Resuscitation Policy

Including guidance on

Do Not Attempt Resuscitation

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<th>Executive Director of Nursing &amp; Quality</th>
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<tbody>
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<tr>
<td>Target audience</td>
<td>All SHSC employees, or contracted staff from other NHS Trusts or private individuals working with SHSC service users.</td>
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Existing Policy updated in line with Resuscitation Council Guidelines 2010 and Yorkshire and Humber DNACPR procedure.
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1. **Introduction**

This policy supports the recommendations for resuscitation published by the Resuscitation Council (UK) (amended 2008) and has been constructed to promote compliance with the NHSLA Risk Management Standards (NHSLA, 2007).

This policy has been reviewed and updated in line with NPSA Rapid Response Report (RRR010/2008), Resuscitation Guidelines 2010 and also the introduction of a single Do Not Attempt CPR form in Sheffield.

2. **Definitions**

- **Cardiac Arrest** is the sudden and complete loss of cardiac functions. This will be evident by the absence of any signs of circulation.
- **Respiratory Arrest** is the complete cessation of breathing, where a pulse is still present.
- **Cardio-Pulmonary Arrest** is a combination of both of the above.
- **Cardio-Pulmonary Resuscitation (CPR)** comprises of chest compressions and rescue breathing. It may involve defibrillation, airway management, suction and the use of oxygen.
- **Basic Life Support (BLS)** comprises of initial assessment, summoning of the emergency services, airway maintenance, rescue breathing and chest compressions to sustain life until the arrival of the emergency services. BLS implies that no equipment apart from an airway/barrier device (e.g. pocket mask) is employed in this procedure.
- **Basic Life Support with Emergency Equipment (BLS+EE)** indicates the addition of emergency equipment to the BLS procedure that is available in the area. This is a standard that the Trust accepts as a minimum for its staff to achieve during resuscitation attempts.
- **Automated External Defibrillator (AED)** is the device used in addition to BLS+EE in an attempt to reverse cardiac arrest. These devices are available on most inpatient units. (NICE, 2005).
- **DNACPR** – Do not attempt Cardio-pulmonary resuscitation (Appendix F).
- **Advanced Life Support (ALS)** - Advanced airway management (e.g. intubation), use of bag/mask/valve with oxygen, defibrillation and use of intra-venous drugs and fluids. Also includes cardiac monitoring.
- **Care Staff** - Doctors, Nursing Staff, Support Workers and Therapists or other staff providing direct care to a patient
- **Registered Practitioner** – Professionally registered staff e.g. Doctor, Nurse or Therapist

3. **Purpose of this Policy**

The purpose of this policy is to set out the arrangements for managing the risks associated with and the systems in place to support, effective resuscitation provision for service users. The policy outlines the duties and responsibilities of the Trust to comply with relevant legislation and guidance, and to monitor compliance with the policy so that an effective service is provided.

4. **Duties**

Healthcare organisations have an obligation to provide an effective resuscitation service to their patients and appropriate training to their staff. A suitable infrastructure is required to establish and continue support for these activities.

4.1 **Executive Board Member** - Chief Nurse
- Responsible for resuscitation services
- Responsible for implementation and monitoring of the policy within the Trust
- Ensure funding for an effective resuscitation service and training

4.2 **Ward/Team Managers** are responsible for ensuring that;
- There is a planned programme of training for staff
• There is appropriate emergency equipment for all their staff which is regularly checked and recorded.
• There are procedures for summoning the emergency services and Trust emergency equipment, if not available in their ward/area.
• An incident report and Resuscitation Record Form (Appendix D) is completed for every resuscitation attempt

4.3 Consultants and GP’s

Overall responsibility for decisions about DNACPR orders rest with the Consultant or GP in charge of the patient’s care.

4.4 All staff with direct contact with service users and all designated first aiders hold responsibility to:

• Attend training and updates (yearly) in Basic Life Support (BLS)/Automatic External defibrillation (AED) as directed by this policy and maintain professional standards. This to include training on choking as directed by NPSA report (2008).
• Report concerns to their line manager
• Initiate CPR in line with policy guidance.
• Complete an incident report for every resuscitation attempt in line with the incident reporting policy.

4.5 ‘Resuscitation Committee’ (Currently within the remit of Physical Health Group)

Responsibilities include:
1. Determining the level of resuscitation training required
2. Facilitating adequate provision of training in resuscitation
3. Determining requirements for and choice of resuscitation training equipment
4. Promoting adherence to national resuscitation guidelines and standards
5. Making available resuscitation equipment for clinical use
6. Producing policies relating to resuscitation and anaphylaxis, including a policy on resuscitation decisions, e.g. Do Not Attempt CPR (DNACPR)
7. Implementing operational policies governing resuscitation practice and training
8. Commissioning audits of resuscitation practice
9. Ensuring the reporting and review of critical incidents in relation to resuscitation
10. Driving and implementing change

4.6 Resuscitation Officer/Training Admin

• Provide training and updating in life support to a level equal to the Immediate Life Support course of the Resuscitation Council (UK) for registered nurses and doctors working in areas where restraint or rapid tranquilisation may be used
• Collate training data and analysis
• Collate data about incidents involving life support and/or resuscitation events

5. Scope of this Policy

As a provider of specialist Mental Health, Learning Disability and Substance Misuse Services, the Trust is not required to provide resuscitation to an advanced level, but is required to provide appropriate resuscitation to a high standard when it is necessary in the range of settings in which it provides services.

This policy applies to all managers with responsibilities derived from it, and all care staff, and staff with First Aid responsibilities including bank, agency and temporary staff. See Section 8 for training matrix.

The likelihood of staff having to carry out resuscitation is very rare. All staff are expected to ensure emergency services are called and appropriate level of Life Support given (this may be a non-trained person following ambulance operator instructions).

• In a cardio respiratory arrest situation in a community hospital, staff will call 2222, provide Basic Life Support and use Advisory defibrillation where available
• In a home environment, Basic Life Support will be initiated and a 999/ 112 call will be made.
6. **Specific details**

Where no explicit decision has been made about the appropriateness or otherwise of attempting resuscitation prior to a patient having a cardiac arrest then there should be a presumption that care staff will make all reasonable efforts to revive the patient.

In the event of staff or a visitor suffering an arrest then attempts should also be made to revive them.

6.1 **Prevention and recognition of arrest/deterioration**

All teams should encourage Service Users to lower the risk of physical deterioration by:

- Offering support with Health and Wellbeing including Lifestyle factors
- Offering a physical examination on admission
- Using track & trigger tools (EWS) to aid recognition and management of deterioration in physical health,
- Efficient models of communication e.g. SBAR
- Recognition of deterioration of physical health through ABCDE approach: Airway, Breathing, Circulation, Disability, Exposure. (Appendix A)

6.2 **Resuscitation Procedures**

The chances of survival following cardio-pulmonary arrest are usually poor; however the rapid initiation of Basic Life Support and defibrillation can improve the outcome considerably.

6.2.1 **Response to a Sudden Cardiac Arrest**

In all instances where a person is suspected of collapsing due to a cardio-pulmonary arrest the ambulance service will be called. This does not apply to units which have a resuscitation service (crash team) provided by an acute trust with whom they share the site.

6.2.2 Basic Life Support (BLS) with/without Automatic External Defibrillation (AED) should be commenced and continue until the emergency services arrive, who will take responsibility for the continuing health care needs and transportation of the person to the appropriate Accident and Emergency Department.

NOTE - This will be the case unless a DNACPR decision has been made (see section 7 of this policy)

6.3 **Initiation of Cardio-Pulmonary Resuscitation**

6.3.1 All health and social care staff (managers, doctors, nurses, social workers, psychologists/therapists, occupational therapists and support staff) that work directly with people using Trust services are expected to recognise cardiac arrest, call for help and/or initiate BLS. Staff who are trained to use the Trusts AED’s should initiate this procedure upon arrival.

6.3.2 All support staff (e.g. Admin and Clerical) who work indirectly with people using Trust services are expected to be able to recognise people in distress, call for help and assist staff in such an emergency as required.

6.4 **CPR on Trust Property**

All persons covered by the policy (adult, older people and children) will be presumed to be for resuscitation in the event of a sudden collapse due to cardio-pulmonary arrest. Each unit must have available a suitable number of airway/barrier devices (e.g. pocket masks) to assist in basic life support. All staff should know the whereabouts of these masks.

6.4.1 When someone is admitted to the Trust for inpatient treatment and care it is the responsibility of the responsible medical officer or nominated deputy to undertake a physical examination. This should be repeated at other times if the persons physical condition changes. This examination should establish the person’s physical health status, determining if there are any life threatening conditions which may result in a cardio-pulmonary arrest. The ability to carry out a physical examination is subject to their consent, see the Trust policy on Consent to Treatment

6.4.2 All staff should be made aware of any person with a physical condition, which may result in respiratory or cardiac arrest. The person must understand where possible the nature of their condition and the resulting management plan to treat them in the event of an emergency.
6.4.3 In certain circumstances people may wish to exercise their right not to be resuscitated either in person or through an advance decision, see the Trust policy on Consent to Treatment. The persons' wishes should always be respected.

