Document Title:	**Resuscitation Policy**
Document Purpose:	Statement of delivery of Resuscitation Services throughout the Trust
Document Statement:	• All patients will receive appropriate cardiopulmonary resuscitation (CPR) interventions when indicated. • Trust staff will receive appropriate resuscitation training in-line with their expected roles and responsibilities. • All clinical areas will have access to appropriately maintained resuscitation equipment. • Resuscitation procedures within the trust will follow the current guidelines from the Resuscitation Council (UK). • Do Not Attempt Resuscitation (DNACPR) decisions will be decided on an individual basis, supported by the policy.
Document Application:	Trust Wide
Responsible for Implementation:	All Clinical Staff, Chief Executive, Medical Director, Director of Nursing, Trust Board, General Managers, Heads of Nursing, Matrons, Ward Managers and Clinical Directors in collaboration with the Resuscitation Team

Main imperatives of this Document are:

- **All clinical staff will provide resuscitation care according to their role and competence.**
- **All clinical staff will attend resuscitation training according to their role and responsibilities.**
- **All clinical staff will use and be aware of the Do Not Attempt Resuscitation decision making process.**

Document Classification:	Corporate	**Document Reference:**	CO/PO/00084
Version Number:	2	**Secondary Reference:**	
Issued by:	Chief Executive	**Effective Date:**	March 2008
Author:	Resuscitation Service	**Review Date:**	July 2014
Sponsor:	Medical Director	**Expiry Date:**	July 2021

Associated Documents

1. Minimal Moving and Handling Policy BTUH 2007.
2. Procedure for use of an Automated External Defibrillator BTUH 2008. (Updated 2010)
3. Guidelines for Care of the Critically Ill Child, Post-Resuscitation Stabilisation, Retrieval and Transfer BTUH 2008. – Under review
4. Transfer of all patients between all wards, departments and external healthcare providers Policy 2006 (Updated 2010).
5. Resuscitation Council (UK) (2004, updated 2008) CPR Guidance for Clinical Practice and Training in Hospitals.
6. Resuscitation Council (UK) (2010) Resuscitation Guidelines 2010 London.
7. HMSO (2005) The Mental Capacity Act.
8. The Association of Anaesthetists of Great Britain and Ireland (May 2009) Do Not Attempt Resuscitation (DNACPR) Decisions in the Perioperative Period
9. Mental Capacity Act 2005 Policy BTUH 2009
10. Advanced Decisions to Refuse Treatment Policy

Validated by Facilitator:	Document Control Group	**Date: 18 February 2011**
Agreed by Specialist Group:	Resuscitation Strategy Group	**Date: 29 July 2011**
Agreed by Board Sub-Committee:	Board of Clinical Directors	**Date: 23 May 2011**

DOCUMENT HISTORY

Revision History

Revision Date	Previous Revision date	Summary of Changes	Changes marked
March 2008		Newly written policy to take into account new published documents regarding resuscitation: Mental Capacity Act Resuscitation Council Clinical Guidelines Revision includes new DNACPR form	
February 2010	March 2008	Revision of entire policy due to Resuscitation Guidelines 2010 Revised DNACPR form	No
June/July 2011		Revision due to Regional DNACPR policy for persons over 16 years.	No

CONTENTS

1. INTRODUCTION

This Resuscitation Policy fully supports the Recommendations for Clinical Practice and Training in Cardiopulmonary Resuscitation published by the Resuscitation Council (UK) (2008) and has been constructed to promote compliance with the NHSLA Risk Management Standards (NHSLA, 2011/12).

The purpose of the policy is to provide direction and guidance for the planning and implementation of a high-quality and robust cardiopulmonary resuscitation across the Trust. It ensures appropriate procedures are in place to safeguard the well being of Basildon and Thurrock University Hospital NHS Trust staff and healthcare users.

This policy includes a comprehensive framework for clinical practice with regards to 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR).

2. DEFINITIONS

2.1 Cardiac Arrest
A person is unresponsive with no signs of life including no breathing or inadequate respiratory effort and no pulse.

2.2 Cardiopulmonary resuscitation (CPR)
Chest compressions and ventilations are provided by the rescuers to the individual in cardiac arrest, thus, providing blood with oxygen to the vital organs.

2.3 Defibrillate / Defibrillation
A procedure, whereby hands free pads from a defibrillator are applied to a patient's chest and a controlled electrical shock is discharged to treat certain cardiac arrest rhythms. The electrical shock is intended to "stun" the heart for a moment, with the hope that the heart will return to a normal functioning rhythm.

2.4 Defibrillator
A medical device designed to provide a measured electrical shock. Please note that defibrillators maybe used in a manual mode where the user recognises the rhythm and delivers the shock or in an automated mode (AED) where the machine will direct staff to deliver a shock when indicated.

2.5 Peri-Arrest or Deteriorating Patient
Where a patient does not require immediate cardiopulmonary resuscitation, but is recognised as being high risk of doing so.

2.6 Do Not Attempt Resuscitation (DNACPR)
A clinical decision has been made that if the patient should go into cardiac arrest no chest compressions or ventilations would be delivered as it would be deemed futile or not in the individual's best interests.

2.7 Proxy decision maker
This would be either a health & welfare attorney or a court deputy.

2.8 Emergency Grab Bag – a bag containing emergency clinical equipment that can be taken to the scene.

2.9 RCUK – Resuscitation Council UK

2.10 ALSG – Advanced Life Support Group

2.11 ALS – Advanced Life Support Course (RCUK)

2.12 ILS – Immediate Life Support Course (RCUK)

2.13 PILS – Paediatric Immediate Life Support Course (RCUK)

2.14 APLS – Advanced Paediatric Life Support Course (ALSG)

2.15 EPLS – European Paediatric Life Support Course (RCUK)

2.16 NLS – Newborn Life Support Course (RCUK)

2.17 ATLS – Advanced Trauma Life Support Course – Royal College of Surgeons

2.18 MOET – Managing Obstetric Emergencies & Trauma Course (ALSG)

2.19 Early Warning Systems - Physiological scoring system that identify patients at risk of cardiac arrest.

3. ROLES AND RESPONSIBILITIES

Resuscitation Service Accountability, Responsibility and Role Clarification

Name	**Accountability and Responsibilities**
Chief Executive	*As Accounting Officer, Accountable to:* The Board of Directors and Secretary of State. *Overall Responsibility for*: Ensuring that resuscitation procedures are in place and that appropriate resuscitation equipment is available at all times.
Board of Directors	*Accountable to:* The Board of Governors *Responsible for*: The Board of Directors has ultimate responsibility for minimising the risks associated with resuscitative practice and the general means by which the Trust prevents and controls such risks. Directors are individually and collectively responsible.
Medical Director	*Accountable to:* The Chief Executive *Responsible for:* Delegated executive lead for ensuring that resuscitation procedures carried out in the grounds of the Trust follow current guidelines. That functional appropriate resuscitation equipment is available, and that medical staff involved in resuscitation are appropriately trained. Reviewing arrangements for resuscitative practice within the trust through the Governance Structure.

