**Clinical Guidance Document –**

**Medical Emergencies**

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# Introduction

## Guidance statement

Patients may present with a medical emergency at any time. GPs, nurses, allied health professionals and non-clinical staff at Sheerwater Health Centre may be faced with the challenge of dealing with, and appropriately managing, a medical emergency. It is therefore imperative that the organisation is prepared for such occurrences.

This guidance provides referenced guidance on the management of medical emergencies and should be read in conjunction with the following GP Mythbusters:

* [GP Mythbuster 1: Resuscitation in GP surgeries](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-1-resuscitation-gp-surgeries)

The Care Quality Commission (CQC) decrees that all GP practices must be equipped to deal with a medical emergency. This includes resuscitation. Due to the ongoing risk of COVID-19 transmission, the guidance issued by the Resuscitation Council UK (RCUK) must be factored in when responding to any medical emergency.

* [GP Mythbuster 9: Emergency medicines for GP practices](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-9-emergency-medicines-gp-practices)

The CQC states that GPs and HCPs need the knowledge, skills and equipment for managing the medical emergencies that they are likely to face.

It is the responsibility of all staff to ensure that they recognise, respond to and take the necessary actions when dealing with any medical emergency. The management team will assume responsibility for ensuring that all staff have undertaken the necessary training and would be able to respond to a medical emergency within the organisation.

[Resuscitation Council UK](https://www.resus.org.uk/professional-resources), or RCUK, develops guidelines that inﬂuence emergency care policy. It provides education, training and research to support the skills needed to save a life. RCUK updates its guidelines every five years, with the last update being in 2021.

At this organisation, staff are aware of the updated [RCUK COVID-19 guidance](https://www.resus.org.uk/library/additional-guidance/guidance-covid-19) dated 10 Aug 2022.

For support completing a risk assessment, refer to both the [Risk Assessment Guidance Document](https://practiceindex.co.uk/gp/forum/resources/1519) and the [COVID-19 Risk assessment aide memoire.](https://practiceindex.co.uk/gp/forum/resources/covid-19-risk-assessment-an-aide-memoire.1518/)

For further guidance on anaphylaxis, refer to the [Clinical guidance document – Allergies intolerances and sensitivites](https://practiceindex.co.uk/gp/forum/resources/clinical-guidance-document-allergies-intolerances-and-sensitivities.1535/)

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* [Basic Life Support (BLS) (Adults)](https://practiceindex.co.uk/gp/forum/threads/basic-life-support-adults.13910/)
* [Basic Life Support (BLS) (Children and Infants)](https://practiceindex.co.uk/gp/forum/threads/basic-life-support-infants-and-children.14410/)
* [Anaphylaxis](https://practiceindex.co.uk/gp/forum/threads/anaphylaxis.13912/)
* [Mental capacity act](https://practiceindex.co.uk/gp/forum/threads/mental-capacity-act.13877/)
* [Risk assessments including COSHH](https://hub.practiceindex.co.uk/courses?sort=name_asc&name=risk&showpublished=1&shownotpublished=1&mandatory=&search=1&tableview=0&src=hub#collapse_2086)

## Status

Sheerwater Health Centre aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents).

Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies. This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment.

# Emergencies in general practice

## Early diagnosis

As stated in NHSE’s [Transforming urgent and emergency care services](https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf), GPs have more contact with patients than any other element of the NHS. Early diagnosis and treatment in the primary care setting will reduce harm and distress for the patient. Effective and timely responses can avoid unwell adults and children being driven to use emergency departments.

## Classifications of medical emergencies

In general practice, medical emergencies have been classified as:

* Cardiovascular
* Respiratory
* Gastrointestinal
* Endocrine
* Neurological
* Overdoses and poisoning
* Other medical emergencies

In addition to the above, the following have been classified as ‘other’ medical emergencies:

* Sickle cell crisis
* Acute renal failure
* Delirium tremens
* Hyperpyrexia (heat stroke)
* Malignant hyperpyrexia

## Initial management by clinicians

Clinicians presented with such emergencies should determine whether it is appropriate to manage the patient in the practice setting, or if the patient should be referred to hospital via emergency ambulance.