6.4.4 Where someone suffers a cardio-pulmonary arrest, a Trust incident form must be completed and forwarded to the appropriate manager who will decide if an investigation is needed (See Trust Incident Reporting and Investigation Policy).

6.5 CPR in the Community

All people receiving community services will be presumed to be for resuscitation unless a decision not to resuscitate has been agreed with the person's general practitioner (GP) prior to a sudden collapse. All decisions with regard to a Do Not Attempt Resuscitation Order by the GP should be documented. Failure to document such a decision places a legal responsibility on the attending community staff to obtain emergency assistance.

6.6 Defibrillation

Defibrillators must only be operated by staff specifically trained in their use. The operation of defibrillators by professionally registered staff is subject to them successfully completing the Trusts BLS plus AED training (ILS equivalent) and the ongoing requalification courses.

6.7 Cross Infection

Whilst the risk of infection transmission from the person receiving to the person giving BLS during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. It is therefore advisable that direct mouth-to-mouth resuscitation (without a barrier device) be avoided at all times. This is particularly important in the following circumstances:

- All people who are known to have or are suspected of having an infectious disease;
- All undiagnosed people entering the Accident & Emergency department, Outpatients or other admission source.
- Other persons where the medical history is unknown.

6.7.1 In situations where airway/barrier devices are not immediately available, staff should start chest compressions whilst awaiting an airway/barrier device.

6.8 Emergency Equipment

All in-patient settings have emergency equipment readily available in the practice area. This equipment is checked weekly to ensure standard contents. A record is maintained of the checks carried out by ward staff and are archived within the practice area. In-patient settings are assessed by Ward/Team managers to ascertain the level of risk (see Appendix B) and the necessary equipment is stored in accordance with the perceived risk level (see Appendix C).

7. Dissemination, storage and archiving

The policy is available on the SHSC intranet and available to all staff within 10 days of ratification. An “All SHSC” e-mail alert will be sent to all staff. The policy will be sent to Clinical Directors for dissemination throughout the Directorates. The integrated Risk/Governance Team will keep a paper & electronic version of the previous policy. Managers will be responsible for removing and replacing paper copies of the policy.

8. Training and other resource implications

8.1 Directors will delegate an assessment of the level of skills, training and equipment required in each service area. See appendix B for suggested equipment list and training guidance.

This assessment should take account of the following factors:

- Total number/composition of staff group
- Staffing levels and skill mix on each shift
- Current level of training of staff, number of key trainers
- Characteristics and risk factors of the client group
• Type of intervention/clinical procedures that take place in the environment
• Number of incidents/cardiac arrests in previous 5 years

This assessment should be repeated at appropriate intervals, a minimum of annually. The responsibility for maintaining skills and equipment lies with the ward/department/Team manager.

Training requires updating annually and should be research based, as a minimum requirement. The identification of training needs should be decided locally (using guidance in appendix B).

Training requirements are set out in the Trust’s Mandatory Training Policy. The frequency of training required and the staff roles are outlined in the Trust’s Training Needs Analysis.

All training is recorded using the OLM system which is maintained by the Education, Training and Development Team. Records of all training should also be maintained on the individual's personal file held by line managers.

For all staff, training is both provided internally and bought in externally by the Trust.

8.2 In areas delivering services to patients, residents or clients there should be a minimum of a face-shield readily available, possibly pinned to notice boards for ease of access, for community staff a key fob with face shield may be the most practicable equipment.

For in-patient areas the minimum should be a single-use pocket mask with a Resuscitation Bag including Oxygen.

In administration/non-clinical areas a face-shield should be available e.g. in a first aid container. Further equipment should be determined as part of the risk assessment using the list in Appendix B. The level of equipment kept should be in line with the level of training of the staff. This may include AED, but is unlikely to include a full resuscitation trolley.

8.3 Items can be ordered through Supplies Department and drugs through pharmacy. For restocking and ordering of partially/empty oxygen cylinders contact Supplies Department. See Appendix C for a list of suppliers.

8.4 When determining the level of equipment and training consider the Chain of Survival:
• Early recognition and prevention - call for help
• Early CPR to buy time,
• Early defibrillation to significantly improve chances of recovery and
• Post Resuscitation Care to restore quality of life.

(Defibrillation at 7 minutes survival up to 30%, defibrillation at 90 seconds survival up to 60%)

8.5 Basic Life Support and choking training will follow a cascading system whereby nominated individuals from each Directorate will deliver training. Resuscitation Trainers will have equipment made available for training purposes (e.g. resuscitation models and cleaning materials). The Trainers will be updated annually to maintain their competence and allow for guideline changes and developments in research. Employees have a responsibility to co-operate with the employer to achieve and maintain competence in resuscitation techniques. Operational Managers have a responsibility to ensure that trainers are able to participate in the provision of training and to provide other staff with adequate opportunity to access training.

Trainers will keep records of staff attending training and the content of the session and send a copy to Service Development Directorate for central collation on the training database. Directorates should also consider how training equipment could be accessed for the purpose of staff practicing skills.

8.6 For areas identified by risk assessment as needing Automated External Defibrillator training (AED), selected clinical staff will be trained in the use of AED along with Basic Life Support and emergency oxygen use. Staff using AED should update training annually. Staff should access training sooner should they no longer feel confident with the procedure.

8.7 Staff involved in situations that require resuscitation are likely to find it extremely stressful and therefore will need additional support. Managers need to be aware of this and consider the use
of post-incident review as well as checking out how individual staff are doing (refer to Incident Reporting and Investigation Policy). Staff can also be supported through the use of existing mechanisms such as clinical supervision and Workplace Wellbeing.

9. Audit, monitoring and review

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<tr>
<td>A) Requirement for a documented plan for vital signs monitoring that identifies which variables need to be measured including the frequency of measurement</td>
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Resuscitation risk assessments, performance of CPR and record keeping of DNACPR decisions should be subject to audit.

Incidents that require resuscitation should be recorded using the Incident Reporting procedure/form and include the Resuscitation Record form in Appendix D. Resuscitation Audit (Appendix E) may highlight a training need, a lack of equipment or equipment unsuitably situated in the building. The purpose of this system is to enable teams and the organisation as a whole to learn from the experience and to improve practice in the future.

‘Do not attempt resuscitation’ decisions need to be based on reliable up to date clinical guidelines. The way DNACPR decisions are documented should be audited against Trust Standards (see appendix F). For some clinical areas these issues will need to be considered and communicated daily and for others the issue may not arise. The level of audit required therefore should be led by need. Resuscitation risk assessments, training and DNACPR issues will also form part of the audit conducted by Team Governance Groups.

This policy will be reviewed in accordance with Resuscitation Council UK guidance.
10. Implementation plan
This policy has previously been implemented.

11. Links to other policies
This policy meets the requirements of the NHSLA Risk Management Standards (NHSLA, 2007), and should be used in conjunction with:

- SHSC: Incident Reporting Procedures
- Physical Health Policy
- Consent Policy
- Advanced Directives and Statements

12. Contact details
Queries relating to the use of the policy should be addressed to Service Development Directorate:

Charlie Turner     Rose Hogan
Senior Nurse - Patient Safety       Senior Nurse - Practice Development

13. References
Mental Capacity Act 2005 Department of Health
National Health Service Litigation Authority (2007) NHSLA Risk Management Standards for Mental Health and Learning Disabilities Trusts
A systematic approach to the acutely ill patient
(adapted from the ALERT™ course)       June 2005

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First steps
Airway (A)
Breathing (B)
Circulation (C)
Disability (D)
Exposure / Examination (E)
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Underlying principles
1. Use a systematic approach, based on airway, breathing and circulation (i.e., the ABCDE’s) to assess and treat the acutely ill patient.
2. Undertake a complete initial assessment and re-assess regularly.
3. Always assess the effects of treatment or other interventions.
4. Always correct life-threatening abnormalities before moving on to the next part of assessment.
5. Recognise the circumstances when additional help is required and ask for it early.
6. Use all members of the multidisciplinary team.
7. Communicate effectively.
8. The underlying aim of the initial interventions should be seen as a “holding measure” that keeps the patient alive, and produces some clinical improvement, in order that definitive treatment may be initiated.
9. Remember that it often takes a few minutes for resuscitative measures to have an effect.

First steps
1. Ask the patient a simple question. In assessing any patient, a simple question such as “How are you” can provide valuable information. A normal verbal response implies that the patient has a patent airway, is breathing and has brain perfusion. If the patient can only speak in short sentences, they may have extreme respiratory distress. Failure of the patient to respond is a clear marker of serious illness.
2. Use vital signs monitoring early. Apply a pulse oximeter, ECG monitor and continuous non-invasive blood pressure monitor to all critically ill patients, as soon as is safely possible.

Airway (A)

Treat airway obstruction as a medical emergency and obtain expert help immediately. Untreated, airway obstruction leads to a lowered PaO₂ and risks hypoxic damage to the brain, kidneys and heart, cardiac arrest, and even death.