Director of Nursing	*Accountable to:* The Chief Executive *Responsible for:* Ensuring that the nursing, midwifery and therapy workforce complies and fulfils the requirements set out in this policy. That staff who may be involved in resuscitation are appropriately trained.
Chair Resuscitation Strategy Group	*Accountable to:* The Clinical Directors Board *Responsibility for:* Clinical lead providing advice on the implementation of Resuscitative practices across the Trust. Reports directly to Clinical Directors Board
Senior Resuscitation Officer	*Accountable to:* Director of Education / Director of Nursing / Resuscitation Strategy Group *Responsible for:* Operational management of the Resuscitation Service and Officers to ensure implementation of high standards of Resuscitative practices across the Trust through achievement of annual objectives and work plan as agreed with the Resuscitation Strategy Group. Ensure the Resuscitation policy is reviewed and updated as appropriate, to ensure distribution, implementation and compliance throughout the organisation of the policy. Lead the Resuscitation Service in implementing and monitoring an effective clinical teaching program. Ensure appropriate resuscitation equipment is made available throughout the trust. Ensure resuscitative practice is evaluated through regular audits, and that these are reported back to the Resuscitation Strategy Group. Ensure resulting recommendations are implemented. Ensure incidents regarding resuscitative practice are effectively investigated.
Resuscitation Officers	*Accountable to:* Senior Resuscitation Officer *Responsible for:* Supporting the Senior Resuscitation Officer in, the provision of an effective Resuscitation Service in accordance with Trust Policies, Procedures and Protocols, ensuring the highest possible standards of practice. Deputise for the Senior Resuscitation Officer as appropriate.
General Managers/ Heads of Nursing and Midwifery/ Clinical Directors	According to their sphere of responsibility; responsible for ensuring that all staff are familiar with the policy and attend recommended training. Responsible for ensuring that their areas have the correct equipment and that the resuscitation equipment is fully functioning, and maintaining adequate stocks of disposable items. The resuscitative management of patients is carried out in their areas in accordance with Trust policy and best practice.

Matrons / Service Managers Ward / Department Managers	Are responsible for ensuring that all staff are familiar with the policy. Responsible for ensuring that their clinical areas have the correct equipment and that it is fully functioning, and maintaining adequate stocks of disposable items. Are responsible for ensuring that staff attend resuscitation training on induction, and annually thereafter. Must ensure that resuscitative management of patients is carried out in their areas in accordance with Trust policy and best practice. Ensure Resuscitative equipment is available at all times, reporting any deficits in equipment, training needs or critical incidents to the Resuscitation Officers.
Consultants and other staff Senior Clinicians	Consultants are responsible for ensuring that they attend appropriate resuscitation training annually and their respective teams comply with Trust policy and best practice. All consultants and Senior Clinicians must ensure they have read and understood the policy and incorporate the guidance into their clinical practice. They should be aware of their role within the resuscitation team and be aware of the location of resuscitation equipment within their clinical areas. They must also ensure they understand the implications of DNACPR orders for patients and relatives.
Clinical Staff	All clinical staff must ensure they have read and understood the policy and incorporate the guidance into their clinical practice. They should be aware of their role and expectations within the resuscitation team and to be aware of the location of resuscitation equipment within their clinical areas. They must also ensure they understand the implications of DNACPR orders for patients and relatives.
Non-clinical Staff	Non-Clinical staff should ensure that they are familiar with the policy and be aware of the emergency telephone system and how to summon appropriate help if needed.

4. CARDIOPULMONARY RESUSCITATION TRAINING

The strategy for cardiopulmonary resuscitation training shall embody the current statements and guidelines published by the Resuscitation Council (UK) & ALSG, incorporating the most recent updates to these guidelines. The Trust has a duty of care to provide an effective resuscitation service to all patients, staff and visitors on Trust premises. Appropriately trained staff should be continuously available to manage cardiopulmonary arrests when they occur. Staff should undergo regular cardiopulmonary resuscitation training to a level appropriate for their expected clinical responsibilities and expected degree of competence.

New members of staff will have cardiopulmonary resuscitation training incorporated into their induction programme. Clinicians will undertake a resuscitation e-learning package, incorporated into this will be a mandatory field where clinicians including locums will inform the organisation of which resuscitation courses they have undertaken, passed and will inform us of the date and course centre. This can then be tracked on Moodle and OLM, reports can be generated for personnel, medical training officers, and resuscitation service when required. Guidelines for cardiopulmonary resuscitation training are detailed in **Appendix A** and incorporate adult, paediatric, newborn and neonatal (obstetric) concepts.

4.1 Responsibilities Regarding Medical Staff Training

The responsibility for ensuring medical staff attendance at Resuscitation training lies with the Medical Director, Clinical Directors, Consultants as well as the individual doctor. A record of attendance will be kept by the Resuscitation Service and be recorded on OLM. Doctors are also required to keep an up to date record of training. The Resuscitation Officers have the responsibility to inform the Clinical Directors / Educational Supervisors if a team consistently achieves a poor percentage of staff trained on an annual basis. Where individual staff may avoid training or be noted to require additional training, the Resuscitation Service has the responsibility to report this to the Directorate Lead and the Associate Medical Director for Education and Training.

