

EMERGENCY RESUSCITATION AND INITIAL STABILIZATION PROTOCOL

Protocol 3: Recognition, Activation, ABCDE Management, Reassessment, and Safe Transfer of Responsibility

DRAFT FOR CLINICAL, NURSING, ADMINISTRATIVE, LEGAL, AND PATIENT-SAFETY REVIEW

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Approved by	[Medical Executive / Nursing Executive / Resuscitation Committee / Hospital Board]
Applies to	All personnel participating in recognition, activation, resuscitation, stabilization, monitoring, documentation, or transfer of critically ill or injured patients
Supersedes	[Insert previous resuscitation or emergency stabilization policy, if applicable]

Important: This protocol defines the common resuscitation system and ABCDE process. Exact medication doses, electrical energy settings, equipment sizes, procedural techniques, and termination criteria must follow the hospital's separately approved and currently displayed adult, paediatric, neonatal, trauma, obstetric, toxicology, and condition-specific algorithms. Staff must work within their training, credentialing, and legal scope of practice.

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Recognize danger early. Call for help. Begin life-saving actions immediately. Assess and treat simultaneously using ABCDE. Reassess after every intervention. Do not delay stabilization for registration, payment, imaging, laboratory confirmation, consultation, or bed allocation.

1. Purpose

To provide a standardized, team-based approach to the immediate recognition, resuscitation, and stabilization of patients with actual or impending life-threatening illness or injury.

To ensure that time-critical care begins without avoidable delay; that responsibilities are explicit; and that no patient leaves the resuscitation process without documented reassessment, an active plan, and transfer of clinical responsibility.

To establish a common safety architecture that supports, but does not replace, current adult, paediatric, neonatal, trauma, obstetric, and condition-specific resuscitation algorithms.

2. Scope

This protocol applies 24 hours a day to all critically ill or injured patients within the Emergency Department and to patients whose deterioration is first recognized at the ED entrance, waiting area, ambulance bay, diagnostic area, or other location under ED responsibility.

It applies to adults, children, pregnant and postpartum patients, trauma patients, persons with poisoning or behavioural emergencies, and patients transferred from another facility.

In a declared mass-casualty incident, the hospital mass-casualty plan may modify staffing, triage, allocation, and documentation. Core life-saving principles remain in force.

3. Core policy statements

Resuscitation begins when a life threat is recognized, not when registration, complete history-taking, diagnostic confirmation, or senior review is completed.

Assessment and treatment shall occur simultaneously. The team shall use a structured ABCDE approach, correct immediately reversible threats as they are found, and restart the assessment from A after deterioration or a major intervention.

Any staff member may activate the resuscitation response. Staff shall not be criticized for activating in good faith when serious deterioration is suspected.

One clinician shall be clearly identified as team leader. One nurse or clinician shall coordinate medications and procedures. One person shall document times, findings, actions, and responses.

Closed-loop communication, explicit task assignment, read-back of critical information, and periodic team summaries shall be used.

The most experienced available clinician shall attend promptly when airway failure, cardiac arrest, refractory shock, major trauma, severe poisoning, obstetric emergency, critically ill child, or other complex instability is present.

Resource limitations, crowding, lack of an inpatient bed, ability to pay, or uncertainty about the receiving service shall not delay immediate life-saving care.

Every intervention requires reassessment. Persistent physiological abnormality must be explained, treated, escalated, or explicitly accepted by the responsible senior clinician.

4. Definitions

Term	Operational definition
Resuscitation	Immediate coordinated assessment and treatment intended to prevent or reverse cardiac arrest, respiratory arrest, shock, neurological deterioration, or other imminent death or serious disability.
Initial stabilization	The phase in which immediate threats are addressed, essential monitoring and access are established, early treatment begins, and the patient is made as safe as reasonably possible for definitive care, admission, procedure, or transfer.
ABCDE	Airway with cervical-spine consideration; Breathing; Circulation with haemorrhage control; Disability; Exposure and environment.
Primary survey	Rapid systematic search for and treatment of immediate life threats using ABCDE.

Term	Operational definition
Secondary survey	More complete history and examination performed after immediate life threats have been addressed and resuscitation is underway.
Team leader	The clinician who maintains situational awareness, sets priorities, assigns tasks, integrates findings, communicates the plan, and confirms reassessment and disposition.
Closed-loop communication	A task is directed to a named person, repeated back, completed, and reported back with the result.
Cardiac arrest	Unresponsiveness with absent normal breathing and no definite pulse or signs of circulation, assessed according to the currently approved resuscitation algorithm.
Peri-arrest	Severe physiological instability with a high risk of cardiac or respiratory arrest.
ROSC	Return of spontaneous circulation.
Reassessment	Repeat evaluation after an intervention or at clinically appropriate intervals to determine response, deterioration, new threats, and next actions.
Definitive care	The specialist procedure, operation, critical-care admission, ward care, antidote, reperfusion, delivery, or other treatment required beyond initial stabilization.

5. Roles and accountability

Role	Minimum responsibility during resuscitation
First staff member recognizing danger	Stay with the patient; call for help; activate the resuscitation response; begin actions within training; direct another person to bring emergency equipment; provide a concise handover.
Triage or receiving nurse	Move the patient immediately to the resuscitation area; initiate approved standing actions; attach monitoring; record arrival and activation times; identify infection, trauma, pregnancy, safeguarding, or hazardous exposure concerns.
Resuscitation team leader	Declare leadership; conduct or direct ABCDE; assign roles; request senior/specialist help; prioritize procedures and diagnostics; lead periodic summaries; confirm response, working diagnosis, and disposition.
Airway clinician	Assess and manage airway and ventilation; prepare backup plans; confirm placement of advanced airway devices using approved methods; prevent unrecognized displacement; communicate difficulty early.
Primary resuscitation nurse	Obtain access; administer approved medications and fluids; label lines and infusions; complete double-checks; report response and complications.