1. Look for the signs of airway obstruction:
   - Airway obstruction leads to paradoxical chest and abdominal movements (‘see-saw’ respirations) and the use of the accessory muscles of respiration. Central cyanosis is a late sign of airway obstruction. In complete airway obstruction, there are no breath sounds at the mouth or nose. In partial obstruction, air entry is diminished and often noisy. Certain noises assist in localizing the level of the obstruction.
   - In the critically ill patient, depressed consciousness often leads to airway obstruction.

2. Treat airway obstruction as a medical emergency:
Obtain expert help immediately. Untreated, airway obstruction leads to a lowered PaO\(_2\) and risks hypoxic damage to the brain, kidneys and heart, cardiac arrest, and even death.

In the majority of cases, simple methods of airway clearance are all that are required (e.g., airway opening manoeuvres, airways suction, insertion of an oropharyngeal or nasopharyngeal airway). Tracheal intubation may be required, where simple airway opening measures fail.

3. Give oxygen at high concentration:

- Provide high concentration oxygen using a mask with an oxygen reservoir. Ensure that the oxygen flow rate is sufficient (usually > 10 litres min\(^{-1}\)) to prevent collapse of the reservoir during inspiration. Where intubation has been necessary, high concentration oxygen can be given via a bag-valve-mask system.

- In acute respiratory failure, the PaO\(_2\) should be kept as close to 13kPa (100 mmHg) as possible, but at least above 8 kPa (60 mmHg) or 90% saturation on a pulse oximeter.

**Breathing (B)**

During the immediate assessment of breathing, it is vital to diagnose and treat immediately life-threatening conditions, e.g., acute severe asthma, pulmonary oedema, tension pneumothorax, massive haemothorax.

1. Look for the general signs of respiratory distress: sweating, central cyanosis, use of the accessory muscles of respiration, abdominal breathing.

2. Count the respiratory rate. The normal rate is between 12 and 20 breaths per minute. High rates, and especially increasing rates, are markers of illness and a warning that the patient may suddenly deteriorate.

3. Assess the depth of each breath, the pattern (rhythm) of respiration and whether chest expansion is equal on both sides.

4. Note any chest deformity (this may increase the risk of deterioration in the ability to breathe normally); look for a raised JVP (e.g., in acute severe asthma or a tension pneumothorax); note the presence and patency of any chest drains; remember that abdominal distension may limit diaphragmatic movement, thereby exacerbating respiratory distress.

5. Record the inspired oxygen concentration (%) given to the patient and the SaO\(_2\) reading of the pulse oximeter (normally 97-100%). However, remember that the pulse oximeter does not detect hypercapnia and that, if the patient is receiving oxygen therapy, the SaO\(_2\) may be normal in the presence of a very high PaCO\(_2\).

6. Listen to the patient’s breath sounds a short distance from his/her face: Rattling airway noises indicate the presence of airway secretions, usually due to the inability of the patient to cough sufficiently or to take a deep breath. Stridor or wheeze suggests partial, but significant, airway obstruction.

7. Percuss the chest; hyper-resonance suggests a pneumothorax, dullness suggests consolidation or pleural fluid.

8. Auscultate the chest: the quality of the breath sounds should be evaluated. Bronchial breathing indicates lung consolidation; absent or reduced sounds suggest a pneumothorax or pleural fluid.

9. Check the position of the trachea in the suprasternal notch. Deviation to one side indicates mediastinal shift (e.g., pneumothorax, lung fibrosis or pleural fluid).

10. Palpate the chest wall to detect surgical emphysema or crepitus (suggesting a pneumothorax until proven otherwise).

11. The specific treatment of respiratory disorders depends upon the cause. Nevertheless, all critically ill patients should receive oxygen. In a subgroup of patients with chronic obstructive pulmonary disease (COPD), high concentrations of oxygen may have disadvantages and some limitations in therapy may be warranted. Nevertheless, this latter group of patients will also sustain end-organ damage or cardiac arrest if their blood oxygen tensions are allowed to decrease. In this group, aim for a target PaO\(_2\) of 8 kPa (60 mmHg) or 90% saturation (SaO\(_2\)) on pulse oximetry.

12. If the depth or rate of breathing of any patient is judged to be inadequate, or absent, use bag-valve-mask ventilation to improve oxygenation and ventilation, whilst calling urgently for intensive care assistance.
Circulation (C)

In almost all medical and surgical emergencies, consider hypovolaemia to be the primary cause of shock, until proven otherwise. Unless there are obvious signs of a cardiac cause, give intravenous fluid to any patient with cool peripheries and a fast heart rate. In surgical patients, rapidly exclude haemorrhage (overt or hidden). Remember that respiratory pathology, such as a tension pneumothorax, can also compromise a patient’s circulatory state. This should have been treated earlier on in the assessment.

1. Look at the colour of the hands and digits: are they blue, pink, pale or mottled?
2. Assess the limb temperature by feeling the patient’s hands: are they cool or warm?
3. Measure the capillary refill time (CRT). It is assessed by applying cutaneous pressure for five seconds on a fingertip held at heart level (or just above) and counting the time it takes for capillary refill after the pressure has been released. The normal value for CRT is usually less than two seconds.
4. Assess the state of the veins: they may be under-filled or collapsed when hypovolaemia is present.
5. Count the patient’s pulse rate.
6. Palpate all the peripheral and central pulses, assessing for presence, rate, quality, regularity and equality. Barely palpable pulses suggest a poor cardiac output, whilst a bounding pulse may indicate sepsis.
7. Measure the patient’s blood pressure. Even in shock, the blood pressure may be entirely normal, as compensatory mechanisms increase peripheral resistance in response to reduced cardiac output. Where possible, the diastolic and systolic values should be noted. A low diastolic BP suggests arterial vasodilatation (as in anaphylaxis or sepsis). A narrowed pulse pressure (difference between systolic and diastolic pressures; normally ~ 35-45 mmHg) suggests arterial vasoconstriction (cardiogenic shock or hypovolaemia).
8. Auscultate the heart.
9. Look for other signs of a poor cardiac output, such as reduced level of consciousness and, if the patient has a urinary catheter, oliguria (urine volume < 0.5 ml kg\(^{-1}\) hour\(^{-1}\)).
10. Examine the patient thoroughly for external haemorrhage from wounds or drains or evidence of concealed haemorrhage (e.g., thoracic, intraperitoneal or into gut). Remember that intrathoracic, intrabdominal or pelvis blood loss may be significant, even if drains are empty.
11. The specific treatment of cardiovascular collapse will be determined by the cause, but should be directed at fluid replacement, haemorrhage control and restoration of tissue perfusion. Seek out the signs of conditions that are immediately life threatening, e.g., cardiac tamponade, massive or continuing haemorrhage, septicaemic shock, and treat them urgently.
12. Insert one or more large (14 or 16 G) intravenous cannulae. Use short, wide-bore cannulae, as they have the highest flow rate.
13. Take blood from the cannula for routine haematological, biochemical, coagulation and microbiological investigations, and cross-matching, before infusing intravenous fluid.
14. Give a rapid fluid challenge (over 5-10 minutes) of 500 ml of warmed crystalloid solution if the patient is normotensive. Give 1 litre, if the patient is hypotensive. Use smaller volumes (e.g., 250 ml) for patients with known cardiac failure and use closer monitoring (listen to the chest for crepitations after each bolus, consider a CVP line).
15. Reassess the pulse rate and BP regularly (every 5 minutes), aiming for the patient's normal BP or, if this is unknown, a target > 100 mmHg systolic.
16. If the patient shows no signs of improvement, the fluid challenge can be repeated.
17. If symptoms and signs of cardiac failure (dyspnoea, increased heart rate, raised JVP, a third heart sound and pulmonary crepitations on auscultation) occur, decrease the fluid infusion rate or stop the fluids altogether. Seek alternative means of improving tissue perfusion (e.g., inotropes or vasopressors).
Disability (D)

Common causes of unconsciousness include profound hypoxaemia, hypercapnia, cerebral hypoperfusion, or the recent administration of sedatives or analgesic drugs.

1. Review the ABCs: exclude hypoxaemia and hypotension.

2. Check the patient's drug chart for reversible drug-induced causes of depressed consciousness.
   Give the appropriate antagonist, where available.

3. Examine the pupils (size, equality and reaction to light).

4. Assess the patient's conscious level using either the AVPU or Glasgow Coma Scales.

5. Measure the blood glucose using a rapid glucose meter or stick method to exclude hypoglycaemia.
   If below 3 mmol l\(^{-1}\), give 25-50 ml of 50% glucose solution intravenously.

6. Nurse unconscious patients in the recovery position, where possible.

Exposure / Examination (E)

In order that patients are examined properly, and detail is not missed, full exposure of the body may be necessary. Do this in a way that respects the dignity of the patient and prevents heat loss.

Additional information

1. Take a full clinical history from the patient, his relatives or friends, and other staff.

2. Review the patient notes and charts
   a. Study both absolute and trended values of vital signs.
   b. Check that important routine medications are prescribed and being administered.

3. Review the results of laboratory or radiological investigations.

4. Consider which level of care is required by the patient (e.g., ward, HDU, ICU).

5. Make complete entries in the patient’s notes of your finding, assessment and treatment. Record the patient’s response to therapy.