4.2 Responsibilities Regarding Clinical Staff (other than doctors) Training

The responsibility for ensuring staff attendance of Resuscitation training lies with the appropriate Ward/Department Manager, as well as the individual obliged to receive the training. A record of attendance will be kept by the Resuscitation Service and be recorded on OLM, the individual's line manager as well as the individual. Where the overall annual training percentages of Wards/Departments are deemed by the Resuscitation Service to be of concern, the Resuscitation Service will inform the Ward/Department Manager, their line Manager and Directorate General Managers.

4.3 Discrepancies in Standards of Performance

As part of the training process, competency assessments will be carried out by the Resuscitation Service. Where acceptable standards are not achieved, the Resuscitation Service will inform the individual concerned that they must re-attend for training as specified by the Resuscitation Service.

Where this situation arises, the Resuscitation Service will send a memorandum to the appropriate Ward/Department Manager or Clinical Director/Lead, who have the responsibility to document and keep a record of all staff that have been assessed as needing to re-attend for training more regularly than annually. They have the responsibility to act upon the request made by the Resuscitation Service to ensure that any individual, who has not achieved the required competency levels, must attend re-training at the earliest opportunity. Training should be valid for a fixed period of time only, with updates recommended yearly as a minimum.

5. EARLY WARNING SYSTEMS

There are several early warning systems in use throughout the trust, which are used in the prompt identification of patients at risk of cardiac arrest. These are incorporated into the observation charts which monitor aspects of the patient's physiological condition. Significant changes in physiology trigger the system that is in place.

5.1 Patient at Risk Score (PARS) is for all adult patients (except those of the Cardiothoracic Centre & Mental Health Unit). When the PARS system is triggered, the ward staff will contact the **Patient at Risk Service on bleep 6427** as well as the patients own On-call doctor. The PARS team will prioritise their workload in accordance of the patient's clinical needs and priority will be given to the sickest patient. Phone advice is always available.

5.2 Modified Early Warning System (MEWS) is for all adult patients in the Cardiothoracic Centre. When the patient triggers the ward staff contact the **Critical Care Outreach Team** on Bleep 6001 (or the night Senior Nurse).

5.3 Children's Early Warning Tool Score (CEWTS) is for all paediatric patients including A&E. When the child triggers appropriate clinical escalation takes place in accordance with the flow chart.

5.4 Modified Early Obstetric Warning Score (MEOWS) is for all maternity patients. When the patient triggers appropriate clinical escalation takes place in accordance with the flow chart. The PARS team are to be contacted when MEOWS score is 5 or above.

All warning score must be audited on a regular basis to ensure that the track and trigger systems are utilised and completed in full to identify those at risk, enabling such patients to be escalated, treated and referred to high levels of care as appropriate.

Monitoring early warning scores is a component of NHSLA Risk Management Standards Standard 4 – Criterion 7: Resuscitation. Therefore regular monitoring of the above score should take place, where monitoring identifies deficiencies the Trust must provide evidence that recommendations and action plans have been developed and changes implemented. The Resuscitation Service is not the lead auditors for monitoring the early warning scores, this should be monitored by the Heads of Nursing.

6. LOCAL ANAESTHETIC TOXICITY / ANAPHYLAXIS

6.1 The management of severe Local Anaesthetic Toxicity should be conducted in accordance with the Anaesthetic Association of Great Britain & Ireland Safety Guidelines. For algorithm see Appendix F.

6.2 The management of suspected anaphylaxis / anaphylactoid reactions should be conducted in accordance with the Resuscitation Council (UK) Guidelines for the management of anaphylaxis. For algorithm see Appendix G.

7. SUMMONING AND ACTIVATION OF THE EMERGENCY TEAMS

7.1 Calling the Team

A **2222** call may be initiated by any member of staff who requires medical assistance immediately. Every employee in the Trust must be familiar with this telephone number, and this should be reinforced in training.

When receiving a **2222** call requesting help, the switchboard operator will respond with a series of questions in order to obtain the correct information. Please see **Appendix B** for a Flowchart detailing the correct procedure. For all **2222** calls it is essential to identify which emergency team is required and also the correct location.

Once a 2222 call is made via switchboard, the appropriate team bleeps will be triggered and the team must respond to the event immediately. The switchboard operator will state the nature of the emergency and the location that the team are required. This message will be repeated three times.

7.2 The Role of Switchboard

It is important that an effective emergency call system is in place in order to summon members of the Emergency Team(s). It is necessary therefore that Switchboard perform twice daily test calls for all of the Emergency Teams to ensure service availability.

All on-call bleep holders **must** contact switchboard to acknowledge the test bleep to ensure service provision. If any bleep holder fails to acknowledge, switchboard must contact the individual to investigate whether a fault has occurred.

All 2222 Emergency team calls must be logged and recorded by switchboard for audit purposes, as this will assist with further identification of appropriate escalation in relation to the deteriorating patient.

8. THE EMERGENCY TEAM(S)

8.1 To meet the needs of different patients, different emergency teams are required to respond to specific emergency events. The role of the team is to work in conjunction with staff from the location, providing direction and advanced life support skills as necessary.

8.2 Prior to the arrival of the team, cardiopulmonary resuscitation should have already commenced, if required. It is therefore best practice to allocate on each shift roles and responsibilities to individual staff members in the event of a cardiac arrest to ensure that each member is aware of their role during such an event.

8.3 A defibrillator and a person trained in defibrillation should be available for all cardiac arrests in less than 3 minutes. All Emergency Teams should also aim to respond to requests for help in under 3 minutes.

8.4 During the hours of 9am to 5pm, Monday to Friday Adult Cardiac Arrests in Accident and Emergency will be managed by the Accident and Emergency Team which will comprise of a Senior Accident and Emergency Doctor (Middle Grade and above) and sufficient Accident and Emergency Nursing staff. Anaesthetic staff will be called to attend by switchboard. However the Medical Cardiac Arrest Team will always be summoned out of hours and if further assistance is required.

8.5 Team members will include those on call and who carry the baton bleeps which must be handed over on personnel change. It is best practice that the entire team should meet at handover to introduce themselves to each other and allocate roles. This will ensure that if they need to respond to a 2222 call, they are aware of the roles and responsibilities', to which they are allocated, this in turn, leads to a more effective team structure and function.