Role	Minimum responsibility during resuscitation
Monitor/defibrillator clinician	Attach monitoring and pads; identify rhythm; operate defibrillator within competency; announce safety checks; report changes.
Recorder/timekeeper	Document times, observations, rhythm, interventions, medication, fluids, procedures, response, consultations, decisions, and disposition; prompt scheduled reassessments when appropriate.
Runner/support staff	Retrieve equipment, blood, medications, and staff; control access; support communication; do not leave an assigned critical task without handover.
Senior ED clinician / consultant	Attend when escalation criteria are met; support complex decisions, procedures, resource allocation, termination or limitation decisions, and interfacility transfer.
Receiving specialty or critical-care team	Respond according to local escalation standards; participate in definitive management; formally accept responsibility through structured handover.
Department lead / shift coordinator	Maintain safe staffing and equipment readiness; mobilize additional staff; manage competing emergencies and crowding; escalate system barriers to administration.

6. Resuscitation-area readiness

The resuscitation area shall be immediately accessible, clearly designated, adequately lit, and kept free of avoidable obstruction. Essential equipment must be standardized, labelled, sealed or checked, and positioned consistently.

A documented readiness check shall occur at the start of each shift and after every use. Missing, expired, damaged, uncharged, or depleted items shall be replaced immediately and escalated if replacement is not available.

- Functional oxygen and suction with appropriate interfaces and backup supply.
- Bag-mask devices and airway equipment in adult and paediatric sizes; difficult-airway and surgical-airway access according to local capability.
- Defibrillator/monitor with charged battery, cables, pads/paddles, ECG capability, and paediatric attenuation where applicable.
- Pulse oximetry, non-invasive blood-pressure equipment, temperature measurement, and capnography where available and indicated.
- IV and intraosseous access equipment; fluids, pressure devices, and blood-administration equipment.
- Resuscitation medications, emergency infusions, antidotes, and medication reference tools approved by pharmacy and the resuscitation committee.
- Haemorrhage-control equipment, pelvic binder, splints, cervical-spine equipment, warming materials, and trauma supplies.
- Personal protective equipment, sharps disposal, decontamination supplies, and a process for hazardous or infectious exposures.
- Paediatric length/weight-based dosing and equipment system; obstetric and neonatal emergency supplies where the service receives these patients.
- Clock visible to the team, resuscitation record, algorithm posters, communication device, and reliable access to laboratory, imaging, blood bank, theatre, critical care, ambulance, and referral contacts.

A resuscitation bay that is not ready is a clinical risk. The shift coordinator must either restore readiness immediately or activate an approved contingency location and notify the responsible manager.

7. Recognition and activation

Level	Examples and required response
Immediate activation	Cardiac or respiratory arrest; unresponsive patient; threatened or obstructed airway; apnoea or ineffective breathing; severe respiratory distress or cyanosis; profound shock; uncontrolled major haemorrhage; active convulsive status; rapidly falling consciousness; anaphylaxis with airway, breathing, or circulatory compromise; major trauma with physiological instability; peri-arrest rhythm; eclampsia; critically ill child; or any clinician's concern that arrest is imminent.
Urgent senior attendance	Need for advanced airway, procedural sedation in an unstable patient, emergency electrical therapy, chest decompression, massive transfusion, vasopressor infusion, complex poisoning management, emergency delivery, interfacility critical-care transfer, or persistent instability despite initial treatment.
Specialist / external activation	Activate applicable trauma, obstetric, paediatric, surgical, anaesthetic, critical-care, stroke, cardiac, toxicology, blood-bank, theatre, security, safeguarding, ambulance, or overseas-referral pathways as soon as the need is recognized. Do not await completion of the full assessment when delay could cause harm.

- Use the local emergency call number, alarm, radio, or designated verbal call.
- State the location, patient age group, main threat, and specific assistance required.
- Send a named person to meet responders when the location is not obvious.
- If the usual activation system fails, use the documented backup communication route and escalate the failure after the event.
- On team arrival, provide a concise handover: identity, presenting event, key findings, interventions, response, known risks, and immediate need.

8. Universal immediate response

1. Ensure scene safety. Use appropriate PPE. Identify electrical, chemical, violent, infectious, radiation, fire, or structural hazards before exposing additional staff.
2. Assess responsiveness and normal breathing immediately. If cardiac arrest is suspected, activate the arrest response and follow the currently approved age-appropriate algorithm.
3. Move the patient to the resuscitation area unless immediate treatment at the point of collapse is safer. Do not delay chest compressions, ventilation, haemorrhage control, or defibrillation for transfer.
4. Position the patient appropriately. Apply cervical-spine precautions when indicated, without allowing equipment or immobilization to obstruct airway or resuscitation.
5. Attach essential monitoring while ABCDE proceeds. Obtain a full set of vital signs as soon as possible without delaying treatment.
6. Establish reliable vascular access when required. Use intraosseous access according to competency and local algorithm when urgent access cannot be obtained promptly.
7. Identify the patient using at least two identifiers when possible. Use an approved temporary identifier when identity is unknown. Treatment shall not be delayed.

8. Obtain a rapid SAMPLE history from the patient, family, ambulance team, records, medication containers, or witnesses while resuscitation continues.
9. Preserve dignity, privacy, warmth, and respectful communication even during high-acuity care.