### Suggested Guidance (this is to assist in completing local Risk Assessments)

<table>
<thead>
<tr>
<th>Area</th>
<th>Equipment</th>
<th>Training (minimum)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Risk</strong>&lt;br&gt;Eg In-patient area&lt;br&gt;Includes rapid tranquillisation and anaphylaxis</td>
<td>1. Pocket masks readily available (additionally individually wrapped face shields may be available)&lt;br&gt;2. Resuscitation bag (contents as listed on next page)&lt;br&gt;3. AED and bag (contents as listed on next page)&lt;br&gt;4. Drugs box for Doctors use (contents as listed on next page)</td>
<td>• ALL ‘direct care’ staff - BLS (annual update)&lt;br&gt;• Registered Practitioners - AED, airway adjuncts and contents of Resuscitation bag (annual update/assessment)&lt;br&gt;• Doctors - IV Drug administration</td>
</tr>
<tr>
<td><strong>Moderate Risk</strong>&lt;br&gt;Eg Residential care, resource centres, day services</td>
<td>Individually wrapped face-shields readily available, and/or preferably pocket masks&lt;br&gt;Possibly Bag/valve/mask (Oxygen and tubing where trained staff available)</td>
<td>All ‘direct care’ staff - BLS annual update&lt;br&gt;Training should take place using equipment as available in the workplace</td>
</tr>
<tr>
<td><strong>Low Risk</strong>&lt;br&gt;Eg Community staff, Patient Transport staff, non-direct care environments</td>
<td>Individually wrapped face-shields available in First Aid container, or for individual staff</td>
<td>Nominated staff (eg First Aider) – BLS&lt;br&gt;Care staff – BLS annual update&lt;br&gt;Patient Transport staff – BLS annual update</td>
</tr>
</tbody>
</table>
**RESUSCITATION EQUIPMENT**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Supplier</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>400550V</td>
<td><strong>Resuscitation Bag: (includes):</strong> 1 x Adult Non-rebreathing 100% Oxygen masks 2 x packs of individual oxygen tubing size 2, 3 &amp; 4 Airways Vitalograph Emergency Aspirator Single use bag and mask (with Oxygen reservoir) Single use pocket mask</td>
<td>Marshall Products</td>
<td></td>
</tr>
<tr>
<td>CD</td>
<td>Lightweight Portable Oxygen Cylinder CD 460L, 3.2KG</td>
<td>BOC</td>
<td></td>
</tr>
<tr>
<td>M3860A</td>
<td><strong>Defibrillation Bag: (includes):</strong> Heartstream Forerunner 2 (with data card inserted) without ECG Display 2 sets of Defibrillator Adhesive Electrode pads Spare Battery</td>
<td>Cardiac Services</td>
<td></td>
</tr>
<tr>
<td>M3868A</td>
<td>Semi rigid carry case for FR2 AED algorithm card</td>
<td>SHSC Risk Department</td>
<td></td>
</tr>
<tr>
<td>code: 9</td>
<td>Tufcut scissors</td>
<td>SHSC Stores</td>
<td></td>
</tr>
<tr>
<td>MRA033</td>
<td>Razor</td>
<td>NHS Supply Chain</td>
<td>pack of 10</td>
</tr>
<tr>
<td>Replacements:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD</td>
<td>Lightweight Portable Oxygen Cylinder CD</td>
<td>B.O.C.</td>
<td></td>
</tr>
<tr>
<td>FDB316</td>
<td>Guedal Airway Size 2 sterile (Green)</td>
<td>NHS Supply Chain</td>
<td>pack of 10</td>
</tr>
<tr>
<td>FDB317</td>
<td>Guedal Airway Size 3 sterile (Orange)</td>
<td>NHS Supply Chain</td>
<td>pack of 10</td>
</tr>
<tr>
<td>FDB318</td>
<td>Guedal Airway Size 4 sterile (Red)</td>
<td>NHS Supply Chain</td>
<td>pack of 10</td>
</tr>
<tr>
<td>FDG464</td>
<td>Oxygen tubing</td>
<td>NHS Supply Chain</td>
<td></td>
</tr>
<tr>
<td>FDD111</td>
<td>Oxygen tubing &amp; non rebreathing Mask</td>
<td>NHS Supply Chain</td>
<td>single</td>
</tr>
<tr>
<td>989803158211</td>
<td>Defibrillator Adhesive Electrode pads FR2</td>
<td>Cardiac Services</td>
<td>pairs</td>
</tr>
<tr>
<td>M3863A</td>
<td>FR2 battery</td>
<td>Cardiac Services</td>
<td>each</td>
</tr>
<tr>
<td>M3868A</td>
<td>Semi Rigid Carry Case For FR2</td>
<td>Cardiac Services</td>
<td>each</td>
</tr>
<tr>
<td>FDJ202</td>
<td>Defibrillator Adhesive Electrode pads FRX</td>
<td>Cardiac Services</td>
<td>each</td>
</tr>
<tr>
<td>FDJ321</td>
<td>FRX battery</td>
<td>Cardiac Services</td>
<td>each</td>
</tr>
<tr>
<td>FDE141</td>
<td>Single use bag/valve/mask</td>
<td>NHS Supply Chain</td>
<td>single</td>
</tr>
<tr>
<td>252236</td>
<td>Single use pocket mask</td>
<td>Medisave</td>
<td>single</td>
</tr>
<tr>
<td>981722</td>
<td>Minijet Adrenaline 1 in 10,000 dilution, 10mls=1mg</td>
<td>SHSC Pharmacy</td>
<td>pack of 12</td>
</tr>
<tr>
<td>EHU006</td>
<td>Micropore tape clear latex free</td>
<td>NHS Supply Chain</td>
<td>pack of 12</td>
</tr>
<tr>
<td>FSP620</td>
<td>2 x Cannulae size grey 16g x 45mm</td>
<td>NHS Supply Chain</td>
<td>single</td>
</tr>
<tr>
<td>FSP610</td>
<td>2 x Cannulae size green 18g x 45mm</td>
<td>NHS Supply Chain</td>
<td>single</td>
</tr>
<tr>
<td>FSP033</td>
<td>2 x Cannulae size pink 20g x 32mm</td>
<td>NHS Supply Chain</td>
<td>single</td>
</tr>
<tr>
<td>Minijet Adrenaline 1 in 10,000 dilution, 10mls=1mg</td>
<td>SHSC Pharmacy</td>
<td>pack of 12</td>
<td></td>
</tr>
</tbody>
</table>

**Box for Doctor’s use only:**
- Micropore tape clear latex free
- 2 x Cannulae size grey 16g x 45mm
- 2 x Cannulae size green 18g x 45mm
- 2 x Cannulae size pink 20g x 32mm
- Minijet Adrenaline 1 in 10,000 dilution, 10mls=1mg

**ORDERING:**
- For **NHS Supply Chain** items use a STOCK requisition (please use codes provided)
- For other items use a NON-STOCK requisition (please quote codes and supplier)
- For **SHSC Pharmacy** contact Pharmacy Department

N.B.
- pack sizes for **NHS Supply Chain** items are minimum order quantities
# Appendix D

## Resuscitation Record Form

Please complete a form following every resuscitation incident

### Section 1 - Patient details

<table>
<thead>
<tr>
<th>Q1</th>
<th>Patients name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q2</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>sex</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q3</th>
<th>Where incident occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4</th>
<th>Profession &amp; grade of first staff member to incident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Profession</td>
</tr>
<tr>
<td></td>
<td>Grade</td>
</tr>
</tbody>
</table>

### Section 2 - Incident details (Actions by anyone other than paramedic/ambulance staff)

<table>
<thead>
<tr>
<th>Q5</th>
<th>Date &amp; time the patient found collapsed (use 24 hour clock)</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>M</td>
<td>M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q6</th>
<th>Time ambulance called? Time ambulance arrived (use 24 hour clock)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>M</td>
<td>M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q7</th>
<th>What time was Basic Life Support (BLS) started? (use 24 hour clock)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>not started</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q8</th>
<th>Profession and grade of individuals administering resuscitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trained in BLS in last year?</td>
</tr>
<tr>
<td>Profession</td>
<td>Grade</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q9a</th>
<th>Was an automated external defibrillator (AED) used? If Yes, what time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q9b</th>
<th>Name of person using AED..............................................</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Job Title:--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Had the person using the AED had training within the last year?</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q9c</th>
<th>If AED was not used what were the reasons (only applicable where Resuscitation equipment assessment indicates AED should be available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>not required</td>
<td>not available</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q10</th>
<th>Were any of the following principles of ALS used by anyone other than paramedic/ambulance staff? If used, had the individual received training in the last year?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous access</td>
<td>Yes</td>
</tr>
<tr>
<td>Administering epinephrine/adrenaline</td>
<td>Yes</td>
</tr>
<tr>
<td>Other, please specify</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q11</th>
<th>What was the outcome of resuscitation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Died</td>
<td></td>
</tr>
<tr>
<td>Survived</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q12</th>
<th>Was an incident form completed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
### Resuscitation Audit

**Audit topic:** Resuscitation Audit  
**Objective:** To ensure that patients are resuscitated in accordance with guidelines  
**Sample:** All attempted resuscitation incidents