Basildon Hospital

8.6 **Medical Cardiac Arrest Team** will constitute a:
Medical Specialist Registrar – Team Leader (should hold a valid ALS certificate).

Anaesthetist
Senior House Officer (FY2)
Medical FY1 Doctor
Senior Nurse from CCU
A&E Nurse for out of area events.

The Adult Resuscitation Team will respond to all 2222 calls within the grounds of the hospital including adult patients in cardiac arrest, peri-arrest, and collapse of any cause including anaphylaxis or any patient who has become acutely unwell and requires immediate medical assistance.

If you attend a 2222 call and the patient is not in cardiac arrest but acutely unwell, please notify the PARS team.

8.7 Accident & Emergency Cardiac Arrest Team will constitute a:
Senior A&E Doctor (Middle Grade or above) – Team Leader (should hold a valid ALS certificate).
Anaesthetist
A&E Senior House Officer (FY2)
A&E Nurses
A&E Departmental Assistant

8.8 The Cardiothoracic (CTC) Resuscitation Team will constitute a:
Cardiology Registrar or Surgical Cardiothoracic Registrar – Team Leader (should hold a valid ALS certificate).
Anaesthetist
ODP
Senior Nurse from Colne ward (CICU)
Senior Nurse from Roding ward (Cardiology)
Scrub Nurse,
Preferably a Perfusionist

The Cardiothoracic Team will respond to all 2222 calls within the vicinity of the Cardiothoracic Centre including adult patients in cardiac arrest, peri-arrest and collapse of any cause.

8.9 The Paediatric Resuscitation Team will constitute a:
Paediatric Registrar – Team Leader (should hold a valid APLS/EPLS certificate)
Anaesthetist,
Paediatric SHO (FY2)
Senior Registered Children's Nurse
Paediatric Consultant must be contacted in the event of all paediatric cardiac arrests.

The Paediatric Resuscitation Team will respond to all 2222 calls within the Hospital site relating to children (excluding neonates) including children in cardiac arrest, peri-arrest and collapse of any cause requiring immediate medical assistance.
The Paediatric Team will attend all trauma calls of children and assist the Trauma Team as necessary

8.10 The Trauma Team will constitute a:
Senior Accident and Emergency Doctor (Consultant or Middle Grade) (should hold a valid ATLS certificate)
Surgical Registrar
Anaesthetist

Orthopaedic FY2
A&E SHO (FY2)
Surgical SHO (FY2)
Two nurses will also be required
Other medical staff including Paediatrics will be co-opted by the trauma team, if and when their expertise is required.

8.11 The Neonatal Team will constitute a
Neonatal Registrar – Team Leader (should hold a valid NLS certificate)
Neonatal SHO (FY2)
Senior Nurse from NICU
Neonatal Consultant must be contacted in the event of all newborn or neonatal cardiac arrests.

The Neonatal Resuscitation Team will respond to all 2222 calls within the hospital site relating to neonates including Maternal Cardiac arrests. The neonatal team should also be called electively for all high-risk deliveries.

8.12 The Obstetric Team will constitute a:
Obstetric Registrar (should hold a valid MOET certificate)
Anaesthetist
Senior Midwife
Obstetric SHO (FY2)
ODP
Scrub Nurse/Midwife.

The Obstetric Resuscitation Team will respond to all 2222 calls within the hospital site involving pregnant women including maternal cardiac arrest (along with the medical resuscitation team), peri-arrest, major haemorrhage and collapse of any other cause. The Obstetric Team will be contacted to attend trauma calls involving pregnant women.

8.13 Resuscitation Officers
A Resuscitation Officer will attend emergency calls for all adult, paediatric, newborn/neonatal cardiac arrest or emergency calls including trauma when available during week days. The role of the Resuscitation Officer is to facilitate best resuscitative practice, support the team leader and team members during and post event. Another component of the role of the Resuscitation Officers is aid debriefing at the end of the event along with the Team Leader.

8.14 Team working, including team leadership of teams
As previously indicated above, the team leaders should hold a current provider certificate within the speciality team they lead and demonstrate competent leadership skills. As stated by the RCUK and ALSG (2010)

'Employers are themselves directly responsible for establishing that their staff have the capabilities requisite to their clinical setting – this is essential in the interests of patient health and safety.'

Therefore it is essential when clinical staff commence employment within the Trust they attend a Resuscitation Training programme for clinicians to provide the Trust with assurance that individuals are familiar with the processes in place and equipment available.

Team leaders must clearly identify themselves on arrival at an event and ensure delegation of roles is appropriate to the skills of the team members; this will ensure cohesion of the team

during an event. 'The team leader provides guidance, direction and instruction to team members to enable successful completion of their stated objective.' (RCUK 2010)

It is the team leader's responsibility to ensure debriefing occurs and that they complete the 2222 form for the event.

8.15 Orsett Hospital

As a stand-alone site providing elective clinical services from different organisations there is no on-site resuscitation team provided. In the event of an emergency for both adults and paediatrics 2222 must be called to activate the Minor Injuries Unit Nurse (SWEPCT) and the Outpatients bleep holder (BTUH) as they will attend with the appropriate equipment including defibrillator (AED) and decide following assessment, whether it is necessary to call the emergency services via 9-999

8.16 Billericay St Andrew's Centre

St Andrew's is a primary care facility and the trust provides a number of services on site including imaging and phlebotomy. There is no on-site resuscitation team, in the event of a cardiac arrest or medical emergency help will be summoned by calling 999. Resuscitation equipment including defibrillator (AED) is provided by BTUH and is located in the physiotherapy department.

8.17 Audit of 2222 calls

All 2222 calls for the Medical Cardiac Arrest Team, Cardiothoracic (CTC) Resuscitation Team, A&E Cardiac Arrest Team, Paediatric Resuscitation Team and Orsett Hospital must have a 2222 form (see Audit Standards 14.1 & 14.2) completed and for the blue copy to be sent to the Resuscitation Service, whilst the white copy is retained in the patients healthcare records.