9. Primary survey: ABCDE

ABCDE is performed rapidly and repeatedly. Treat life threats when found rather than completing the entire survey first. After a major intervention, unexpected deterioration, transfer, or handover, restart at A.

9.1 A - Airway with cervical-spine consideration

Component	Required practice
Look/listen/feel	Ability to speak or cry; airway sounds; secretions, blood, vomit, burns, swelling, trauma, foreign body, facial injury; work of breathing; mental status.
Immediate actions	Open and clear the airway using appropriate manoeuvres; suction; remove visible obstruction when safe; position; use basic airway adjuncts; provide oxygen and ventilation support; protect the cervical spine when trauma is possible.
Escalate immediately	Complete obstruction; stridor with deterioration; severe facial or neck trauma; airway burn or progressive swelling; inability to protect airway; recurrent aspiration; severe agitation or low consciousness preventing adequate ventilation; failed basic manoeuvres.
Advanced airway safety	Call the most experienced available airway clinician early. Prepare primary, backup, and rescue plans. Preoxygenate where feasible. Confirm and continuously monitor device position using clinical assessment and capnography when available. Secure the device and reassess after every move.
Do not	Do not make repeated unplanned attempts; do not allow cervical-spine equipment to obstruct airway management; do not delay a life-saving rescue airway while awaiting imaging or a specialist who is not immediately available.

9.2 B - Breathing

Component	Required practice
Assess	Respiratory rate, effort, chest movement and symmetry, oxygen saturation, air entry, breath sounds, tracheal position when relevant, cyanosis, wounds, chest wall stability, and adequacy of ventilation.
Support	Give oxygen for hypoxaemia or critical illness according to the locally approved target and condition-specific pathway. Assist ventilation when breathing is absent or inadequate. Use bag-mask ventilation with airway positioning and adjuncts; obtain skilled help early.
Treat immediate threats	Follow approved pathways for severe bronchospasm, pulmonary oedema, anaphylaxis, tension pneumothorax, open chest wound, massive haemothorax, flail chest, opioid toxicity, or other reversible cause. Credentialed clinicians may perform emergency decompression when indicated; imaging must not delay treatment of a clinically diagnosed immediate threat.

Component	Required practice
Monitor response	Reassess respiratory effort, oxygen saturation, chest movement, air entry, mental status, blood pressure, and capnography or blood gas when available and clinically indicated.
Ventilation safety	Avoid prolonged interruption of ventilation or chest compressions. Confirm mask seal and chest rise. After ROSC or stabilization, titrate oxygen and ventilation to the approved physiological targets rather than continuing avoidable hyperoxia or hypo-/hyperventilation.

9.3 C - Circulation with haemorrhage control

Component	Required practice
Assess	Pulse, heart rate and rhythm, blood pressure, capillary refill, skin temperature/colour, mental status, urine output when relevant, visible bleeding, and signs of occult haemorrhage or shock.
Control bleeding	Apply direct pressure, wound packing, haemostatic dressings, tourniquet, pelvic stabilization, or other approved measures as indicated. Record tourniquet application time. Activate surgical and blood-bank support early for major haemorrhage.
Access and samples	Obtain appropriate IV access; use intraosseous access when urgently required and within competency. Draw only investigations that will inform time-critical care, ideally during access placement.
Restore perfusion	Treat the likely cause. Administer fluids, blood components, vasopressors, or other therapy according to the approved pathway, patient age, comorbidity, and clinical response. Avoid automatic large-volume fluid administration without reassessment.
Rhythm and electrical therapy	Attach monitoring and defibrillation pads early when arrest or unstable arrhythmia is possible. Follow the currently approved rhythm-specific algorithm for defibrillation, synchronized cardioversion, pacing, and medications.
Reassess	After each bolus, blood component, electrical therapy, medication, or procedure, reassess perfusion, lungs, mental status, blood pressure, rhythm, and evidence of ongoing loss or fluid intolerance.

9.4 D - Disability

Component	Required practice
Assess	AVPU or Glasgow Coma Scale as appropriate; pupils; limb movement; focal deficit; seizure activity; behaviour; pain; blood glucose; temperature; and signs of raised intracranial pressure or toxidrome.

Component	Required practice
Immediate actions	Correct hypoglycaemia; treat active seizures using the approved algorithm; protect the airway; manage severe agitation with de-escalation and safe clinical support; consider naloxone when opioid toxicity is suspected and follow local guidance.
Time-critical pathways	Activate stroke, intracranial haemorrhage, meningitis/encephalitis, poisoning, eclampsia, or neurosurgical pathways when suspected. Record last-known-well time and seizure onset/cessation times when relevant.
Safety	Do not attribute altered mental status to alcohol, psychiatric illness, dementia, or behaviour until serious medical, traumatic, toxicological, metabolic, and neurological causes have been considered.
Reassess	Repeat consciousness, pupils, focal signs, glucose, ventilation, and haemodynamics after intervention and whenever the condition changes.

9.5 E - Exposure and environment

Component	Required practice
Expose safely	Remove or cut clothing sufficiently to identify injuries, bleeding, rash, burns, medical devices, pregnancy, needle marks, or concealed pathology. Preserve dignity and obtain a chaperone when feasible.
Prevent secondary harm	Prevent hypothermia with warm blankets, active warming, warmed fluids where available, and reduced unnecessary exposure. Cool patients with life-threatening hyperthermia using the approved pathway.
Complete immediate survey	Inspect the back and pressure areas when safe; log-roll trauma patients with coordinated spinal care when indicated; check all limbs and hidden areas for haemorrhage or injury.
Decontamination	Patients with chemical, biological, radiological, or hazardous contamination must be managed under the hospital decontamination plan before entry when feasible. Staff safety takes priority over uncontrolled exposure.
Safeguarding and evidence	Preserve forensic evidence when possible without delaying life-saving care. Identify concerns for abuse, assault, neglect, trafficking, or self-harm and activate safeguarding procedures.