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to resuscitate a patient the following should occur:</td>
<td></td>
</tr>
<tr>
<td>1. An ambulance should be called immediately on recognition of arrest.</td>
<td>100%</td>
</tr>
<tr>
<td>2. Basic life support should begin immediately on recognition of arrest.</td>
<td>100%</td>
</tr>
<tr>
<td>3. Staff giving Basic Life Support (BLS) should have received training in the last year.</td>
<td>100%</td>
</tr>
<tr>
<td>4. If an automated external defibrillator was used:</td>
<td></td>
</tr>
<tr>
<td>Staff should have had their AED training in the last year.</td>
<td>100%</td>
</tr>
<tr>
<td>5. If Advanced Life Support (ALS) is used staff should have been:</td>
<td></td>
</tr>
<tr>
<td>Trained in the principles of ALS within the last three years.</td>
<td>100%</td>
</tr>
<tr>
<td>6. An incident form should be completed.</td>
<td>100%</td>
</tr>
</tbody>
</table>
The Process of DNACPR

The National End of Life Care (EOLC) Strategy identified DNA CPR decisions as important elements of end of life care. It noted that whilst many providers had DNA CPR policies in place they were not always consistent or across all care providers. As such this has had implications for the ambulance service and how DNA CPR decisions are implemented when patients transfer between providers, or to their own home or care home. Thus the National Strategy advocated that providers should work together to see how best they can put resuscitation policies into practice that best meet patients’ needs, following the revision of existing guidance by the British Medical Association (BMA), the Royal College of Nursing (RCN), and the Resuscitation Council (UK).

Sheffield’s EOLC Strategy prioritised the need for NHS Sheffield to work collaboratively with providers to take this forward through a multiagency DNA CPR group. Simultaneously NHS Bradford and Airedale, as the lead commissioners for the Yorkshire Ambulance Service were mandated by the Healthy Ambitions Pathway Delivery Board for EOLC (Strategic Health Authority) to lead a piece of work to coordinate DNA CPR across the Yorkshire and the Humber region. As a result the common DNA CPR form is a regional form to be implemented across Yorkshire and the Humber, whilst the processes to support implementation have been agreed locally.

Cardio-pulmonary resuscitation (CPR) could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are inevitable as part of dying and thus, theoretically CPR could be used on every individual prior to death. It is therefore essential to identify patients for whom cardio-pulmonary arrest represents the terminal event in their illness and for whom CPR is inappropriate. It is also essential to identify those patients who would not want CPR to be attempted in the event of an arrest and who competently refuse this treatment option. Some competent patients may wish to make an Advance Statement about treatment (such as CPR) that they would not wish to receive in some future circumstances. These statements must be respected as long as these decisions are informed, current, and applicable and made without coercion.

Where patients are admitted to hospital acutely unwell or become medically unstable in their existing home or healthcare environment, their resuscitation status should be considered as soon as is reasonably possible. When no explicit decision has been made about resuscitation before a cardio-pulmonary arrest, and the express wishes of the patient are unknown, it should be presumed that staff would attempt resuscitation.

Overall responsibility for decisions about DNACPR orders rests with the Consultant or GP in charge of the patient’s care. Where care is shared between a hospital and general practice, or two hospitals, the doctors should discuss with each other and agree who should take responsibility for recording the decision and conveying it to those who need to know, both in primary and secondary care, including locum staff and GP deputising services.

Care environments that have patients on a DNACPR order should ensure that this is communicated, daily in handovers and regularly in multidisciplinary team meetings, to ensure everyone is aware of the DNACPR including temporary staff. It is important to consider each individual patient’s own particular circumstances in reaching the decision rather than categories of patients. Patients and carers should be provided with the information leaflet (Appendix K).

Three elements will guide decision-making:

- **The likely clinical outcome including the likelihood of successfully restarting the patient’s heart and breathing, the overall benefits achieved from successful resuscitation.**
  
  No benefit is gained if only a very brief extension of life is achieved and the patient’s co-morbidity is such that death cannot be averted. Similarly no benefit is gained by the patient if he or she will never have awareness or the ability to interact and is therefore unable to experience benefits. It may not be appropriate to resuscitate a patient that is in a terminal phase of illness.

- **The patient’s known consistent/sustained wishes.**
  
  If a person “with capacity” (see note below) decides they have reached a stage where treatment to prolong their life, although possible, would be inappropriate this must be respected. Resuscitation must not be attempted if CPR is contrary to the recorded sustained wishes of an adult, who had capacity, and was aware of the implications at the time of making that decision.
A person with capacity is the best judge of what represents an acceptable level of burden or risk for him or herself, where there is a chance of an outcome the person considers acceptable, many will consider the risk of even significant disadvantage a burden worth taking. Information on resuscitation for patients and carers is situated in Appendix K.

**CPR** carries risk of side effects (such as internal fracture, rib fracture or splenic rupture). Most patients require either coronary or intensive care post resuscitation. If there is delay between arrest and resuscitation brain damage will result. Sometimes attempting resuscitation can be traumatic so the patient will die in a manner they would not have wished, this would also be difficult for the people close to them.

- **The patient’s human rights including right to life and the right to be free from degrading treatment.**

It is ethically appropriate to consider whether cardiac function is likely to fail repeatedly and whether there are any costs to the patient in terms of pain or distressing side effects. The duty to protect life (Human Rights Act, 1998, Article 2) needs to be balanced with the obligation not to subject the patient to inhuman or degrading treatment (Article 3).

*Within the Mental Capacity Act 2005, are 5 basic principles regarding decision making:

- An adult (over 16 years) is assumed to have capacity. A lack of capacity has to be clearly demonstrated.
- No-one should be treated as unable to make a decision unless all practicable (reasonable) steps to help them have been exhausted and shown not to work.
- A person can make an unwise decision. This does not necessarily mean they lack capacity.
- If it is decided that a person lacks capacity then any decision taken on their behalf must be in their best interests.
- Any decision taken on behalf of a person who lacks capacity must take into account their rights and freedom of action. Any decision should show that the least restrictive option or intervention is achieved.

Decision-making capacity refers to the ability that individuals possess to make decisions or to take actions that influence their life. Patients over 16 years of age are presumed to have capacity to make decisions for themselves unless there is evidence to the contrary. Individuals are, however, considered legally unable to make decisions for themselves if they are unable to:

- understand the information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decisions, or communicate the decisions (whether by talking, using sign language, visual aids or by other means).

The views of all members of the team responsible for the care of the individual including those involved in primary and secondary care and people close to the patient are all valuable in forming the decision. Consensus among all those that are involved in the discussion is the aim.

Some people may identify a point in the future after which they no longer want treatment. The person may choose to express their wishes in a written document an advance directive or "living will". Where a person with capacity expresses clear consistent wishes and this discussion is recorded in the notes this has the same status as a written advance directive.

Consensus in the team should be reached on clinical outcome. If this is not possible the matter can be referred to another doctor. Where no advance decision can be reached the reasons for this should be documented. In the event of an arrest with no advanced decision CPR should be attempted unless other factors interfere, such as unavoidable delay in starting CPR or severe deterioration in the patient’s condition since the last discussion.

A decision not to resuscitate a patient applies only to CPR. It should be made clear to the patient, people close to the patient and care staff that it does not imply "non treatment" and other treatment and care appropriate for the patient will be considered and offered.
Decisions about resuscitation must be reviewed regularly and in the light of changes in the patient's condition and wishes. The frequency of reviews should be determined by the Consultant/G.P. and will be influenced by the patient's diagnosis, potential for improvement and response to treatment. Reviews must be clearly documented as such. Ordinarily a review will occur in a specified number of days, up to a maximum of fourteen. Occasionally review may be less frequent but the reason for this must be clearly documented.

To avoid confusion the Do Not Attempt Cardiopulmonary Resuscitation Form should be used and placed at the front of the medical notes. Reasons for a DNACPR order are clearly documented, signed and dated by a senior member of the clinical team (Consultant, or GP in community).

**THE DNACPR FORM**

- For any patient being transported by Yorkshire Ambulance Service/SHSC Transport, the DNACPR form incorporates a Specific Instruction section which may need to be completed. Ensure that ambulance control/Transport is aware of the existence of the DNACPR form at the time of booking the ambulance.
- The DNACPR form should follow the patient from setting to setting.
- On transfer of medical responsibility of the patient from the care of one senior healthcare professional to another the DNACPR status should be reviewed by the senior healthcare professional who is assuming medical responsibility for the patient. For patients being discharged to the community this will usually be the GP. It is the responsibility of the supervising healthcare professional to inform the receiving healthcare professional of the presence of a DNACPR form.
- Where a patient with a DNACPR form is being discharged home or is dying at home it is the medical and nursing team’s responsibility to ensure that the family are aware of its existence and know what to do in the event of an arrest. Where it is considered potentially harmful for the DNACPR form to be in the patient’s house it should be sent immediately to the GP.
- Ensure that out of hours services are informed (where appropriate) whenever a DNACPR order is reversed.

When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form; writing CANCELLED in large capital letters and adding your signature and date. It should then be recorded and filed in the patient’s records.

