NHS
National Patient Safety Agency

RESUSCITATION IN MENTAL HEALTHCARE

A NPSA Rapid Response Report outlines how to reduce the risk of choking and cardiac/respiratory arrest in learning disability and mental health units

Introduction and evidence
Patients in mental health and learning disability inpatient settings can be vulnerable to cardiac or respiratory arrest through physical illness, self harm, the effects of medication (including rapid tranquillising) and physical intervention or seclusion. They can also be vulnerable to choking through dysphagia associated with illnesses such as dementia, food bolting, pica (attempting to eat non-food items) or self harm.

The National Patient Safety Agency received 599 reports related to choking or cardiac and respiratory arrest in mental health and learning disability settings occurring between January 2006 and March 2008.

These incidents showed a wide variation in the standards of resuscitation and included:

- An apparent lack of staff knowledge or skills, problems in availability or use of resuscitation equipment and unnecessary patient transfer.
- Missed physical symptoms, including misinterpreting physical deterioration of an impending cardiac arrest as hyperventilation or a panic attack;
- Patients with no history of swallowing difficulties choking unexpectedly on food;
- Confusion over whether a mental health unit in an acute hospital could access the crash team;
- Intoxicated patients suffering from choking or respiratory or cardiac arrest while not being observed or monitored closely.

Examples of the free text from some of the incidents are as follows:

- *Crash team were called, unable to gain access to the unit due to locked door on the third floor…. Patient had regurgitated, hence large amounts of vomit was in the airway. Suction unit provided was inadequate…. Ward staff were unfamiliar with the equipment…. There was confusion regarding availability of equipment for the resuscitation….*
- *At approximately 10.10 staff helped service user into the bath, because he was visibly anxious and sweating profusely. At approximately 10:25 staff tried to assist service user to get out of the bath. It was at this point that service user became very rigid and his breathing started getting very laboured. Staff obtained a pulse reading of 148 beats per minute and an oxygen sats reading of 89%….*
- *… observed foaming profusely from her mouth, staff nurse attended to the patient. The emergency medical team were called and 999 dialled. There was evidence of several pieces of apple in her mouth and the staff on duty had removed these pieces before the emergency team arrived. There are no recorded or verbal evidence of any difficulties with swallowing. Patient was transferred to [acute hospital] and died at [time]…. some particles of the raw apple may have been aspirated into the lungs.*

Jayne Wheway, clinical reviewer, NPSA

FIVE WAYS TO SAFER RESUSCITATION IN MENTAL HEALTH/LEARNING DISABILITIES

1 Keep basic skills up to date and know where to access experts
Attend basic life support training and updates, and ensure you know what to do if a patient chokes. If rapid tranquillising, physical intervention or seclusion are used, ensure you know where to access staff trained in immediate life support who have access to ILS equipment.

2 Manage and maintain life support equipment
Make sure you know where your nearest basic life support equipment is, that maintenance records are up to date and stock levels checked regularly. If applicable, know where your nearest automated external defibrillator is kept and ensure it can reach all patient areas within three minutes.

3 Organise a trial run
Take part in practice runs or drills. This could include making calls for help, finding and assembling equipment and starting resuscitation.

4 Avoid patient transfer
The sooner resuscitation is started the more likely it is to be successful. Don't move the patient to another room unless there is no alternative. To protect dignity consider movable screens.

5 Keep colleagues updated
Assessment information and changes regarding eating and swallowing must be communicated between staff.

Ensure you can access an automated external defibrillator within three minutes

Alamy

WHAT SHOULD MY TRUST BE DOING?

The NPSA rapid response report identified key actions to make practice safer.

The NPSA has asked your organisation to ensure that:

- Its basic life support training includes management of choking.
- All patient areas have immediate access to BLS equipment, such as self inflating bag masks or mouth to mouth devices.
- All patient areas where a cardiac arrest might be expected at least once every five years should have access to automated external defibrillators within three minutes.
- Units where rapid tranquillising, restraint or seclusion may be used have access to staff trained in immediate life support and equipment specified in NICE guidance (www.nice.org.uk/cg025).
- Where feasible, training includes regular practices or drills.
- A lead for resuscitation is named, and attendance at life support training is audited, reported to a senior level and any lapses acted on.

HOW TO USE THE RAPID RESPONSE REPORT TO CHANGE PRACTICE

Jacqui Pointon, senior mental health practitioner, Tier 4 child and adolescent mental health services, Cheshire and Wirral Partnership Foundation Trust, organised a resuscitation drill in response to recommendations in the Rapid Response Report.

"I have a role in leading on health and safety, medical devices and CPR and was responsible for disseminating the RRR to our teams.

"The trust has a timetable of mandatory training: all inpatient staff are trained in immediate life support. But we are always keen to relook at the trust's policies including equipment, checking procedures and training.

"What the RRR flagged up for us is that, because our service users are under 18, we rarely have incidences where we need to put resuscitation skills into practice.

"This means staff don't get the opportunity to be reminded of what they need to do if it was required.

"For this reason, I decided to pick up on one of the report's recommendations and organise a drill.

"Although our service users are young, some may have undiagnosed medical conditions, or they may have an eating disorder, that could increase their risk of collapsing. There are also people visiting the unit, such as grandparents.

"As well as testing our team's resuscitation skills, the purpose of the drill was also to test the time it takes to get equipment that is needed to the scene.

"In the few weeks leading up to the drill I told staff what I planned to do, but not when it would happen. This meant they kept the drill at the forefront of their minds.

"I initiated the drill by standing in the waiting area – which is the part of the unit furthest from the resuscitation equipment – and triggered the alarm.

> "Resuscitation drills give staff an opportunity to identify and iron out any problems before anything actually happens for real"

"Staff did not know that it was a drill until they arrived at the scene. I then told them I was timing the whole thing, to check we could respond within the recommended [according to RRR] three minutes.

"I'm pleased to say that all staff actioned their training excellently – it provided validation for them that their mandatory training really does work.

"As well as providing that confidence, the drill gave us a chance to relook at our policies and procedures. It has reassured everyone that we are doing all the right things and have everything in place if it is needed.

"As there was only a section of our staff on duty at the time, I plan to carry out further drills on different times and days, similar to a fire drill.

"Resuscitation drills is something I would definitely recommend. It gives staff an opportunity to identify and iron out any problems before anything actually happens for real. That is what health and safety is all about.

"By carrying out regular drills we hope to keep resuscitation at the forefront of everyone's mind. We have a responsibility to know exactly what to do.

"The RRR has focused our attention on this issue, giving us an opportunity to review policies and procedures while being broad enough to be relevant to any mental health or learning disabilities area."

EVERY REPORTED INCIDENT COUNTS
Each serious incident you report is reviewed at the NPSA. We see if there is potential for national action (an RRR) by looking for further evidence of harm in our database of more than four million incidents reported by nurses, doctors and others. Each RRR starts with a single incident – in this case, a report of staff not knowing what to do with a choking patient. Please carry on reporting to ensure safe care. **tinyurl.com/npsaguidance**

Find the Rapid Response Report and additional information (including a briefing sheet for nurses and FAQs) on the NPSA website at tinyurl.com/RRR-resus

DID YOU KNOW?

- **Automated external defibrillators are now commonly provided in settings such as railway stations, supermarkets and leisure centres and are estimated to have saved 132 lives in public places between 1999 and 2006.**
- **Basic life support implies no equipment is required to give cardiopulmonary resuscitation, other than a protective device to allow the responder to give ventilations without risk of infection transmission.**
- **Immediate life support equipment includes automated external defibrillators, bag valve mask, oxygen, cannulas, fluids, suction and first line medications.**
- **The Resuscitation Council (UK) and the National Institute for Health and Clinical Excellence provide the national standards for clinical practice in this area, which can be viewed at www.resus.org.uk and www.nice.org.uk.**
- **The NPSA is evaluating the implementation of the Rapid Response Report with a national survey.**