At the end of the primary survey, the team leader shall state: immediate threats found; actions completed; response; unresolved threats; working cause; next priorities; required consultations; and planned destination.

10. Cardiac arrest response

Cardiac arrest management shall follow the hospital's currently approved age-appropriate basic and advanced life-support algorithms, based on current international or nationally adopted resuscitation guidance. These algorithms shall be displayed in the resuscitation area and reviewed after major guideline updates.

- Recognize arrest rapidly and activate the response.

- Start high-quality chest compressions immediately unless a valid decision not to attempt resuscitation is confirmed.
- Provide ventilation and oxygen according to the applicable algorithm; minimize interruptions in compressions.
- Apply the defibrillator or AED as soon as available; identify shockable rhythms and deliver electrical therapy using the approved energy and safety sequence.
- Change compressor at appropriate intervals or sooner if fatigued, without unnecessary pauses.
- Obtain IV or IO access without interrupting essential CPR; give medications according to the displayed algorithm and document exact times.
- Actively search for and treat reversible causes using the locally adopted framework.
- Use quantitative waveform capnography when available for an advanced airway and to support assessment of CPR quality and possible ROSC.
- Pause only when required by the algorithm and keep pauses as short as possible.
- After ROSC, transition immediately to structured post-cardiac-arrest care and definitive disposition.
- Paediatric, neonatal, pregnancy-associated, traumatic, drowning, hypothermic, toxicological, and other special-circumstance arrests require their specific approved modifications.

10.1 Resuscitation safety pause before shock

- The defibrillator operator announces that a shock is being prepared.
- Continue compressions while charging when the approved algorithm and device allow.
- Before shock, the operator clearly states “Stand clear” or the locally approved phrase.
- Visually confirm no person is touching the patient, bed, connected equipment, or conductive fluid.
- Confirm oxygen and other fire risks are managed according to device and local safety guidance.
- Deliver the shock, announce delivery, and resume CPR immediately according to the algorithm.

11. Peri-arrest and severe instability

Clinical state	Operational response
Threatened airway / respiratory failure	Call senior airway support; prepare for deterioration and difficult airway; optimize positioning, oxygenation, ventilation, and reversible causes; ensure backup equipment and post-intubation monitoring.
Shock	Identify likely distributive, hypovolaemic, cardiogenic, obstructive, or mixed cause; control haemorrhage; obtain access; use focused diagnostics; give cause-directed fluids, blood, vasopressor/inotrope, antidote, or procedure; reassess after each intervention.
Unstable arrhythmia	Assess whether hypotension, shock, altered mental status, ischaemic chest discomfort, acute heart failure, or other instability is caused by the rhythm; follow the approved rhythm-specific electrical and medication algorithm.
Severe neurological deterioration	Protect airway and ventilation; check glucose; treat seizures; control temperature; identify stroke, haemorrhage, infection, toxin, or metabolic cause; expedite imaging or specialist care without allowing transport to interrupt stabilization.
Anaphylaxis	Remove trigger when possible; give the first-line medication and supportive care immediately according to the approved anaphylaxis protocol; monitor for refractory or biphasic deterioration; arrange observation and specialist disposition as indicated.

Clinical state	Operational response
Sepsis with organ dysfunction	Recognize early; obtain appropriate cultures without delaying treatment; give antimicrobials and haemodynamic support according to the sepsis pathway; identify source control needs; reassess perfusion and organ function.
Obstetric emergency	Activate obstetric, anaesthetic, neonatal, theatre, and blood-bank support early. Position and resuscitate with pregnancy-specific modifications. Prioritize maternal resuscitation while preparing for time-critical delivery when indicated.
Poisoning	Protect staff; identify substance, dose, route, time, and co-exposures; contact the approved toxicology or poison-information resource; use antidotes and decontamination only as recommended; anticipate delayed deterioration and transfer needs.

12. Trauma stabilization

Trauma patients shall receive the same ABCDE approach with immediate haemorrhage control and cervical-spine consideration. Mechanism alone does not replace physiological assessment, and normal initial vital signs do not exclude serious injury.

- Activate the trauma response according to local criteria and available team structure.
- Control catastrophic external haemorrhage immediately, including tourniquet or wound-packing when indicated.
- Maintain airway and ventilation while considering cervical-spine injury; remove obstructive immobilization when necessary for life-saving care.
- Identify and treat clinically apparent tension pneumothorax or other immediately fatal chest injury without waiting for imaging.
- Assess for occult haemorrhage in chest, abdomen, pelvis, retroperitoneum, and long bones; activate blood and surgical support early.
- Use pelvic stabilization when indicated and avoid unnecessary repeated movement.
- Prevent hypothermia and coagulopathy; minimize delays to theatre, interventional care, or definitive transfer.
- Perform secondary survey only after life threats are addressed, and repeat it after transfer, deterioration, or return from imaging.
- Document mechanism, time of injury, prehospital treatment, neurological findings, wounds, procedures, blood loss, and all transfer times.