**A. If the patient is dying as a result of an irreversible condition, CPR is unlikely to be successful. If the medical team is as certain as it can be that CPR would not realistically have a medically successful outcome, it is inappropriate to offer it as a treatment option and will:**

- Allow a natural death.
- Good palliative care should be in place to ensure a comfortable and peaceful time for the patient, with support for the relevant others.
- Do not burden the patient or relevant others with having to decide about CPR when it is not a treatment option.
- Ensure that patient has and understands as much information about their condition as they want and need (the reasons why CPR will not work may be part of this information).
- Document the fact that CPR will not benefit the patient.
- Complete DNACPR form.
- The absence of a DNACPR form should not alter the appropriate management of an arrest.
- Review if medical circumstances change in a way the means CPR could result in a successful outcome.
- Review if medical responsibility for the patient changes (e.g. patient discharged home from hospital)
- All reviews that take place should be documented and signed (see section 3 of the DNACPR form) and within the patient record.
B. If the patient is thought not to be dying and the team is as certain as it can be that CPR would realistically have a possibility of a medically successful outcome, the next decision is whether the patient is competent to take part in this discussion and fully comprehend the implications of the decision.

- Patients with capacity are able to understand their situation and the consequences of their decisions. Adults should be presumed to have capacity unless there is evidence to the contrary. Evidence that a patient is suffering from depression or is under the influence of others would warrant a formal assessment of competence. An assessment of capacity should relate to the specific decision the patient is being asked to make and their ability to fully comprehend their situation and the implications of their decision. Patients who are judged to not have the capacity to make decisions about their care should be managed according to the principles of the Mental Capacity Act (2005).

- If the patient has capacity for this decision and is agreed by the team that discussion would not cause unnecessary distress:
  - Discuss the options with the patient unless they make it clear they do not wish to have this discussion.
  - Continue to communicate progress to the patient and relevant others if the patient agrees.

- If the patient does not have the capacity for this decision:
  - Enquire about previous wishes from the relevant others to help the clinical team make the most appropriate decision. Continue to communicate progress to them
  - Patients should be involved according to the principles of the Mental Capacity Act (2005).
  - Continue to communicate progress to the relevant others.

- Document this discussion in the medical and nursing records detailing the circumstances that any decision relates to and who was involved in the decision making process.
- Complete DNACPR form if appropriate.
- Review regularly and if circumstances change.
- In the event of a cardio-pulmonary arrest, act according to the patient’s previous wishes (or if the patient was not competent, follow the decision made by the clinical team).
Do Not Attempt Resuscitation Guideline

Reason by the RMO for DNAR order should be clearly documented in the medical notes and a DNAR form completed (placed at the front of the medical records)

- A – Patient with capacity
  - Provide patient with information leaflet. Discussion with the patient about DNAR should be documented in the notes.

- B – Patients condition indicates that CPR is unlikely to be successful
  - Provide next of kin with information leaflet. There should be discussion with next of kin. This should be documented in the nursing/care & medical records.

- C – Length & quality of life following CPR would not be in the best interest of patient
  - There should be a discussion about DNAR in the Multidisciplinary Team meeting. This should also be documented in the notes and entry made on the DNAR form.

The Consultant/GP should clearly write in the notes ‘in the event of a cardiac or respiratory arrest (patient name) Do not attempt cardio-pulmonary resuscitation’.

The above should be signed by the doctor to say that they have involved all key individuals in the discussion. Notification to the senior nurse/manager on duty should also be documented.

The DNAR order should be reviewed at least every 14 days. This should include the doctor’s signature and the status of DNAR order. If there is a longer review date there should be a clear reason documented.

If the DNAR order has been rescinded this needs to be clearly documented in all sections of the patients record and all appropriate individuals notified.
When patients wishes are not known with respect to disclosure of information, Doctors may disclose information to people close to the patient where this is necessary to discuss the patients care and not contrary to the patients best interests.

The Consultant/G.P. should discuss resuscitation sensitively with people close to the patient/patient advocate

Information sought from relatives is to help ascertain what the patient would have wanted in their circumstances as opposed to what those consulted would like for the patient or what they would want for themselves in the same situation.

 Relatives and others close to the patient should be assured that their views on what the patient would want to be taken into account but they cannot insist on treatment or non-treatment.

A DNACPR decision needs to be sensitively communicated to people close to the patient.

The entry in the medical records should clearly document the date of the decision and the reasons for it, also DNACPR form completed and placed in the front of the medical notes. This entry should be made by the Consultant/G.P.

This person should ensure the decision is communicated effectively to other relevant professionals in both primary and secondary care. The Consultant/G.P. will lead this process but may delegate the task of informing other appropriate staff.

The decision should be recorded in the nursing/care records by the primary nurse/carer or most senior person in the team who’s responsibility it is to inform the rest of the team.

DNACPR decisions should be communicated at the hand over and discussed in multidisciplinary reviews.
The Consultant/G.P. should sensitively explore the patient's wishes regarding resuscitation. It may be helpful to ask patients, if they do become incapacitated, who they would like to be involved in the decision making.

If a patient does not want CPR this should be discussed to ensure the decision is based on accurate information and not a misunderstanding.

If a patient requests CPR when clinical evidence suggests that it will not effectively restart the heart and breathing, or that it cannot provide an overall benefit, sensitive efforts should be made to convey a realistic view to the patient. If the patient asks for a DNACPR order not to be made then this should be respected.

Patients who want to be involved in decision making will be made aware of the decision that has been reached and should be told how this will be communicated to the health/social care team.

Clearly document the date, the decision and the reasons for it. This should be done by the Consultant/G.P. Complete DNACPR form and place in the front of the medical records.

This person should ensure the decision is communicated effectively to other relevant professionals in both primary and secondary care. The Consultant/G.P. will lead this process but may delegate the task of informing other appropriate staff.

The decision should be recorded in the nursing/care records, by the primary nurse or most senior person in the team, whose responsibility it is to inform the rest of the team.

Refusal by a competent patient to disclose information to family and friends should be respected.

DNACPR decisions should be communicated at the hand over and discussed in multidisciplinary reviews.
In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) will be made. All other treatment should be given where appropriate.

NHS No | Hospital No | Next of Kin / Emergency Contact
Name
Address | Relationship
Postcode | Date of Birth | Tel Number

Section 1  Reason for DNACPR: Select as appropriate from A - D (see reverse)
Details of all discussions, mental capacity assessments and MDT decisions must be recorded in the patient’s notes.

A. CPR has been discussed with this patient. It is against their wishes and they have the mental capacity to make this decision.

B. CPR is against the wishes of the patient as recorded in a valid advance decision.
The right to refuse CPR in an Advance Decision only applies from the age of 18.

C. The outcome of CPR would not be of overall benefit to the patient and:
   i) They lack the capacity to make the decision  or
   ii) They have declined to discuss the decision 
   This must be discussed with relevant others wherever possible (details overleaf)
   This has been discussed with ........................................ (name) Relationship to patient:.................................

D. CPR would be of no clinical benefit because of the following medical conditions:

   Even in situations in which CPR is not expected to be successful, it is still good practice to explain to the patient and/or relevant others why CPR will not be attempted.
   This has been discussed with the patient  
   This has not been discussed with the patient because it would cause them unnecessary distress  
   This has been discussed with ........................................ (name) Relationship to patient:.................................

Section 2  Healthcare professionals completing DNACPR form (see reverse)
Name & Designation | Name & Designation
Organisation | Organisation
Signature | Date | Signature | Date

Section 3  Review of DNACPR decision (if appropriate)
This order is to be reviewed by: Date: ..........................

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Full Name and Designation</th>
<th>Signature</th>
<th>Still applies</th>
<th>Next Review Date</th>
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AMBULANCE CREW INSTRUCTIONS
If Cardiopulmonary Arrest occurs, please do not attempt CPR. All other appropriate treatment should be given.
Any other specific instructions:  ...........................................................................................................
These guidelines are based on an agreement within the Yorkshire and Humber region. For more details refer to your local policy relating to DNACPR. This is not a legally binding document; the decision may change according to clinical circumstances.

Section 1  Guidance  (Please write legibly and with black ink)

Option A
Record details in the patient’s notes, including the assessment of the patient’s mental capacity to make this decision.

Option B
The Mental Capacity Act [2005] confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:
1. The decision is in writing, signed, witnessed and the patient is aged 18 or over;
2. It includes a statement that the advance decision is to apply even if the patient’s life is at risk;
3. The advance decision has not been withdrawn;
4. The patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
5. The patient has not done anything clearly inconsistent with its terms; and
6. The circumstances that have arisen match those envisaged in the advance decision.

16 and 17-year-olds: Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.

Option C
1. The term "overall benefit" is used in the context defined by GMC Guidance 2010 (Treatment & Care towards the End of Life, para’s 6, 13, 40-46) and takes into account "best interests" as defined by the Mental Capacity Act, 2005.
2. This situation must be discussed with relevant others where possible. Record details of your discussion in the patient’s notes.
3. The term “relevant others” is used to describe a patient’s relatives, carers, representatives, people with lasting power of attorney, independent mental capacity advocates (IMCAs), advocates, and court appointed deputies (refer to Mental Capacity Act) http://www.dh.gov.uk

Option D
1. Record underlying condition/s eg poor Left Ventricular function, end stage obstructive airway disease, disseminated malignancy with poor performance status.