Some medical emergencies can be managed completely within the practice setting whilst others will require hospital referral following initial management. The determining factors for on-site management are:

* Level of clinical expertise available
* Severity of the presenting condition
* Proximity of the nearest secondary care facility
* Availability of paramedical crews to transfer the patient

The responsibility for the management of the patient rests with the clinician.

## ABCDE approach to resuscitation

The Resuscitation Council UK recommends the [ABCDE approach](https://www.resus.org.uk/library/abcde-approach) to resuscitation. The underlying approach to all deteriorating or critically ill patients is uniform, namely:

* Use the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach to assess and treat the patient
* Complete an initial assessment and re-assess regularly
* Treat life-threatening problems before moving on to the next part of the assessment
* Assess the effects of the treatment
* Recognise when extra help is needed and call for appropriate help early
* Use all members of the organisation team to enable all necessary actions to be undertaken simultaneously
* Communicate effectively using one of the following techniques/approaches:
	+ Situation, Background, Assessment, Recommendation (SBAR)
	+ Reason, Story, Vital signs, Plan (RSVP)
* The aim of the initial treatment is to keep the patient alive and to achieve some clinical improvement to allow time for further treatment and making a diagnosis
* All are to be reminded that it may take a few minutes for treatments to work, so a short time is often needed before reassessing the patient for intervention

## Using NEWS2

The National Early Warning Score or [NEWS](https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/) is a well-validated track-and-trigger early warning score system that is used to identify and respond to patients at risk of deteriorating.

An NHS video is available to explain [NEWS2](https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/#guidance-on-the-use-of-news-in-community-acute-ambulance-and-acute-mental-health-settings).

It is based on a simple scoring system in which a score is allocated to physiological measurements already taken when patients present to, or are being monitored in, healthcare settings.

Scores of 0 – 3 points are allocated to each of the following six physiological parameters:

* Respiratory
* Oxygen saturation
* Temperature
* Systolic blood pressure
* Pulse rate
* Level of consciousness

The Royal College of Physicians recommends that sepsis should be considered for any patient with a NEWS score of 5 or more.

A resource pack produced by the Royal College of Physicians to enable the safe adoption of NEWS2 is available from [NHS England](https://www.england.nhs.uk/publication/patient-safety-alert-safe-adoption-of-news2/).

## Non-clinical staff responsibilities

Non-clinical staff are to be trained to recognise patients who may present with medical emergencies and identify patients who show signs of:

* Shortness of breath
* Wheezing
* Dizziness
* Obvious signs of distress/pain
* Sweating profusely and/or paleness
* Appearing confused or disorientated

It should be noted that this list is not exhaustive.

In such instances, non-clinical staff should alert a clinical colleague to ensure that patients are afforded the most appropriate level of care in a distressing situation.

## External emergencies

If an incident arises in close proximity to the practice, clinical staff should provide the appropriate assistance until specialist help arrives (Ambulance Service). For nurses, the Nursing and Midwifery Council [Code](https://www.nmc.org.uk/standards/code/) places a professional duty on a nurse to provide appropriate assistance within their sphere of knowledge and competence.

The [RCN Duty of care](https://www.rcn.org.uk/Get-Help/RCN-advice/duty-of-care) makes clear that there is no legal duty to volunteer to help in an emergency situation. However, there is a professional duty that can be read in the above RCN link.

Similarly, GPs have an ethical duty to provide what assistance they can if an emergency arises. [GMC guideline 26](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-2----safety-and-quality) states:

* *You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence, and the availability of other options for care.*

On occasion, members of the public may ask the organisation to provide a defibrillator whilst they await the Ambulance Service. In such instances, it would be appropriate for a clinician and a non-clinical member of staff to attend the incident with the emergency equipment (defibrillator) to provide support within the scope of their clinical competence until specialist help arrives.

Clinicians should ensure that they record their involvement at the incident accurately, as this information may be required at a later date by the patient’s GP, hospital staff or possibly legal representatives.

Staff must ensure that any emergency equipment is returned to the organisation as soon as it is no longer needed at the scene of the emergency. This will ensure that the equipment can be prepared for future use immediately.

## Conducting CPR during the COVID-19 pandemic

COVID-19 is spread in a way similar to seasonal influenza, person-to-person through close contact and droplets.