13. Special populations and circumstances

Population / circumstance	Required modification
Children	Use age- or length/weight-based equipment and medication systems. Record weight or best available estimate. Involve the most experienced paediatric clinician available. Children may compensate before sudden deterioration; concern from caregivers must be taken seriously.
Pregnancy and postpartum	Confirm gestational or postpartum status when possible without delay. Use pregnancy-specific positioning and arrest modifications. Activate obstetric and neonatal services early. Consider haemorrhage, hypertensive emergencies, thromboembolism, sepsis, and ectopic pregnancy.

Population / circumstance	Required modification
Older adults and frailty	Serious illness may present with subtle signs. Establish baseline function, cognition, comorbidity, medications, anticoagulation, and goals of care. Do not withhold indicated resuscitation solely because of age or disability.
Patients with obesity or limited mobility	Anticipate difficult access, airway, imaging, transfer, and equipment needs. Obtain sufficient staff and appropriate devices to protect patient and worker safety without delaying essential care.
Communicable disease	Use appropriate isolation and PPE while continuing urgent care. Use the least delay-producing precautions compatible with staff safety. Limit unnecessary personnel and follow approved aerosol-generating procedure controls.
Behavioural emergency	Treat agitation as a clinical emergency when safety or physiology is threatened. Use verbal de-escalation, environmental control, and the least restrictive safe intervention. Search for medical, toxicological, traumatic, and metabolic causes. Monitor continuously after sedation or restraint.
Unknown identity / unaccompanied patient	Use temporary identifiers, preserve belongings, seek collateral information, and activate safeguarding or police processes when appropriate. Necessary treatment proceeds under emergency authority when capacity is absent and delay threatens life.
Known limitation of treatment	Verify the validity and applicability of any advance directive, do-not-attempt-resuscitation order, or documented treatment limitation. In uncertainty during a time-critical event, begin appropriate stabilization while seeking senior and legal/ethical clarification, unless local law directs otherwise.

14. Monitoring and reassessment

- Assign a named clinician or nurse to maintain continuous observation of every unstable patient.
- Document heart rate, rhythm, respiratory rate, oxygen saturation, blood pressure, consciousness, temperature, pain, glucose when relevant, and other condition-specific variables at intervals matched to severity.
- Use continuous ECG, pulse oximetry, capnography, invasive monitoring, urine output, or other monitoring when clinically indicated and available.
- Confirm that alarms are audible, limits are appropriate, and a named person responds to alarms. Never silence an alarm without assessing the patient and reason.
- Reassess ABCDE after every significant intervention, bolus, electrical therapy, procedure, movement, imaging trip, handover, and any deterioration.
- Record whether the patient improved, remained unchanged, or deteriorated; document the resulting decision.
- If instability persists, the team leader shall explicitly escalate: request more experienced help, reconsider diagnosis and reversible causes, activate definitive intervention or transfer, and address resource barriers.

State	Minimum reassessment principle
Cardiac arrest	Continuous team observation; rhythm and pulse checks only as required by the approved algorithm; document CPR cycles and intervention times.

State	Minimum reassessment principle
Peri-arrest / unstable	Continuous observation and monitoring; repeated ABCDE, commonly every few minutes and after each intervention, with frequency determined by clinical state.
Recently stabilized high-risk patient	Continuous or very frequent observation until a senior clinician confirms a safe monitoring level and destination.
During transport or imaging	Monitoring and escort capability must match the risk. A patient too unstable for the destination or available escort must not be moved unless the move is itself life-saving.

15. Investigations and treatment during resuscitation

- Diagnostics shall answer an immediate clinical question and must not interrupt essential airway support, ventilation, circulation, haemorrhage control, seizure treatment, defibrillation, or other life-saving action.
- Use bedside tests and focused imaging when they can rapidly alter management and can be performed without compromising resuscitation.
- Every specimen, image, ECG, or point-of-care test must have a named clinician responsible for review and action.
- Critical results must be communicated directly to the responsible clinician, read back, time-stamped, and acted upon.
- Medication and blood-product administration require patient identification where possible, allergy review, correct indication, dose, route, compatibility, and documentation. Emergency exceptions must be documented.
- Infusions, lines, drains, tubes, and blood products must be labelled. High-alert medications should receive an independent check when time and staffing permit; do not create an unsafe delay in a true life-threatening emergency.
- Bedside ultrasound may support diagnosis and procedures when performed by trained clinicians, but it must not cause prolonged CPR interruption or substitute for treatment of an obvious immediate life threat.
- If required diagnostics or treatment are unavailable, the senior clinician must activate the contingency or transfer pathway early and document interim risk-reduction measures.

16. Communication, consent, safeguarding, and family presence

- Use closed-loop communication and name the person responsible for each task.
- The team leader should give periodic summaries: current ABCDE findings, response, working diagnosis, outstanding tasks, anticipated deterioration, and destination.
- Use an interpreter when needed and available. Do not rely on a child to interpret critical information except in an unavoidable immediate emergency.
- When the patient lacks capacity and delay threatens life or serious function, provide necessary emergency treatment under applicable law and policy while seeking a substitute decision-maker when feasible.
- Inform the patient and family honestly and compassionately without obstructing care. Assign one team member to communicate when staffing permits.
- Family presence during resuscitation may be supported when safe, with a designated staff member, provided it does not compromise care, privacy, infection control, evidence, or staff safety.
- Concerns for abuse, neglect, assault, self-harm, trafficking, sexual violence, or vulnerable persons must trigger the safeguarding pathway. Life-saving care takes priority, but observations and evidence should be documented carefully.
- Communicate adverse events, delays, unavailable resources, or transfer barriers to the responsible senior clinician and record the mitigation plan.