Section 2  Authorisation
Responsibility for making the DNACPR decision lies with a senior doctor (e.g. Consultant, GP) who has responsibility for the patient. In some localities, other healthcare professionals who have undertaken the necessary training may make the DNACPR decision.

If junior medical staff or other authorised professionals have been instructed to sign the form by a senior clinician, the form should be countersigned by the senior doctor, as soon as possible or as per local policy.

Section 3  Review – In accordance with your local Policy.
It is considered good practice to review DNACPR status in the following circumstances:
- At the consultant ward round, MDT or Gold Standards Framework meeting;
- On transfer of medical responsibility (e.g. hospital to community or vice versa); or
- Whenever there are significant changes in a patient’s condition.

When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form, writing CANCELLED in large capitals and adding your signature and date. It should then be filed in the patient’s notes.

COMMUNICATING DNACPR DECISIONS
It is the responsibility of the healthcare professional completing the form to ensure that the DNACPR status is communicated to all who need to know.

For patients being transferred between different care settings, it is essential that all professionals including Out of Hours (OOH) and Ambulance (e.g. Yorkshire Ambulance Service) are made aware of this DNACPR order
1. Send the original form with the patient.
2. A photocopy should only be retained in the patient’s notes for audit, marked with the words ‘COPY’ in large capitals, signed and dated.
3. In circumstances where patients are being transferred to community: the DNACPR status should be communicated to patient (if appropriate) and ‘relevant others’. They may prefer the form to be placed in a clearly marked envelope.
4. For discharges to community settings: communicate to the GP, Out of Hours service, and any other relevant services as appropriate e.g. Hospice.
Process to Implement Whole System Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) Form in Sheffield

Appropriate health professionals in organisations and/or care settings (hospital, hospice, intermediate care, care home, home) to identify patients that require a DNA CPR form, discuss and complete the form as per the guidance. Where it is thought that an individual may move care settings with the DNA CPR form in place this is to be identified early to enable discussion to take place with the patient, family, carers, as part of care planning in advance for end of life. Where this is a young person (YP) in transition the receiving organisation will where possible review the incoming paperwork (Limitations of Treatment Agreement – LOTA and/or DNA CPR Form), discuss with the discharging clinical team and agree to utilise the paperwork (LOTA/DNA CPR Form) going forward that is in the best interest of the young person.

For patients that are to move care settings with their DNA CPR form:
The Yorkshire Ambulance Service (YAS) will routinely request the DNA CPR status of each patient at the point of booking patient transport services (PTS), and communicate this to the relevant PTS crew prior to arrival at the patient to be transported.

The Hospital/Hospice will ensure that:
- The DNA CPR form has been completed in line with the guidance
- The form has a review date that is individual for the patient (could be unlimited).
  Acknowledging the need to enable time for the GP to see the patient post discharge (suggested 1 month), and the best practice would be to review the form at least annually.
- A discussion with the patient/family/carer inline with the DNA CPR policy has taken place
- Utilise the booking form for patient transport services to enable handover of DNA CPR info (this is not possible via the PAS download).
- They hand over the original DNA CPR Form to the patient or crew to travel with the patient (it is suggested that the form is put in a clearly marked envelope for transfer)
- They keep a copy, to be marked COPY and kept in the back of the patient’s notes for audit
- The DNA CPR status and review date are captured clearly in both the discharge slip and formal discharge communication to the patient’s GP, and if the patient is especially close to end of life this is supplemented by further communication (phone/fax).

The patient transport service will ensure that:
- The crews are aware of the DNA CPR status of the patient they are due to transport prior to arrival at the discharging organisation
- The crews collect patients with a form directly from where they are being discharged
- The crews request and take possession of the original DNA CPR form to travel with the patient (it is suggested that the form is put in a clearly marked envelope for transfer).
- If the form is not available upon arrival prior to transport they will transport the patient with the default that they would perform CPR if necessary
- The crews hand over the original DNA CPR form upon arrival at another organisation (hospital, hospice, intermediate care)
- The crews ensure that the original DNA CPR form is deposited in the front of the patient’s notes – Your Care Record, upon arrival at the patient’s home or a care home.
For patients in the community, their own home or care home the GP will ensure that:
- Where a form is enacted a discussion with the patient/family/carer inline with the DNA CPR policy has taken place
- Where a patient is discharged the DNA CPR form is reviewed prior to the designated review date, and the patient’s status is recorded on the clinical system
- The DNA CPR status is communicated as appropriate to other healthcare professionals involved in the patient’s care including community nursing teams
- The DNA CPR status is communicated to the GP’s out of hours service if the patient is on the palliative care/EOLC register and identified as approaching end of life via ‘Special Notes’
- The GP Collaborative may query expect DNA CPR as part of their call and will query upon a visit, they will know where to locate the DNA CPR form, at the front of the ‘Your Care Record’.
- The communication to other health care professionals and GP out of hours services is ongoing as an outcome of review of the DNA CPR status and form, as is updating the patients status on the practices clinical system.

Where patients in the community, their own home or care home, with a DNA CPR form require patient transport to a planned hospital appointment
The hospital will book patient transport using the patient transport booking request form (rather than utilise the PAS download) and YAS/PTS will routinely request DNA CPR status at the point of booking and notify the crew if a form is in place prior to arriving with the patient. The Crews will be instructed that the Form will be at the front the patient’s ‘Your Care Record’ in the patient’s own home or notes in their care home and to transport it with the patient.

Where a patient requires urgent transport to hospital for an admission
The GP will arrange this as normal through PCT Single Point of Access. They will routinely ask if the patient has a DNA CPR form, share this information with the A&E crew prior to arrival with the patient and ask the GP to ensure the form will be available for transport with the patient.

In an emergency if an ambulance crew is called to a patient at home/care home for a situation that is not life threatening but requires transferring the patient to A & E.
There is not currently an IT solution that will enable the DNA CPR status to be flagged to the crew prior to arrival, but A & E crews will be asked to look in the front of the patient’s ‘Your Care Record (notes) for a potential form, and to transport this with the patient to hospital.

If the patient has a respiratory/cardiac arrest during transport with the DNA CPR form, the order will stand, and the crew will call dispatch and:
- first follow any specification instructions on the form
- If no specific instructions they will take the patient either back to the hospice if transporting post discharge or to the nearest A&E.
What happens if my heart stops?
Do Not Attempt CPR (Cardiopulmonary Resuscitation)
Information for patients, family, friends and carers
This is a general leaflet for all Patients but it may also be useful to your relatives, friends and carers.

It tries to explain:
• what CPR is;
• how you will know whether it is relevant to you; and
• how decisions about CPR are made.

It may not answer all your questions about CPR, but it should help you to think about the issue. If you have any other questions, please talk to one of the doctors or nurses caring for you.

What is CPR?

If someone’s heart or breathing stops suddenly, the brain can only live for about three to four minutes before death may result. When this happens it may be possible to try to restart the heart and breathing with emergency treatment called CPR or cardiopulmonary resuscitation.

What happens in CPR?

CPR usually includes:
• ‘mouth-to-mouth’ breathing to get air in the lungs; and
• repeatedly pushing down very firmly on the chest to pump blood round the body, until further help arrives.

In hospital, or healthcare premises, the emergency team may then:
• use a machine to give electric shocks to try to restart the heart;
• insert a tube into the windpipe to give oxygen; and
• give drugs to help the heart and lungs work properly.
Is my heart likely to stop suddenly?

The healthcare team caring for you are the best people to discuss the likelihood of your heart or breathing stopping suddenly whilst you are in hospital/hospice/home. People with the same illness or symptoms do not always respond to their treatment in the same way, so it is usual for professionals and patients to discuss what might happen in advance.

Is CPR tried on everybody whose heart and breathing stop?

Yes, in an emergency if there is a chance that it will work and the person has not refused CPR. When the heart and breathing stop without warning, for example if a person has a serious injury or heart attack, the healthcare team will try to revive the patient. Some members of the public are also trained to do CPR. The priority is to try to save the person’s life. However, a person’s heart and breathing also stop working as part of the natural and expected process of dying. If people are already very seriously ill and near the end of their life, there may be no benefit in trying to revive them each time their heart and breathing stop. This is particularly true when patients have other things wrong with them that mean they don’t have much longer to live. In these cases, restarting their heart and breathing may do more harm than good by prolonging the pain or suffering of someone who is soon to die naturally.

Does CPR work?

The chance of CPR reviving you will depend on:

- why your heart and breathing have stopped;
- any illnesses or medical problems you have (or have had in the past);
- and
- the overall condition of your heart and lungs.

Less than 2 out of 10 patients who have needed CPR leave hospital alive. The figures are much lower for patients with serious underlying conditions. It is important to remember that this is a general picture. Everybody is different and the healthcare team will explain whether they think CPR will help you.
Does my age or the fact that I have a disability affect this?

No, your age does not affect the decision, nor does the fact that you may have a disability. What is important is:
- your state of health;
- your wishes; and
- the likelihood of you getting back to a decent life.

Do people get back to normal after CPR?