Therefore, standard principles of infection control and droplet precautions are the main control strategies and should be followed rigorously. As aerosol transmission can occur, attention to hand hygiene and containment of respiratory secretions produced by coughing and sneezing are the cornerstones of effective infection control.

Additional support and guidance relating to maintaining infection control principles during COVID-19 can be found at:

* [Pandemic Management Policy](https://practiceindex.co.uk/gp/forum/resources/pandemic-management-policy.1439/)
* [Infection Prevention Control Policy](https://practiceindex.co.uk/gp/forum/resources/infection-prevention-control-policy-ipc.700/)
* [Cleaning Standards and Schedule Policy](https://practiceindex.co.uk/gp/forum/resources/cleaning-standards-and-schedule-policy.1388/)

## DNACPR

Do not attempt cardio-pulmonary resuscitation, or DNACPR, is a pre-arranged agreement between the patient, family and friends, and clinical staff, should the patient have capacity. If the patient does not have capacity, then it will be agreed between all other parties if there is no previously agreed TEP in place.

 Conversations about “do not attempt cardiopulmonary resuscitation” (DNACPR) should not happen in isolation and should involve a multi-disciplinary process. As such, DNACPR decisions must take place as part of broader conversations about the treatment and future care of patients.

Further information on DNACPR can be found in [GP Mythbuster 105: DNACPR](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-105-do-not-attempt-cardiopulmonary-resuscitation-dnacpr) updated 3 Nov 22 and” [Mental Capacity Act Policy](https://practiceindex.co.uk/gp/forum/resources/mental-capacity-act-policy.1105/). Additionally, further information about DNACPR and COVID-19 can be found in [Section 2.12](#_DNACPR_during_COVID-19).

## Treatment escalation plan

A Treatment Escalation Plan or TEP should be considered for those patients whose condition is likely to deteriorate significantly. It is especially important for a TEP to be discussed for those patients whose mental capacity is likely to diminish.

The [BMJ](https://www.bmj.com/content/371/bmj.m4563) advises that systems should have a broad approach to advance care planning and suggest a TEP.

DNACPR should be part of the TEP, and any consultation regarding ongoing treatment, including the level of life sustaining therapeutic interventions or actions, must involve the patient and their family and friends in addition to any health and care professionals directly involved in their care.

Importantly, the TEP must be an individual plan. It is intended to guide health and care staff so that the patient or family’s wishes are considered, and to reduce harm from over-treatment in people for whom death is inevitable and under-treatment in people who need symptomatic relief at the end of life.

If needed, further reading on DNACPR can be found in the following UK variants:

* [England](https://practiceindex.co.uk/gp/forum/resources/dnacpr-policy-england.1756/)
* [Scotland](https://practiceindex.co.uk/gp/forum/resources/dnacpr-policy-scotland.1819/)
* [Wales](https://practiceindex.co.uk/gp/forum/resources/dnacpr-policy-wales.1788/)

East Kent Hospitals University NHS Foundation Trust have created an [example](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjC6py5_a_7AhWEZsAKHdjKCtAQFnoECBEQAw&url=https%3A%2F%2Fwww.ekhuft.nhs.uk%2FEasySiteWeb%2FGatewayLink.aspx%3FalId%3D501014&usg=AOvVaw33YromG4R3lpq2cyWfPeEp) Treatment escalation plan. The following YouTube [video](https://www.bing.com/videos/search?q=Treatment+Escalation+Plan&docid=608029694149673912&mid=C624D0E80917C6BDF1F0C624D0E80917C6BDF1F0&view=detail&FORM=VIRE) further explains TEP.

## ReSPECT

The Recommended Summary Plan for Emergency Care and Treatment ([ReSPECT](https://www.resus.org.uk/sites/default/files/2020-09/ReSPECT%20v3-1-formSPECIMENFINAL_0.pdf)) is a process which records recommendations to guide immediate decision-making about a person’s care and treatment, including whether CPR should or should not be attempted, in case of a future emergency in which they lack capacity.

The ReSPECT process is increasingly being adopted within health and care communities around the UK. The process supports conversations about care in a future emergency and is now being used by most communities within England.

The aim is to develop a shared understanding between the healthcare professional and the patient of the patient’s condition, the outcomes the patient values, their concerns, and how treatments and interventions, such as cardiopulmonary resuscitation (CPR), fit into this. It supports the important principle of personalised care.

The latest version (v3) of the RCUK ReSPECT [form](https://www.coventryrugbygpgateway.nhs.uk/resources/respect-form-v3/?gpage_id=10329) was introduced in September 2020 and should be used to document conversations and recommendations made for care and treatment in an emergency. RCUK advises that this latest version is more patient-centred and contains more prompts for explicit clinical reasoning.

The CQC considers the ReSPECT process as being best practice in advance care planning. The RCUK provides the following [resources](https://www.resus.org.uk/respect/respect-resources) to support the use of ReSPECT:

* [Detailed](https://www.resus.org.uk/respect) information on ReSPECT for both staff and patients
* [Information](https://www.resus.org.uk/about-us/news-and-events/resuscitation-council-uk-introduces-version-3-respect-form) on v3 of the ReSPECT form, coupled with FAQs
* [Advice](https://www.resus.org.uk/library/publications/publication-decisions-relating-cardiopulmonary) on decisions relating to cardiopulmonary resuscitation (CPR)

## DNACPR during the COVID-19 pandemic

The COVID-19 pandemic has highlighted the importance of sensitive and well-structured conversations regarding a patient’s realistic healthcare choices and the need for a shared understanding between all involved persons.

DNACPR decisions during the COVID-19 pandemic raised concerns that there was a blanket application of DNACPR decisions to groups of people, rather than those decisions being applied based on an assessment of each person’s individual circumstances.

As such, the CQC has explored the implementation of best practice DNACPR

Guidance, and the key points raised were that *“conversations about DNACPR should not happen in isolation”* and that the CQC expects *“DNACPR decisions to take place as part of broader conversations about future care and treatment.”*

See further reading from the CQC regarding DNACPR:

1. [Announcement](https://www.cqc.org.uk/news/releases/cqc-finds-combination-increasing-pressures-rapidly-developing-guidance-may-have) dated 3 December 2020
2. [Interim Report](https://www.cqc.org.uk/sites/default/files/20201204%20DNACPR%20Interim%20Report%20-%20FINAL.pdf) dated January 2021
3. [Final Report](https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf) dated March 2021

# Emergency equipment

## General emergency equipment

To enable Sheerwater Health Centre to deal with an emergency effectively, processes are in place to ensure that emergency equipment is serviceable and in date, including all ancillary equipment. Patient safety is paramount and therefore all staff are trained and aware of what to do in an emergency.

Checklists are an effective way of ensuring compliance and they provide evidence of good practice.

At Sheerwater Health Centre, oxygen, a defibrillator and other emergency equipment are stored in the Treatment room. Overall responsibility for this equipment rests with Wendy Mayne (Practice Nurse). This equipment must be routinely checked on a regular basis to ensure its serviceability.

GP Mythbuster 9 advises of the suggested emergency drugs that are to be considered and is further detailed at [Section 3.4](#_Emergency_drugs), whereas, RCUK have a [minimum suggested equipment](https://www.resus.org.uk/quality-standards/primary-care-equipment-and-drug-lists/#equipment) to support CPR in primary care settings. As this list is not comprehensive, it has been interpreted and [risk assessed](https://practiceindex.co.uk/gp/forum/resources/risk-assessment-toolkit.1464/) to ensure that appropriate cover can be maintained during a medical emergency.

The following list of factors is also taken into consideration in preparation for any emergency.

* List size and demographics
* Proximity to the nearest hospital
* Medical conditions that are likely to be faced
* Current stock levels
* Shelf-life
* Supporting medicines that staff are confident in using
* Waiting times for ambulances to convey patients to hospital
* Longer delays for transfer
* Previous history of usage, including consideration for increased COVID-19 requirements
* Speed of resupply from supplier
* Local resources i.e., other surgery
* Staffing levels and consideration for longer waits for transfer. Need for overtime or lone working concerns

All emergency equipment is checked regularly for serviceability. An emergency equipment checklist can be found at [Annex A](#_Annex_A_–). Checklists will be filed and retained for six years, until the time for any likely legal action has passed.

A poster advising staff where emergency equipment is located can be found [here](https://practiceindex.co.uk/gp/forum/resources/emergency-equipment-location-poster.1583/).