17. Post-ROSC and post-stabilization care

Domain	Required actions after ROSC or major stabilization
Airway and breathing	Confirm airway position and security; reassess ventilation; use capnography when available; obtain appropriate blood gas; titrate oxygen and ventilation to approved post-resuscitation targets; identify pulmonary complications.
Circulation	Obtain 12-lead ECG when indicated; treat hypotension and cause; reassess perfusion and lactate or other markers where useful; arrange reperfusion, surgery, antidote, or source control as required.
Neurological care	Document consciousness, pupils, seizure activity, glucose, temperature, and sedation. Prevent fever and follow the approved post-cardiac-arrest temperature-control and neuroprognostication pathway.
Cause and complications	Identify and treat the cause of arrest or instability; review medications, electrolytes, acid-base status, bleeding, infection, thrombosis, and procedure-related complications.
Destination	Arrange critical care, theatre, catheterization, obstetric, paediatric, specialist, or interfacility transfer. Continue full monitoring and treatment until responsibility is formally accepted.
Communication	Explain the event and immediate plan to the patient or family when appropriate. Document who was informed, by whom, and any decisions about goals of care.

18. Handover and disposition

Resuscitation responsibility does not end when an admission, operation, imaging study, or transfer is requested. The ED team remains responsible until a qualified receiving clinician or team has accepted responsibility and the patient reaches an appropriately staffed and equipped destination.

- Use ISBAR or another approved structured handover.
- State identity, event timeline, working diagnosis, relevant history, allergies, treatment limitations, ABCDE findings, trends, procedures, medications, fluids/blood, results, response, risks, pending tasks, and required next actions.
- Provide current vital signs and monitoring status immediately before movement.
- Confirm that all tubes, lines, drains, infusions, oxygen supplies, batteries, and equipment are secure and sufficient for the journey.
- Choose an escort with competencies matched to anticipated deterioration. Provide appropriate emergency equipment and medications.
- Confirm acceptance, destination, route, transport, and contingency plan. Record departure time and receiving handover time.
- An unstable patient shall not be sent to an area that cannot provide required monitoring or treatment unless the transfer is necessary for immediate definitive life-saving care and the risk is accepted by the responsible senior clinicians.

19. Withholding or terminating resuscitation and death

Decisions not to start, to limit, or to terminate resuscitation are governed by applicable law, valid advance decisions, hospital policy, current resuscitation guidance, and senior clinical judgment. This general protocol does not create stand-alone termination criteria.

When a valid treatment-limitation decision is known and applies to the present situation, staff shall provide all care consistent with that decision, including comfort, dignity, symptom control, and family support.

When termination is being considered after attempted resuscitation, the team leader shall involve the most senior appropriate clinician available, confirm that the approved algorithm and reversible causes have been addressed, consider special circumstances, and document the clinical and legal basis for the decision.

After death, follow the hospital death, coroner/medical examiner, organ or tissue donation, police, safeguarding, forensic evidence, bereavement, property, and mortuary procedures. Support staff and family respectfully.

A signature on a form is not a substitute for verification that a treatment-limitation decision is valid, applicable, and available to the treating team. Uncertainty must be escalated immediately.

20. Documentation and team debrief

- Use the approved resuscitation record in real time whenever possible. Documentation shall not delay life-saving action.
- Record objective times: recognition, activation, team arrival, CPR start, first rhythm analysis, shocks, airway interventions, access, medications, blood, procedures, ROSC, consultations, decision, departure, handover, or death as applicable.
- Record serial ABCDE findings and vital-sign trends, not only interventions.
- Document names and roles of team members, working diagnosis, reversible causes considered, response to treatment, outstanding risks, family communication, treatment limitations, and disposition.
- Correct documentation errors transparently according to records policy. Do not reconstruct or alter times deceptively.
- Conduct a brief “hot” debrief after significant resuscitations when operationally possible: what happened, what went well, what was difficult, immediate equipment or safety issues, staff welfare, and actions requiring follow-up.
- Refer cases meeting local criteria for structured multidisciplinary review. Debriefing and review should support learning and system improvement, not blame.

21. Quality indicators and audit

Indicator domain	Suggested measure
Activation reliability	Proportion of eligible cases in which the resuscitation response was activated and documented.
Time to first clinical response	Median and outlier times from recognition/arrival to resuscitation clinician response, stratified by presentation.
Cardiac arrest process	Time to CPR, time to first rhythm analysis/defibrillation when indicated, chest-compression interruptions where measurable, and adherence to current algorithm.
ABCDE completion	Proportion with documented primary survey, treatment of identified threats, and repeat assessment.
Physiological monitoring	Proportion with appropriate serial vital signs and documented response after major intervention.
Airway safety	Unrecognized oesophageal intubation, unplanned extubation, repeated attempts, peri-intubation arrest, and use of confirmation/monitoring methods.

Indicator domain	Suggested measure
Medication and blood safety	Wrong dose/route/patient, infusion errors, transfusion reactions, delayed antidote or blood activation, and near misses.
Transfer safety	Deterioration during transport, equipment/oxygen failure, inadequate escort, incomplete handover, or transfer before acceptance.
Readiness	Completion of shift and post-use checks; missing, expired, depleted, or malfunctioning critical equipment.
Outcomes and equity	ROSC, survival to admission/discharge where appropriate, unplanned death, delayed escalation, and variation by age, sex, disability, social status, referral source, or time of attendance.
Team learning	Debrief completion, incident reporting, action closure, simulation findings, and staff competency compliance.

22. Training and implementation

- All relevant staff shall receive orientation before implementation, including activation, roles, ABCDE, closed-loop communication, documentation, and local escalation routes.
- Clinical staff assigned to resuscitation shall maintain role-appropriate competency in basic life support and, where applicable, advanced adult, paediatric, neonatal, trauma, airway, defibrillation, sedation, and transfer skills.
- Conduct multidisciplinary simulation using local equipment and common high-risk scenarios, including cardiac arrest, respiratory failure, shock, major trauma, critically ill child, obstetric emergency, difficult airway, and failed communication systems.
- Competency assessment shall include knowledge, observed performance, equipment familiarity, and ability to escalate beyond personal scope.
- Post the approved algorithms and quick-reference tools at the point of care. Remove superseded versions immediately.
- Before go-live, the hospital must approve local activation methods, response standards, team composition, standing orders, medication lists, airway and procedural privileges, transfer routes, and treatment-limitation processes.
- Review this protocol after major guideline revisions, serious incidents, changes in service capability, or identified audit gaps.

Annex A. One-page resuscitation workflow

Step	Required action
1. RECOGNIZE	Unresponsive, threatened airway, ineffective breathing, shock, major haemorrhage, seizure, severe neurological change, unstable rhythm, major trauma, or clinical concern.
2. ACTIVATE	Call the resuscitation response; state location, age group, main threat, and assistance required. Bring resuscitation equipment.
3. START	Ensure safety and PPE. Begin immediate life-saving actions. Move to resuscitation area when safe. Attach monitoring and obtain help.
4. ABCDE	Assess and treat simultaneously. Airway; Breathing; Circulation/haemorrhage; Disability/glucose; Exposure/temperature.
5. TEAM	Name the leader. Assign airway, circulation/medications, monitor/defibrillator, recorder, and runner. Use closed-loop communication.
6. REASSESS	Repeat ABCDE after every intervention, deterioration, move, or handover. State response and unresolved threats.
7. DEFINITIVE PLAN	Activate specialist care, theatre, critical care, obstetrics, paediatrics, toxicology, blood bank, or transfer early.
8. HANDOVER	Current status, trends, treatment, response, pending tasks, risks, destination, escort, equipment, and formal acceptance.
9. DOCUMENT & DEBRIEF	Complete the record, communicate with patient/family, report incidents, restore equipment, and conduct a brief team debrief.
STOP POINT BEFORE LEAVING RESUSCITATION: Is the patient reassessed? Are current vital signs documented? Are airway/lines/infusions secure? Has a qualified receiving team accepted responsibility? Are escort and equipment adequate?	

Annex B. ABCDE quick-reference guide

Domain	Assess	Act now
A - Airway	Can the patient speak/cry? Is there obstruction, stridor, swelling, blood, vomit, burn, trauma, or inability to protect?	Open, clear, suction, position, adjuncts, oxygen/ventilation, cervical-spine consideration, call skilled airway help.
B - Breathing	Rate, effort, symmetry, saturation, air entry, cyanosis, chest injury, ventilation adequacy.	Oxygen if indicated, assist ventilation, treat immediate chest/airway causes, monitor response and capnography where available.

Domain	Assess	Act now
C - Circulation	Pulse/rhythm, BP, perfusion, mental status, bleeding, occult haemorrhage, shock cause.	Control bleeding, access, ECG/pads, cause-directed fluid/blood/medication/procedure, reassess after every intervention.
D - Disability	AVPU/GCS, pupils, focal signs, seizure, glucose, temperature, toxin or metabolic clues.	Correct glucose, treat seizure, protect airway, activate stroke/toxicology/neurological pathway, repeat examination.
E - Exposure	Injuries, rash, burns, hidden bleeding, pregnancy, devices, temperature, contamination, safeguarding.	Expose adequately, preserve dignity, prevent hypothermia, decontaminate safely, complete survey, protect evidence.

Annex C. Resuscitation team roles

Role	Actions
Team leader	Stand where the patient and team are visible; identify self; assign roles; lead ABCDE and algorithm; avoid becoming fixed on one procedure when another skilled operator is available; summarize and decide.
Airway / breathing	Airway assessment, oxygen, suction, bag-mask ventilation, airway devices, capnography, ventilator, chest assessment, escalation and backup plan.
Compressions / procedures	High-quality compressions during arrest; haemorrhage control or other assigned procedure; announce fatigue and exchange safely.
Monitor / defibrillator	Pads, rhythm, ECG, charging, safety call, shock/cardioversion/pacing according to algorithm, report changes.
IV/IO / medications	Access, samples, drugs, fluids, blood, compatibility, double-checks, labelling, report completion and response.
Recorder / timekeeper	Times, rhythm, vital signs, interventions, doses, procedures, response, consultations, prompts, destination.
Runner / communicator	Equipment, blood, calls, transfer arrangements, family liaison or access control as assigned.

Annex D. Resuscitation-area readiness checklist

Area	Check
Environment	Bay clear; lighting; power; outlets; bed/trolley; clock; hand hygiene; PPE; waste/sharps; warming; communication device.
Oxygen and suction	Wall/cylinder supply; regulators; masks/cannulae; tubing; suction function; catheters; backup.

Area	Check
Airway and ventilation	Adult/paediatric bag-mask devices; adjuncts; laryngoscopy/video equipment where available; tubes; bougie/stylet; supraglottic devices; difficult/rescue airway; securing; capnography.
Monitoring and electrical	Monitor/defibrillator self-test; battery; cables; adult/paediatric pads; ECG paper; SpO2; BP cuffs; temperature; pacing/cardioversion capability.
Circulation	IV/IO equipment; fluids; pressure bags; blood tubing; tourniquets; haemostatic supplies; pelvic binder; infusion pumps.
Medications	Approved arrest, peri-arrest, sedation, analgesia, anaphylaxis, seizure, antidote, obstetric, and paediatric supplies; expiry and seals checked.
Trauma / procedures	Dressings; chest decompression/drain equipment according to capability; splints; cervical equipment; burns supplies; procedure kits.
Documentation and references	Resuscitation chart; drug and equipment references; adult, paediatric, neonatal and special-circumstance algorithms; transfer contacts.
After use	Restock; clean; replace oxygen; recharge devices; report fault; replenish drugs; restore standard layout; sign check.