Each person is different. Patients with many medical problems are less likely to make a full recovery. A few patients do make a full recovery, some recover but have health problems but, unfortunately, most attempts at CPR do not restart their heart and breathing despite the best efforts of everyone concerned. It depends on why their heart and breathing stopped working and their general health. It also depends on how quickly their heart and breathing can be restarted. Patients who are revived are often still very unwell and need further treatment afterwards, usually in a coronary care or intensive care unit. The techniques used to restart the heart and breathing also sometimes cause side effects, for example, bruising or broken ribs and punctured lungs. Some patients never get back the level of physical or mental health they enjoyed before the cardiopulmonary arrest. Some may end up with brain damage or go into a coma.

What if I have already decided that I don’t want CPR?

If you don’t want CPR, you can refuse it and the healthcare team must respect your wishes. You must inform them of your wishes so they can record it in your medical notes.

Living Wills

You can make a Living Will (also called an “Advance Decision”) to put your wishes in writing. If you already have one, you must make sure that the doctor looking after you knows about it and puts a copy of it in your health records. You should also let your family and close friends know so that they can tell the healthcare team your wishes if you are unable to do so. The contents of a Living Will should usually be respected, but in an emergency, where the team have not been made aware of it or seen a copy of it, then CPR may be attempted.
Will someone talk to me about CPR?

Yes, if you would like them to. Your healthcare professional will usually talk to you about:

- your illness;
- what you can expect to happen; and
- what can be done to help you.

If you want, your family and close friends can be involved in these discussions. You can also ask someone who shares your religious faith to join you. If you are in a hospital or hospice, the chaplaincy service may be able to arrange for a leader of your faith to visit you to discuss this.

What if I don’t want to talk about it?

You do not have to talk about CPR at all if you don’t want to, or you can put a discussion off if you feel you are being asked to decide too much too quickly. Your family or close friends might be able to help you make a decision you are comfortable with. Otherwise, the doctor in charge of your care will decide whether or not CPR should be attempted, taking into account things you may have said. If you are under 18, your parents can decide for you.

Who makes the decision about CPR?

The team looking after you will look at all the medical issues, including whether CPR is likely to be able to restart your heart and breathing if they stop, and for how long. It is beneficial to attempt resuscitation if it might prolong your life in a way that you can enjoy. Sometimes, however, restarting a person’s heart and breathing leaves them with a severe disability or only prolongs their suffering. Prolonging life in these circumstances is not always beneficial; your doctor will discuss this with you. Your wishes are very important, and the healthcare team will want to know what you think. In most cases, doctors and their patients agree about their treatment when there has been good communication.

What if I am too poorly to decide about CPR?

If you are not able to make a decision due to your illness, the doctor in charge of your care is responsible in law for deciding on your behalf.
Your family and friends are not allowed to make this decision for you, but it can be helpful for the healthcare team to talk to them about your wishes. However, if there are people you do not want to be asked about your wishes, you should let the healthcare team know.

**What if I want CPR to be attempted, but my doctor says it won’t work?**

Although nobody can insist on having treatment that will not work, no doctor would refuse your wish for CPR if there was any real possibility of it being successful. If CPR might restart your heart and breathing, but is likely to leave you severely ill or disabled, your opinion about whether these chances are worth taking is very important. The healthcare team will listen to your opinions and to the people close to you, if you want them involved in the discussion. If there is doubt whether CPR might work for you, the healthcare team can arrange a second medical opinion if you would like one.

**What if I haven’t decided and my heart stops?**

The doctor in charge of your care will make a decision about what is right for you at the time.

**What happens if it is decided that CPR won’t be attempted?**

There will be a dated and signed note placed in your confidential health records that you are ‘not for CPR’. This is usually called a ‘do not attempt cardio-pulmonary resuscitation’ or DNACPR decision. The doctor will make sure that other members of the healthcare team are informed. Your family and close friends may be told about the decision, unless you don’t want to talk about it with them.

The healthcare team will continue to give you the best possible care and treatment.

**What if my condition changes?**

If your condition changes at any time for better or worse, the healthcare team will review any decisions about CPR and make the necessary written changes in your records. They will also be expected to discuss any changes with you.

**What if I change my mind?**

You can change your mind at any time, and ask to talk to any of the healthcare team caring for you.
Will this decision affect any other treatment I receive?

Not at all. A do not attempt cardio-pulmonary resuscitation (DNACPR) order is about CPR only. You will still receive the best possible treatment for your illness even if you, or the team looking after you, have decided against CPR.

Can I talk to anyone else about this?

If you feel that you have not had the chance to have a proper discussion with the healthcare team, or you are not happy with the discussions you have had, please tell a member of the team caring for you. You can also ask someone to contact the PALS (Patient Advice and Liaison Service) Officer in the hospital, care trust or primary care trust, who can help you or the people close to you deal with your worries or complaints.

Alternatively you may wish to request spiritual advice from the hospital or hospice chaplaincy or your preferred minister.

Your local PALS contact details

Ask your healthcare team for your local PALS telephone number. If you need this leaflet in other languages or formats, please contact your local PALS team.

This leaflet has been adapted from a model information leaflet created by:
The British Medical Association;
The Resuscitation Council (UK);
The Royal College of Nursing; and Age Concern.

Approved by: NHS Bradford and Airedale and adopted by the regional DNACPR strategic group.
Publication date: September 2010
Regional review date: August 2012
Regional lead contact:
Palliative medicine consultant, Airedale NHS Foundation Trust, West Yorkshire
### Appendix L  Equality Impact Assessment Form

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
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<th>Yes/No</th>
<th>Comments</th>
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<tr>
<td>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
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<td>Ethnic origins (including gypsies and travellers)</td>
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<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
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<tr>
<td>2. Is there any evidence that some groups are affected differently?</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4. Is the impact of the policy/guidance likely to be negative?</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>5. If so can the impact be avoided?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. What alternatives are there to achieving the policy/guidance without the impact?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Can we reduce the impact by taking different action?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have identified a potential discriminatory impact of this procedural document, please refer it to Liz Johnson (Head of Patient Experience Inclusion) together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact Liz Johnson (Head of Patient Experience Inclusion and Diversity)
Appendix M  Human Rights Act assessment checklist

1

1.1 What is the policy/decision title?
Resuscitation Policy
1.2 What is the objective of the policy/decision?
To give appropriate guidance to staff re resuscitation issues.
1.3 Who will be affected by the policy/decision?
Patients, staff and more rarely visitors

2

2.1 Will the policy/decision engage anyone’s Convention rights?
NO

2.2 Will the policy/decision result in the restriction of a right?

3

3.1 Is the right an absolute right?

3.2 Is the right a limited right?

3.3 Will the right be limited only to the extent set out in the relevant Article of the Convention?

4

4 The right is a qualified right
1) Is there a legal basis for the restriction? AND
2) Does the restriction have a legitimate aim? AND
3) Is the restriction necessary in a democratic society? AND
4) Are you sure you are not using a sledgehammer to crack a nut?

Get legal advice
Regardless of the answers to these questions, once human rights are being interfered with in a restrictive manner you should obtain legal advice. And you should always seek legal advice if your policy is likely to discriminate against anyone in the exercise of a convention right
Appendix N

Development and consultation process

This policy version is a review of an existing policy which had full consultation & ratification.

This update has been carried out in line with new guidance from:

Resuscitation Council Guidelines 2010

Mental Capacity Act 2005

SHSC Policy on Policies

and other guidance from professional organisations

This review has been carried out in consultation with:

Charlie Turner          Senior Nurse Patient Safety
**Emergency Bag – Weekly/After Use Checklist**

**Emergency Bag - Location:……………………………**  
Month/Year……………………

Please verify that the emergency bag contains the following items, in date & full working order.

<table>
<thead>
<tr>
<th>Date</th>
<th>Adult Non-rebreathing 100% Oxygen masks</th>
<th>x2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual oxygen tubing</td>
<td>x2</td>
</tr>
<tr>
<td></td>
<td>Guedal Airway Size 2 sterile</td>
<td>x1</td>
</tr>
<tr>
<td></td>
<td>Guedal Airway Size 3 sterile</td>
<td>x1</td>
</tr>
<tr>
<td></td>
<td>Guedal Airway Size 4 sterile</td>
<td>x1</td>
</tr>
<tr>
<td></td>
<td>Vitalograph Emergency Aspirator</td>
<td>x1</td>
</tr>
<tr>
<td></td>
<td>Single use bag, valve and mask (with Oxygen reservoir)</td>
<td>x1</td>
</tr>
<tr>
<td></td>
<td>Single use pocket mask</td>
<td>x1</td>
</tr>
<tr>
<td></td>
<td>Tufcut Scissors</td>
<td>x1</td>
</tr>
<tr>
<td></td>
<td><em>Naso Pharyngeal Airway Size 6</em></td>
<td>x1</td>
</tr>
<tr>
<td></td>
<td>Lightweight Portable Oxygen Cylinder</td>
<td>x1</td>
</tr>
<tr>
<td></td>
<td>Ligature Cutter</td>
<td>x1</td>
</tr>
</tbody>
</table>

**Inspected by:**
Signature of person inspecting

**Remarks, Problems, Corrective Actions**

**Action completed**
Date:  
Signature: