Resuscitation Council UK

Resuscitation Council UK statement on COVID-19 for healthcare workers (HCW) in primary and community healthcare settings

This statement is for healthcare workers (HCWs) who are performing cardiopulmonary resuscitation (CPR) in a primary or community care setting including (but are not limited to) GP surgeries and community-based clinics.

Definitions of PPE

- **Aerosol Generating Procedure (AGP) PPE (also referred to as Level 3 PPE):** disposable gloves, fluid resistant coverall/gown, filtering face piece (FFP3) mask, eye protection
- **Non AGP PPE (also referred to as Level 2 PPE):** disposable gloves, disposable plastic apron, disposable fluid resistant mask, eye protection

Reference

Recommended PPE for primary, outpatient, community and social care by setting, NHS and independent sector: click here to view

1. Purpose

1.1 COVID-19 is thought to spread in a way similar to seasonal influenza: from person-to-person, through close contact and droplets. Standard principles of infection control and droplet precautions are the main control strategies and should be followed rigorously. Aerosol transmission can also occur. Attention to hand hygiene and containment of respiratory secretions produced by coughing and sneezing are the cornerstones of effective infection control.

1.2 All HCWs managing those with suspected or confirmed COVID-19 must follow local and national guidance for infection control and the use of PPE.

1.3 During CPR, there is always the potential for rescuers to be exposed to bodily fluids, and for procedures (e.g. chest compressions or ventilation) to generate an infectious aerosol or droplets. Individual healthcare organisations should carry out local risk assessments, based on the latest guidance from RCUK/DHSC/PHE regarding PPE for HCWs to develop local guidance.

1.4 HCWs must be trained to put on/remove PPE safely and to avoid self-contamination. For more information, visit: https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

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1.5 The Royal College of General Practitioners (RCGP) has provided ethical guidance on COVID-19 in primary care settings as those working in primary care will need to consider their responsibilities to patients, practices, themselves and family, friends and the public. View their guidance: https://elearning.rcgp.org.uk/mod/page/view.php?id=10557

2. Guidance on CPR in patients with a COVID-19 like illness or a confirmed case of COVID-19 in primary care settings

2.1 Resuscitation is an invasive medical procedure and ideally should only be provided after careful consideration with the patient of the benefits and burdens provided by resuscitation prior to the need for CPR arising. These discussions should be compliant with Mental Capacity Act and may require the involvement of a Lasting Power of Attorney. Conversations and treatment escalation planning must be a priority. Where appropriate, patients should have an individual emergency care treatment plan that includes recommendations for the appropriateness of cardiopulmonary resuscitation. If appropriate, ensure treatment escalation plans and "do not attempt cardiopulmonary resuscitation" (DNACPR) decisions are well documented and communicated.

2.2 Identify as early as possible any patients who are at risk of acute deterioration or cardiac arrest. Take appropriate steps to prevent cardiac arrest. Seek advice at an early stage from the appropriate service/medical expert as to the need for admission to hospital for acute/advanced medical care. For those for whom resuscitation would be inappropriate, decisions must be made and communicated.

2.3 It is recognised that a sudden collapse may happen in many different situations in the primary or community care setting, and this precludes provision of specific guidance for every eventuality.

2.4 A HCW may encounter a patient who has had a cardiac arrest in a public place (i.e. without the benefit of resuscitative equipment or PPE). Under such circumstances they should follow guidance for members of the public, being aware of their professional obligations. Please refer to our statement on COVID-19, CPR and resuscitation in first aid and community settings for more information.

2.5 AGP PPE is the safest option for HCWs when undertaking chest compressions and other resuscitation procedures on patients with suspected or confirmed COVID. However, it is recognised that this may not be achievable in a primary or community care setting depending on the availability or otherwise of PPE. In the absence of AGP PPE, non AGP PPE if available for clinical care, must be worn as a minimum for resuscitation events.

2.6 When it is difficult to ascertain whether a person may or may not have COVID-19, the HCW must decide how to act in the circumstance in which they find themselves.

2.7 In any situation when a person with suspected or confirmed COVID is/becomes unresponsive, it is important to minimise the risk of droplet transmission.

During your assessment:

- Look for signs of life and normal breathing. Do **not** listen or feel for breathing by placing your ear and cheek close to the person's mouth
- Feel for a carotid pulse if trained to do so
- Shout for help early so potential helpers are aware of the situation. They should remain at a distance of >2 metres from the unresponsive person
- If a person is unresponsive and not breathing normally, call the ambulance service in accordance with local protocols
- When calling, state the risk of COVID-19 if appropriate
- If an AED is available nearby and/or if a helper can fetch the device, it should be collected immediately

2.8 In any primary care situation the HCW should attach a defibrillator, if available, to assess the initial rhythm. They should administer up to 3 shocks if the patient has an initial shockable rhythm, as early defibrillation has a high chance of success.

2.9 Following this action, or if a defibrillator is not available, the HCW must decide what to do next having taken into account the person's history, the setting, the availability and proximity of help and/or equipment, and the skills they themselves have. Each HCW should be aware of the ethical issues involved (see 1.5) in deciding the course of action and the potential outcomes.

2.10 If willing and able, and depending on the situation, the HCW could decide to commence chest compression-only CPR ensuring the person's mouth and nose are covered, either by a cloth or a mask.

2.11 If unable, or the situation is such that to undertake CPR would lead to a high level of risk to the HCW (e.g. from the patient's history, or the HCW's own medical history), then further resuscitation procedures may have to be delayed until responders wearing PPE arrive.

2.12 As soon as HCWs in AGP PPE arrive, the first HCW must withdraw to a safe distance of over 2 metres if not wearing AGP PPE. A brief handover must be given to the HCW taking over the resuscitation, including a history of the immediate event and relevant medical conditions.

2.13 In most instances, the Advanced Life Support (ALS) response will be provided by the ambulance service. However, in any setting where HCWs have additional airway management skills AGP PPE must be available and accessible.

2.14 An early call to the receiving acute unit may facilitate the safe transfer of a person with return of spontaneous circulation (ROSC). If the resuscitation attempt is unsuccessful, appropriate care must be put in place for both the person and any bystanders present.

2.15 The COVID ALS algorithm should be followed and decisions must be made regarding the continuation of the resuscitation event. Decisions on whether to continue or discontinue resuscitation must be made considering the circumstances of the individual case.

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3. Post event considerations

3.1 Follow local guidance for safely removing PPE to avoid self-contamination and dispose of it in clinical waste bags as per local guidelines. Hand hygiene has an important role in decreasing transmission. Thoroughly wash hands with soap and water; alternatively, alcohol hand rub is also effective.

3.2 Dispose of, or clean, all equipment used during CPR following the manufacturer's recommendations and local guidelines. Any work surfaces used for airway/resuscitation equipment will also need to be cleaned according to local guidelines.

3.3 Debrief at the end of the resuscitation attempt with any staff present.

3.4 Ensure appropriate documentation is completed and submitted to the relevant organisation/authority.

Additional information

Paediatric advice

We are aware that paediatric cardiac arrest is likely to be caused by a respiratory problem, making ventilations crucial to the child's chances of survival.

For out-of-hospital cardiac arrest, calling an ambulance and taking immediate action is vitally important. If a child is not breathing normally and no actions are taken, cardiac arrest will follow soon.

It is possible that the child/infant having an out-of-hospital cardiac arrest may be known to the rescuer. It is possible that doing rescue breaths will increase the risk of transmitting the COVID-19 virus, either to the rescuer or the child/infant. This may be mitigated by the use of airway adjuncts such as a face shield, pocket mask or bag-mask device. However, this risk is small compared to the risk of taking no action as this will result in certain cardiac arrest and the death of the child.

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