotated within the Treatment Escalation Plan on Unity.

It is expected good practice that this decision will be discussed and communicated with the patient and relatives where appropriate.

"Not for EMRT" must be a Consultant decision, with the reasons documented in the Treatment Escalation Plan. It must be communicated to all members of the Multidisciplinary Team (MDT) caring for that patient. If a Consultant is not available, the decision can be made by an appropriately senior member of staff (as described within the DNACPR/TEP policy) and must be discussed with and countersigned by a Consultant within the timescale defined in that policy. The medical staff below a registrar tier level are not considered senior enough to make this temporising decision. If this decision is made, consider commencing the End of Life care plan (Supportive Care Plan A Guide for Clinicians (SWBH/Pt Care/100)).

7.7 Simultaneous EMRT Calls - MMUH

Managing Multiple Calls: In the event of a second simultaneous emergency team call within MMUH, the team leader is responsible for assigning available team members to attend the second call if resources permit. If this is not feasible, the team leader must promptly contact the switchboard via 2222 to activate the opposite A or B team. Quick and decisive action is crucial to minimise any inevitable delays and to optimise outcomes for all patients involved.

Notification of Delays: Staff initiating the second call must be informed by the switchboard at the time of the call about the possibility of a short delay. They should continue providing emergency treatment, whether basic or advanced, within their scope of practice despite the potential delay in the arrival of additional support.

Pre-Agreed Roles: The emergency team members can pre-assign roles during the briefing, identifying who will respond to a second call. If this hasn't been done, the team leader should send non-essential staff from the first incident to the second as soon as it is safe. Other team members will respond to the second incident as soon as the first is resolved.

Communication with Switchboard: The team leader must ensure that the switchboard is updated on the status and response to both incidents.

7.8 Relatives Witnessing Resuscitation

The Trust supports relatives if they wish to be present during a resuscitation attempt. There will be occasions when the emergency team leader deems it inappropriate for relatives to be present.

The overall decision remains with the emergency team leader, which must be documented if this occurs. A competent member of staff must be delegated to stay with the relatives and liaise with the emergency team on their behalf.

This member of the team must have the ability to pre-empt what process or intervention will be coming next to sufficiently prepare the family or relative.

7.9 EMRT Call during a Fire Alarm

If there is an emergency team call during a fire alarm, the following must be adhered to: Fire Safety Management Policy (SWBH/ORG/043).

Core EMRT members will attend the call if their safety is maintained.

7.10 Major Incident

During a major incident, the emergency team will continue to operate in the same

way. SWB Major Incident Plan - Incident Response Plan (SWBH/ORG/01).

7.11 MANAGEMENT OF TRAUMA

7.11.1 Management of Trauma at MMUH

A person may be present with serious injuries at MMUH. This will be a rare event and will include incidents such as falls from height (eg from overhanging levels, falls down escalators), violence (eg blunt or penetrating wounds), hanging, or drowning.

Staff must consider their safety, undertake a personal dynamic risk assessment and not approach if this would significantly endanger them.

Call 2222 to activate the standard emergency team response.

The switchboard will call the ambulance service upon receiving a 2222 call for a seriously injured person. The ambulance service will determine which assets, such as enhanced care teams (e.g. MERIT, Critical Care Paramedic, HEMS) or Hazardous Area Response Teams, to send to the scene. Police and fire services may also be called to attend.

At MMUH, there is a trauma team (accessed via 2222) that is available to respond and will be called for predetermined incidents (eg fall from a significant height) or after patient assessment by the initial emergency team. The trauma team will provide additional emergency care in situ.

The seriously injured patient will be moved as soon as possible to MMUH Emergency Department, if possible and appropriate, or taken to the major trauma centre by the ambulance service, as per the regional major trauma triage tool.

For major haemorrhage from trauma, management might include any or all of the following:

a. Applying appropriate direct pressure
b. Elevation of the affected area
c. Use of a Combat Application Tourniquet (CAT) if trained to do so
d. Use of appropriate wound bandaging
e. Conveying the patient to the appropriate emergency department as required.

7.12 Canal Incidents

If a person is found in the canal, no attempt to rescue by entering the water is expected. Appropriate flotation devices should be deployed.

7.13 Management of Trauma in Retained Estates

In the absence of a dedicated trauma team in areas such as the retained estates, the patient should be managed in situ with appropriate first-aid treatments.

A 999-emergency response will be initiated.

For major haemorrhage from trauma, management might include any or all of the following:

a. Applying appropriate direct pressure
b. Elevation of the affected area
c. Use of a Combat Application Tourniquet (CAT) if trained to do so
d. Use of appropriate wound bandaging
e. Conveying the patient to the appropriate emergency department as required.

7.14 Priority Lift Access MMUH

Members of the Emergency Medical Response Team (EMRT) at Midland Metropolitan University Hospital are granted priority lift access to ensure rapid response during emergencies. This priority access allows team members to override lifts when attending an emergency or for the critical transfer of patients following or during an emergency.

Priority lift access is strictly for use during emergencies and critical patient transfers. It must not be used for non-emergency situations.

Lift override keys or cards are provided to enable priority access. These cards are to be always kept with the emergency baton bleep.

Staff members are responsible for safeguarding the lift override keys/card. They must ensure that these are properly handed over during shift changes and reported immediately if they are lost or misplaced.

8: EQUITY AND DIVERSITY

The Trust recognises the diversity of the local community and those in its employ. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity, and appropriately to their needs.

The Trust recognises that equity impacts all aspects of its day-to-day operations and has produced an Equity Policy Statement to reflect this.

References:

Royal College of Nursing (2024) Recognising and managing deteriorating patients. Available at: https://www.rcn.org.uk/Page-Testing/Recognising-and-managing-deteriorating-patients (Accessed: 17 September 2024).