Annex E. Proposed local activation and escalation standards

Local approval required: The following are governance prompts, not externally mandated universal time standards. The hospital should adopt targets that are clinically safe, measurable, and achievable, and define a contingency response when they are missed.

Standard	Proposed requirement	Local decision
Emergency call activated	Immediately on recognition of actual or impending life threat	[Approve / amend]
Initial life-saving action	Immediately by the first competent responder	[Approve / amend]
Resuscitation leader identified	On team arrival; no later than the first team summary	[Approve / amend]
Senior ED clinician attendance	Immediate for arrest; urgent for peri-arrest or persistent instability	[Insert local target]
Anaesthesia / airway support	Urgent when advanced or difficult airway is anticipated	[Insert local target]
Specialist / critical-care response	According to condition and escalation policy	[Insert by service]
Blood-bank major haemorrhage activation	As soon as major haemorrhage is suspected	[Insert process]

Standard	Proposed requirement	Local decision
Reassessment after intervention	Immediately after intervention and at frequency matched to instability	[Approve / amend]
Transfer acceptance	Before departure except under the approved emergency exception	[Insert process]
Hot debrief	After event when operationally possible	[Insert expectation]

Annex F. Minimum resuscitation record

Domain	Required elements
Patient and event	Two identifiers or temporary identifier; age/estimated age; sex; arrival/collapse location; mode of arrival; presenting event; key history; allergies; medications; pregnancy; treatment limitations.
Times	Recognition, activation, team arrival, ABCDE, CPR, first rhythm, shocks, airway, access, medications, blood, procedures, ROSC, consultations, decision, departure, handover, death.
Assessment	Serial ABCDE findings; vital signs; rhythm; GCS/AVPU; pupils; glucose; temperature; pain; weight in children; injuries; bleeding; relevant point-of-care findings.
Treatment	Oxygen/ventilation; airway; CPR; electrical therapy; drugs with dose/route/time; fluids/blood; haemorrhage control; procedures; warming/cooling; antidotes; immobilization; sedation/restraint.
Response	Improved/unchanged/deteriorated after each major intervention; adverse effects; complications; unresolved threats.
Decision and communication	Working diagnosis; reversible causes; consultations; treatment limitation; patient/family discussion; safeguarding; destination; accepting clinician; escort and equipment.
Team	Leader and team roles; recorder; senior clinicians; receiving team; signatures or approved electronic authentication.
After event	Debrief; equipment fault; medication error/near miss; incident report; case-review referral; actions assigned.

Annex G. Post-stabilization CARE checkpoint

Checkpoint	Confirm before leaving resuscitation
C - Clinical status	ABCDE repeated; immediate threats addressed; current vital signs and trends documented; response known; outstanding instability escalated.
A - Actions completed	Required treatment initiated; essential results reviewed; lines/tubes/infusions secure and labelled; monitoring and oxygen adequate; pending actions assigned.

Checkpoint	Confirm before leaving resuscitation
R - Responsibility transferred	Receiving clinician/team has accepted; structured handover completed; patient/family informed as appropriate; escort competency matches risk.
E - Exit safely	Destination suitable; equipment, batteries, oxygen, drugs and documents sufficient; contingency plan in place; departure and handover times recorded.

Annex H. References and source tools

1. World Health Organization. Emergency Care Toolkit. [Source](#)
2. World Health Organization, International Committee of the Red Cross, International Federation for Emergency Medicine. Basic Emergency Care: Approach to the Acutely Ill and Injured. [Source](#)
3. World Health Organization. Basic Emergency Care course and materials. [Source](#)
4. World Health Organization. Clinical Checklists: Medical Emergency Checklist and Trauma Care Checklist. [Source](#)
5. American Heart Association. 2025 Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. [Source](#)
6. American Heart Association. 2025 CPR and ECC Algorithms. [Source](#)
7. International Liaison Committee on Resuscitation. 2025 Consensus on Science with Treatment Recommendations and continuing evidence evaluations. [Source](#)
8. World Health Organization. Communication During Patient Hand-Over. [Source](#)

Local documents to insert before approval: adult, paediatric, neonatal and special-circumstance arrest algorithms; airway policy; massive haemorrhage protocol; trauma activation; anaphylaxis, seizure, sepsis, stroke, poisoning and obstetric emergency pathways; procedural sedation policy; blood-transfusion policy; transfer policy; treatment-limitation and death policies; safeguarding policy; infection prevention and decontamination plan; medication formulary; staff credentialing matrix; emergency contact list.

Local approval and sign-off

Role	Name	Signature	Date
Emergency Department Medical Lead			
Emergency Department Nursing Lead			
Anaesthesia / Critical Care Lead			
Paediatric Lead			
Obstetric Lead			
Resuscitation Committee Chair			
Pharmacy Lead			
Clinical Governance / Patient Safety			
Hospital Executive Approval			

DRAFT FOR LOCAL VALIDATION. Before implementation, confirm local law, scopes of practice, credentialing, equipment, medication supply, laboratory and imaging capability, blood-bank arrangements, specialist response, critical-care access, transport, and regional/overseas referral pathways.