Further information can be sought within the organisation’s [Record Retention Schedule](https://practiceindex.co.uk/gp/forum/resources/record-retention-schedule.767/).

## Oxygen

The number of oxygen cylinders that are to be held in the organisation has been reviewed, and a risk assessment that includes oxygen requirements has been conducted. Oxygen stores will be reviewed on a regular basis and following any incident.

Checks on oxygen equipment should include the cylinder (oxygen has a shelf life, as does the cylinder). Whilst most cylinders are now composite with a built-in regulator, should any cylinders have a detachable regulator, then that too will have a shelf-life.

All ancillary equipment such as masks and tubing also have expiry dates and must therefore be included in any equipment checking and replaced accordingly.

Further reading on cylinder storage and handling can be sought from:

* [BOC](https://www.bochealthcare.co.uk/en/quality-and-safety/safety-and-technical-data/storage-and-handling-medical-gas-cylinders/storage-and-handling.html)
* [Medicines and medical gases storage protocol](https://practiceindex.co.uk/gp/forum/resources/medicines-medical-gases-storage-protocol.704/)

## Defibrillators

Refer to [GP Mythbuster 1: Resuscitation in GP Surgeries](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-1-resuscitation-gp-surgeries), as this provides detailed advice on the need for an automated external defibrillator (AED) coupled with the adhesive defibrillator pads and the requirement to retain a spare set of pads as a response to a cardiac arrest.

When checking, it should be noted that AED pads have a shelf-life of approximately 18 months, whereas the battery life is four years from date of manufacture. Routine checks should be regularly conducted and note that the packaging for the pads can easily deteriorate.

AED pads should be able to be used for both adults and paediatrics.

Further reading can be sought from RCUK [A guide to Automated External Defibrillators (AEDs)](https://www.resus.org.uk/library/publications/publication-guide-automated-external-defibrillators).

## Emergency drugs

The monitoring of the emergency drugs and doctor’s bag are the responsibility of the Wendy Mayne (Practice Nurse) and are located in the Treatment Room.

|  |  |
| --- | --- |
| **Drug** | **Indication** |
| Adrenaline for injection  | Anaphylaxis or acute angio-oedema |
| Antiemetic such as cyclizine, metoclopramide or prochlorperazine | Nausea and vomiting |
| Aspirin soluble tablets | Suspected myocardial infarction |
| Atropine (for practices that fit coils or where minor surgery is performed) | Bradycardia |
| Benzylpenicillin for injection  | Suspected bacterial meningitis |
| Chlorphenamine for injection  | Anaphylaxis or acute angio-oedema |
| Dexamethasone 5mg/2.5ml oral solutionRequires date opened sticker and new expiry once seal broken (or soluble prednisolone – NOTE off-label use) | Croup (children) |
| Diclofenac (intramuscular injection)  | Analgesia |
| Furosemide | Left ventricular failure |
| Glucagon (needs refrigeration) GlucaGen® Hypokit® has an 18-month expiry out of fridge – should be labelled with new expiry date) Or alternative medicine to treat hypoglycaemia  | Hypoglycaemia |
| Glyceryl trinitrate (GTN) spray or unopened in date GTN sublingual tablets | Chest pain of possible cardiac origin |
| Hydrocortisone for injection and/or soluble prednisolone | Exacerbations of asthma, severe or recurrent anaphylaxis |
| Midazolam (buccal) or diazepam (rectal) | Epileptic fit |
| Naloxone (dependent on whether opiates are kept at the practice) | Opioid overdose |
| Opiates – diamorphine, morphine or pethidine ampoules for injection. (Water for injection may be required to reconstitute) | Severe pain including myocardial infarction |
| Salbutamol, either nebules or inhaler with volumatic and ipratorium bromide (children) – consider strengths stocked | Asthma |
| [Add as required] |  |

**Notes:**

1. The above list is not exhaustive and additional medicines may need to be added depending on the needs of the local population and local arrangements for services e.g., district nurse, palliative care and substance misuse.
2. Naloxone is a medicine used to reverse the effects of opiates. Organisations that stock opiates (either in the practice or in the doctor’s bag) should also stock naloxone.

A risk assessment may be needed based on the patient group. For example, patients with addiction or those patients who present with opiate related problems.

1. The CQC would expect to see evidence that an appropriate [risk assessment](https://practiceindex.co.uk/gp/forum/resources/risk-assessment-toolkit.1464/) has been conducted. This is to identify a list of medicines that are not suitable for a practice to stock and how this is kept under review.
2. There should be a process and system in place to check that drugs are in date and equipment is well maintained.

Further advice on what should be should be kept in a doctor’s emergency bag can be found [here](https://patient.info/doctor/doctors-bag-contents).

# Life support obligations and FAQs

The RCUK have a section of [FAQs](https://www.resus.org.uk/home/faqs/faqs-basic-life-support-cpr) covering basic and advanced life support (CPR) including:

* Adult Basic Life Support
* CPR
* Defibrillators
* Choking
* Paediatric Basic Life Support
* Training in CPR and AEDs

Whilst there are no statutory legal provisions in the UK relating to the practice of resuscitation or defibrillation, further reading can be sought from the RCUK in its publication titled [CPR, AEDs and the law](https://www.resus.org.uk/library/publications/publication-cpr-aeds-and-law) dated April 2018.

# Management of specific medical emergencies

The RCUK produces guidelines approximately every five years, with the latest version being 2021.

The below links detail the management of the following emergencies:

* [ALS (Adults) (2021)](https://www.resus.org.uk/library/2021-resuscitation-guidelines/adult-advanced-life-support-guidelines)
* [ALS (Paediatric) (2021)](https://www.resus.org.uk/library/2021-resuscitation-guidelines/paediatric-advanced-life-support-guidelines)
* [BLS (Adults) (2021)](https://www.resus.org.uk/library/2021-resuscitation-guidelines/adult-basic-life-support-guidelines)
* [BLS (Paediatric) (2021)](https://www.resus.org.uk/library/2021-resuscitation-guidelines/paediatric-basic-life-support-guidelines)
* [Anaphylaxis (2021)](https://www.resus.org.uk/covid-19-resources)

# Further reading

The following can support additional training and guidance with the management of medical emergencies:

* NHS E publication [Talking do not attempt cardiopulmonary resuscitation](https://www.england.nhs.uk/publication/talking-do-not-attempt-cardiopulmonary-resuscitation-dnacpr/)
* [www.resus.org.uk](https://www.resus.org.uk/)
* [RCGP](https://elearning.rcgp.org.uk/mod/page/view.php?id=11672?utm_source=resuscounciluk_medium=tw_date=211220) e-Learning on the new anaphylaxis guidelines dated December 2020
* [Clinical guidance document – Allergies, intolerances and sensitivities](https://practiceindex.co.uk/gp/forum/resources/clinical-guidance-document-allergies-intolerances-and-sensitivities.1535/) alludes to the management of anaphylaxis
* For anaphylaxis in children support, see [www.sparepensinschools.uk](http://www.sparepensinschools.uk/)

# Summary

All staff have an essential role to play in identifying, responding to and managing medical emergencies at Sheerwater Health Centre, and therefore training is an essential component to ensure an appropriate response to a medical emergency.

Early recognition and summoning help are key if further distress and harm are to be prevented in medical emergencies.

# Annex A – Emergency equipment checklist

Date of check………………………………… Checked by………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Equipment details** | **Make and serial number** | **Location** | **Expiry date** | **Calibration date** |
| AED (Defibrillator) |  |  |  |  |
| AED pads (Adult and Paed) |  |  |  |  |
| AED battery |  |  |  |  |
| Oxygen and regulator |  |  |  |  |
| Adult and paediatric masks |  |  |  |  |
| Airways |  |  |  |  |
| Syringes/needles (2ml/5ml) |  |  |  |  |
| Cannulas |  |  |  |  |
| Sphygmomanometer |  |  |  |  |
| Cuffs (various sizes) |  |  |  |  |
| Glucometer/lancets/test strips |  |  |  |  |
| Thermometer |  |  |  |  |
| Stethoscope |  |  |  |  |
| Tongue depressors |  |  |  |  |
| Diagnostic kit |  |  |  |  |
| Specimen bottles |  |  |  |  |
| Sharps box |  |  |  |  |
| Multistix |  |  |  |  |
| Torch |  |  |  |  |
| Hand gel |  |  |  |  |
| Pulse oximeter |  |  |  |  |
| [Add as appropriate] |  |  |  |  |