9. POST RESUSCITATION CARE

When a patient has a return of spontaneous circulation (ROSC) they usually clinically unstable, and requires an immediate systematic reassessment, including appropriate investigations such as a chest x-ray, ABG, bloods (electrolytes, FBC, clotting, glucose), 12 lead ECG and ECHO. Continuity of care during this period is vital, the Team Leader should seek expert help from the patients own Consultant, the Intensivists and/or the Cardiothoracic team, regarding patient transfers and continuing critical care management. The safe transfer or retrieval of the patient should only occur once the patient is stable.

For children the above applies, specific advice regarding post resuscitation care and transfer can be obtained from external specialist paediatric transfer teams. Information can be found in the procedural document "Guidelines for Care of the Critically Ill Child including, Post-Resuscitation Stabilisation, Retrieval and Transfer" this is currently being updated.

9.2 Therapeutic Hypothermia

Induction of hypothermia after Return of Spontaneous Circulation (ROSC) has been associated with improved functional recovery and reduced cerebral deficits. The RCUK (2011) has made the following recommendations 'based on evidence available and expert consensus to consider therapeutic hypothermia for any mechanically ventilated patient admitted to ICU for post resuscitation organ support.'
Due to the risk of arrhythmias, coagulopathies and infection, induction of therapeutic hypothermia should only be considered in adult patients after discussion with a Consultant Intensive Care Doctor. Patients should be cooled to 32℃ to 34℃ for 12 to 24 hour. The Intensive Care Unit can be contacted on ext **3440.**

9.3 Transfer of Patients

For advice regarding transfer and availability of Paediatric Critical Care (ITU / HDU) beds, please refer to the Trust document "Guidelines for Care of the Critically Ill Child including, Post-Resuscitation Stabilisation, Retrieval and Transfer".

For adult patients please contact the Intensive Care Department on ext **3440** or for cardiothoracic patients Colne Ward on ext **4272.** Equipment for monitoring in transfer is available from Accident and Emergency, Intensive Care Department and Puffin Ward (for children).

The patient's condition should be stabilised as far as possible and the patient transferred with full monitoring, but this should not delay definitive treatment. For children, the Team Leader may be required to liaise with either the Neonatal Intensive Care Unit or the Children's Acute Transfer Service (CATS) Team on 0800 085 0003.

Prior to transfer the following steps should be considered:

1. Ensure appropriate equipment is available e.g.; Cardiac monitor/ Defibrillator and machines that can record blood pressure, oxygen saturations, Caponography.

   a. Transfer stack with oxylog ventilator available from Critical Care (ITU / HDU)
   b. Defibrillator and Grab bag from A&E

2. Ensure adequate cardiac arrest and peri- arrest drugs available.

3. Confirm oxygen cylinder is full prior to transfer and battery operated suction is available and working.

4. Ensure patient is referred to an appropriate specialist with a full and complete hand over to both medical and nursing staff (SBAR).

5. Confirm completed documentation accompanies the patient.

6. The Team Leader must make certain the patient being transferred is accompanied by appropriately competent staff during intra or inter-hospital transfers.

7. Verify that the patient's relatives have been informed with regards to the patient's transfer.

The Team leader must complete the Trust 2222 Audit form and ensure adequate documentation concerning the event.

Please also refer to the Transfer of all patients between all wards, departments and external healthcare providers Policy 2006 (Updated 2010).

10. RESUSCITATION EQUIPMENT

10.1 Provision of Resuscitation Equipment

Clinical areas and the choice of resuscitation equipment available will depend on the anticipated workload of the area/ward, availability of equipment from nearby departments and specialised

local requirements. Hospitals have a duty of care to ensure appropriate equipment is available in the event of a cardiac arrest, and that this equipment is adequately maintained. This is a standard of the Care Quality Commission, and the RCUK.

If a new clinical area is to open a risk assessment must be undertaken by the Resuscitation Service to determine the type of equipment required. The costing for this must be incorporated into the budget planned for that new area. The same risk assessment applies if an area changes its designation.

When equipment is at the end of its service life, a rolling programme is in place and is planned into the ongoing Capital Investment Bids to ensure that the equipment is replaced/upgraded. For any changes to the type of equipment this will be proposed to the Resuscitation Strategy Group and the tendering process commenced.

10.2 Checking of Resuscitation Equipment

Successful advanced life support relies, in part, upon the availability and correct functioning of resuscitation equipment. A registered healthcare professional must be allocated to check the resuscitation equipment daily or when an area is clinically open, to ensure that when an emergency occurs the equipment is available and functional. This is to take place during the day or immediately after use, the person allocated to check the equipment will be identified on the rota. If gaps in checking are identified the individual named is responsible and will be accountable for not checking the equipment. The Resuscitation Service does not recommend that the same individuals always check the equipment.

Equipment for cardiopulmonary resuscitation, including defibrillators, should be standardised throughout the hospital and be stored on a standard trolley or a grab bag. Portable oxygen and suction should be available on all resuscitation trolleys. Where piped or wall oxygen and suction are available, these should always be used in preference.

A registered healthcare professional must check, print legibly and sign in the Resuscitation Equipment Signing book that:

- All equipment is present.
- Suction equipment works.
- The defibrillator works by performing a daily operational check test.
- Equipment is plugged in and charged.
- Check expiry dates on perishable equipment i.e. drugs and electrodes.
- Empty or near empty oxygen cylinders, must be replaced immediately by contacting a member of the portering staff.
- Resuscitation equipment including trolleys, suction units and defibrillators should be cleaned weekly and after use in accordance with the infection control policy.

This must include documentation of any items missing or faults with equipment and the immediate action taken. In the event of a resuscitation event, the same checks must be performed immediately afterwards.

10.3 Resuscitation Trolleys and Equipment

Each Trolley has a checklist detailing all the equipment that must be available on the resuscitation trolley. The trolley must be stocked according to this list and no items should be added or removed without the agreement of the Resuscitation Service.

All members of staff must be familiar with the resuscitation equipment in their area. New members of staff and locum/agency staff must familiarise themselves with the resuscitation equipment and its location. Ward/Department Managers are responsible for ensuring that their areas have the correct equipment and that the resuscitation equipment is fully functioning, and adequate stocks of disposable items are maintained.

All resuscitation equipment must be checked on a daily basis. It is the ward/department managers' responsibility to check that the daily checks are taking place by reviewing the Resuscitation Equipment Signing book weekly. Resuscitation Equipment Signing books must be kept for 10 years in accordance with the Department of Health (2009) records management - retention periods. The Resuscitation Service will monitor the compliance of Resuscitation Equipment checking by performing "Spot Checks" and will produce quarterly audits and the ward/area manager will be informed of the outcomes.

10.4 Missing equipment

This is to be replaced immediately from either the ward/department stocks or from the Emergency Cupboard which is on Level B (Old Block) and James McKenzie Ward, for the CTC the Resuscitation store is located on Colne ward. Details of where replacement items can be sourced are contained within the information folder on each resuscitation trolley. If there is no stock available, staff must contact either the Resuscitation Service during office hours or the duty Sister/Charge Nurse or the Night Nurse Practitioners, and place an urgent order with Distribution to replace ward stock.

10.5 Faulty Equipment

Faulty equipment is to be reported immediately to MEMS (Medical Equipment Management System) and to the Resuscitation Service. Outside office hours faulty resuscitation equipment must be reported in the first instance to the duty Sister/Charge Nurse or the Night Nurse Practitioners.

10.6 Emergency buzzers

Emergency buzzers on the ward/department must be checked on a weekly basis. The Ward/Department Manager must ensure that this audible test is carried out and recorded in the resuscitation equipment signing book. It this is not working it needs to be reported to estates.

10.7 Grab Bags for cardiac arrests that occur outside of clinical areas

If an adult or paediatric emergency occurs outside of clinical areas, but within the environs of the trust e.g. car parks, dining areas, plant rooms, kitchens, education centre, etc. grab bags for adult and paediatric patients containing emergency equipment are available.
Adult grab bags are located on James McKenzie Ward and the A&E Department, and contain an AED and basic equipment such as airways and a bag-valve mask. The senior nurse from James McKenzie Ward, who is the bleep holder for the Cardiac Arrest Team, will collect the adult grab bag located in the treatment room before taking it to the location. The senior nurse (cardiac arrest bleep holder) from A&E will allocate an appropriate member of staff to bring a trolley and defibrillator. (9-999 maybe activated to summon an ambulance aid safe transfer dependant on area.)
For calls outside of paediatric clinical areas, a paediatric grab bag should be taken from Puffin Ward by the senior paediatric nurse responding to the arrest call. If she/he is unable to attend

the bag may be sent with another member of staff or a Porter. Paediatric Grab bags are also kept in the Accident & Emergency Department and ITU.

All emergency grab bags will have their contents and expiry dates checked **daily**. The Ward/Department Manager should ensure this takes place.

11. MANUAL HANDLING

In situations where a collapsed patient is on the floor, in a chair or in a restricted or confined space the Trust guidelines for the movement of the patient must be followed to minimise the risks of manual handling and related injuries to both staff and the patient. Please also refer to the Resuscitation Council (UK) Guidance for safer handling during resuscitation in healthcare settings which can be found at http://www.resus.org.uk/pages/safehand.pdf

12. CROSS INFECTION

Whilst the risk of infection transmission from patient to rescuer during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. It is recommended that members of staff **should not** perform mouth to mouth whilst on Trust premises. All clinical areas should have immediate access to ventilation devices (e.g. a pocket mask) to minimise the need for mouth-to-mouth ventilation. However, in situations where equipment is not immediately available, (after calling for help on 2222) start chest compressions whilst awaiting a ventilation device.

13. DEFIBRILLATION

Ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT) accounts for approximately 25% of both out of and in hospital cardiac arrests. (RCUK, 2010) These rhythms have the advantage of being the most amenable to treatment; the treatment being the application of a defibrillatory shock. Treatment of VF and pulseless VT are identical.

Early defibrillation is the single most important determinant of survival from cardiac arrest due to VF or pulseless VT. The chances of successful outcome for casualties in VF or pulseless VT depends on the time taken to defibrillate for every minute where a patient does not receive cardiopulmonary resuscitation nor defibrillation successful outcomes decrease by 10 – 12%. (RCUK, 2011)

Nursing staff are most often the group that witness/discover a patient who has suffered a cardiac arrest, it is logical that registered nurses should be trained to defibrillate using an Automated External Defibrillator if optimum survival is to be achieved.

13.1 All registered nurses working in areas which have advisory defibrillators should have shock-advisory defibrillation training on an ILS course. This will include a competency-based assessment as detailed in the document “Procedure for use of an Automated External Defibrillator (non medical staff)” BTUH 2010

13.2 All non-clinical and clinical staff taking on the role of manual defibrillation must have a current valid ALS certificate, and thereafter yearly assessments of competence by the Resuscitation Service.

14. DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FOR PERSONS OVER 16

14.1 The Decision Not to Attempt Cardiopulmonary Resuscitation

It is essential to identify (a) patients for whom cardiopulmonary arrest is an anticipated terminal event and in whom cardiopulmonary resuscitation (CPR) would be futile or not in the patients best interest; and (b) patients who do not wish to be treated with CPR.

Any person who suffers a Respiratory or Cardio-Respiratory arrest must receive cardiopulmonary resuscitation, unless a decision not to attempt resuscitation has been made and documented, in accordance with this policy, or until the Cardiac Arrest Team Leader, in liaison with other Cardiac Arrest Team members decides that further resuscitation would be inappropriate or unlikely to succeed.

When it is deemed that CPR would not be in the patient's best interest, it is preferable that where possible, a discussion takes place about CPR and a decision is made in advance. This is better than making decisions in a crisis when there may be insufficient time to gather and consider all of the relevant information relating to the patient's wishes and clinical condition. Making such decisions in a crisis can be more stressful for the staff and those close to the patient. Clinical and Nursing staff should always offer the opportunity to discuss DNACPR decisions and aspects of care with any patient, carer or family member who initiates a discussion regarding resuscitation (a Trust patient information leaflet is available in the first instance).

A DNACPR decision is a decision not to implement cardiopulmonary resuscitation **only**. Other treatments, interventions and care are not affected by DNACPR decision e.g. dignity, nutrition, pain relief, antibiotics, ventilation etc and must be decided on the basis of clinical need.

If a DNACPR decision has not been made and documented, or if staff are unsure as to whether such an order is in place, resuscitation should be carried out until a decision to stop resuscitation is made by the Cardiac Arrest Team Leader, in consultation with other team members, or a documented DNACPR order is made available.

This policy does not address the entire complex clinical considerations that healthcare teams face such as withdrawal of specific therapies and interventions such as inotropes or mechanical ventilation. This policy also does not distinguish between basic and advanced CPR because the underlying ethical and legal principles that govern decision-making are the same (BMA & RCN Decisions Relating to Cardiopulmonary Resuscitation (2007).

A Trust patient information leaflet regarding resuscitation is also available on both the website and intranet and can be given in the first instance to patients, relatives or carers. However, it may be necessary to arrange for the individual patient's Consultant to clarify any questions.

14.2 Non-discrimination

Any CPR decision must be tailored to the individual circumstances of the patient. It must not be assumed that the same decision will be appropriate for all patients with a particular condition. Decisions must not be made on the basis of assumptions based solely on factors such as the patient's age, disability, or on a professional's subjective view of a patient's quality of life.

14.3 STATEMENT REGARDING DNACPR POLICY FROM THE EAST OF ENGLAND STRATEGIC HEALTH AUTHORITY (EoE SHA) FOR ADULTS OVER 16

14.3.1 Basildon and Thurrock University Hospital NHS FT have adopted components of the EoE SHA regional DNACPR policy. The aim of the regional policy is to prevent inappropriate, futile and / or unwarranted attempts at cardiopulmonary resuscitation (CPR) in adults (please note that an adult will be referred to as a person) aged over 16 years in all care settings across the East of England.

It does not refer to other aspects of care, for example, analgesia, antibiotics, suction, treatment of choking, treatment of anaphylaxis or other interventions which are sometimes loosely referred to as "resuscitation".

14.3.2 Variations in local policies can cause misunderstandings and lead to distressing incidents for patients, families and staff. Increased movement of patients and staff between different care settings makes a single, integrated and consistent approach to this complex and crucial area a necessity.

14.3.3 All persons are initially presumed to be for cardiopulmonary resuscitation unless a valid DNACPR decision or a valid Advance Decision to Refuse Treatment (ADRT), refusing cardiopulmonary resuscitation, has been made and documented.

14.3.4 DNACPR decisions are based on current legislation and guidance.

14.3.4.1 Legislation

Under the Mental Capacity Act (2005) clinicians are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made. See BTUH Mental Capacity Act 2005 Policy.

The following sections of the Human Rights Act (1998) are relevant to this policy:

- The individual's right to life (article 2)
- To be free from inhuman or degrading treatment (article 3)
- Respect for privacy and family life (article 8)
- Freedom of expression, which includes the right to hold opinions and receive information (article 10)
- To be free from discriminatory practices in respect to those rights (article 14).

14.3.4.2 Guidance

General Medical Council (2010) – Treatment and care towards the end of life: good practice in decision making

Recommending standards for recording "Do not attempt resuscitation" (DNACPR) decisions (2009)

Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing. (October 2007, updated November 2007). www.resus.org.uk/pages/DNACPR.pdf

14.4 General Medical Council 2010 – Treatment and care towards the end of life: good practice in decision making – May 2010

14.4.1 Cardiopulmonary Resuscitation
(Information/guidance is copied directly from the GMC document)

14.4.2 When someone suffers sudden cardiac or respiratory arrest, CPR attempts to restart their heart or breathing and restore their circulation. CPR interventions are invasive and include chest compressions, electric shock by an external or implanted defibrillator, injection of drugs and ventilation. (GMC, 2010)

14.4.3 If attempted promptly, CPR has a reasonable success rate in some circumstances. Generally, however, CPR has a very low success rate and the burdens and risks of CPR include harmful side effects such as rib fracture and damage to internal organs; adverse clinical outcomes such as hypoxic brain damage; and other consequences for the patient such as increased physical disability. If the use of CPR is not successful in restarting the heart or breathing, and in restoring circulation, it may mean that the patient dies in an undignified and traumatic manner. (GMC, 2010)

14.5 When to consider making a Do Not Attempt CPR (DNACPR) decision

14.5.1 If cardiac or respiratory arrest is an expected part of the dying process and CPR will not be successful, making and recording an advance decision not to attempt CPR will help to ensure that the patient dies in a dignified and peaceful manner. It may also help to ensure that the patient's last hours or days are spent in their preferred place of care by, for example, avoiding emergency admission from a community setting to hospital. These management plans are called Do Not Attempt CPR (DNACPR) orders, or Do Not Attempt Resuscitation or Allow Natural Death decisions. (GMC, 2010)

14.5.2 In cases in which CPR might be successful, it might still not be seen as clinically appropriate because of the likely clinical outcomes. When considering whether to attempt CPR, you should consider the benefits, burdens and risks of treatment that the patient may need if CPR is successful. In cases where you assess that such treatment is unlikely to be clinically appropriate, you may conclude that CPR should not be attempted. Some patients with capacity to make their own decisions may wish to refuse CPR; or in the case of patients who lack capacity it may be judged that attempting CPR would not be of overall benefit to them.
However, it can be difficult to establish the patient's wishes or to get relevant information about their underlying condition to make a considered judgement at the time they suffer a cardiac or respiratory arrest and an urgent decision has to be made. So, if a patient has an existing condition that makes cardiac or respiratory arrest likely, establishing a management plan in advance will help to ensure that the patient's wishes and preferences about treatment can be taken into account and that, if appropriate, a DNACPR decision is made and recorded. (GMC, 2010)

14.5.3 If a patient is admitted to hospital acutely unwell, or becomes clinically unstable in their home or other place of care, and they are at foreseeable risk of cardiac or respiratory arrest, a judgement about the likely benefits, burdens and risks of CPR should be made as early as possible. (GMC, 2010)

14.6 Discussions about whether to attempt CPR

14.6.1 As with other treatments, decisions about whether CPR should be attempted must be based on the circumstances and wishes of the individual patient. This may involve discussions

with the patient or with those close to them, or both, as well as members of the healthcare team. You must approach discussions sensitively and bear in mind that some patients, or those close to them, may have concerns that decisions not to attempt CPR might be influenced by poorly informed or unfounded assumptions about the impact of disability or advanced age on the patient's quality of life. (GMC, 2010)

14.6.2 If a patient lacks capacity to make a decision about future CPR, the views of members of the healthcare team involved in their care may be valuable in assessing the likely clinical effectiveness of attempting CPR and whether successful CPR is likely to be of overall benefit. You should make every effort to discuss a patient's CPR status with these healthcare professionals. (GMC, 2010)

14.7 Making DNACPR decisions when CPR will not be successful

14.7.1 If a patient is at foreseeable risk of cardiac or respiratory arrest and you judge that CPR should not be attempted, because it will not be successful in restarting the patient's heart and breathing and restoring circulation, you must carefully consider whether it is necessary or appropriate to tell the patient that a DNACPR decision has been made. You should not make assumptions about a patient's wishes, but should explore in a sensitive way how willing they might be to know about a DNACPR decision. While some patients may want to be told, others may find discussion about interventions that would not be clinically appropriate burdensome and of little or no value. You should not withhold information simply because conveying it is difficult or uncomfortable for you or the healthcare team. (GMC, 2010)

14.7.2 If you conclude that the patient does not wish to know about or discuss a DNACPR decision, you should seek their agreement to share with those close to them, with carers and with others, the information they may need to know in order to support the patient's treatment and care. (GMC, 2010)

14.7.3 If a patient lacks capacity, you should inform any legal proxy and others close to the patient about the DNACPR decision and the reasons for it. (GMC, 2010)

14.8 Making DNACPR decisions when CPR may be successful

14.8.1 Patients who have capacity

14.8.1.1 If CPR may be successful in restarting a patient's heart and breathing and restoring circulation, the benefits of prolonging life must be weighed against the potential burdens and risks. But this is not solely a clinical decision. You should offer the patient opportunities to discuss (with support if they need it) whether CPR should be attempted in the circumstances that may surround a future cardiac or respiratory arrest. You must approach this sensitively and should not force a discussion or information onto the patient if they do not want it. However, if they are prepared to talk about it, you must provide them with accurate information about the burdens and risks of CPR interventions, including the likely clinical and other outcomes if CPR is successful. This should include sensitive explanation of the extent to which other intensive treatments and procedures may not be seen as clinically appropriate after successful CPR. For example, in some cases, prolonged support for multi-organ failure in an intensive care unit may not be clinically appropriate even though the patient's heart has been restarted. (GMC, 2010)

14.8.1.2 You should explain, in a sensitive manner, any doubts that you and the healthcare team may have about whether the burdens and risks of CPR would outweigh the benefits, including whether the level of recovery expected after successful CPR would be acceptable to the patient. (GMC, 2010)

14.8.1.3 Some patients may wish to receive CPR when there is only a small chance of success, in spite of the risk of distressing clinical and other outcomes. If it is your considered judgement that CPR would not be clinically appropriate for the patient, you should make sure that they have accurate information about the nature of possible CPR intervention and, for example, the length of survival and level of recovery that they might realistically expect if they were successfully resuscitated. You should explore the reasons for their request and try to reach agreement; for example, limited CPR interventions could be agreed in some cases. When the benefits, burdens and risks are finely balanced, the patient's request will usually be the deciding factor. (GMC, 2010)

14.8.1.4 If, after discussion, you still consider that CPR would not be clinically appropriate, you are not obliged to agree to attempt it in the circumstances envisaged. You should explain your reasons and any other options that may be available to the patient, including seeking a second opinion. (GMC, 2010)

14.8.2 Patients who lack capacity

14.8.2.1 If a patient lacks capacity to make a decision about future CPR, you should consult any legal proxy who has authority to make the decision for the patient. If there is no legal proxy with relevant authority, you must discuss the issue with those close to the patient and with the healthcare team. In your consultations or discussions, you should be clear about the role that others are being asked to take in the decision-making process. If they do not have legal authority to make the decision, you should be clear that their role is to advise you and the healthcare team about the patient. You must not give them the impression that it is their responsibility to decide whether CPR will benefit, or be in the best interests of, the patient. You should provide any legal proxy and those close to the patient, with the same information about the nature of CPR and the burdens and risks for the patient. (GMC, 2010)

14.8.2.2 If the legal proxy requests that CPR with a small chance of success is attempted in future, in spite of the burdens and risks, or they are sure that this is what the patient wanted, and it is your considered judgement that CPR would not be clinically appropriate and not of overall benefit for the patient, you should explore the reasons for the proxy's request. If after further discussion you still consider that attempting CPR would not be of overall benefit for the patient, you are not obliged to offer to attempt CPR in the circumstances envisaged. You should explain your reasons and any other options that may be available to the legal proxy, including their right to seek a second opinion. (GMC, 2010)

14.9 Resolving disagreements

If there is disagreement about whether CPR should be provided, please go to section 14.15 and 14.19.

14.10 Recording and communicating CPR decisions

Any discussions with a patient, or with those close to them, about whether to attempt CPR, and any decisions made, should be documented in the patient's record or advance care plan. If a DNACPR decision is made and there has been no discussion with the patient because they indicated a wish to avoid it, or because it was your considered view that discussion with the patient was not appropriate, you should note this in the patient's records. (GMC, 2010)

Once the decision has been made it must be recorded on the SHA approved DNACPR form and documented in the person's Health Care Records notes. (EoE, 2011)

Additional information regarding the background to the decision, the reasons for the decision, those involved in the decision and a full explanation of the process must be recorded in the individual's notes / care records / care plans. (EoE, 2011)

14.11 Treatment and care after a DNACPR decision

14.11.1 You must make it clear to the patient, to those close to them and to members of the healthcare team that a DNACPR decision applies only to CPR. It does not imply that other treatments will be stopped or withheld. Other treatment and care will be provided if it is clinically appropriate and agreed to by a patient with capacity, or if it is of overall benefit to a patient who lacks capacity. (GMC, 2010)

14.11.2 A DNACPR decision should not override your clinical judgement about CPR if the patient experiences cardiac or respiratory arrest from a reversible cause, such as the induction of anaesthesia during a planned procedure, or if the circumstances of the arrest are not those envisaged when the DNACPR decision was made. (GMC, 2010)

14.12 Emergencies and CPR

Emergencies can arise when there is no time to make a proper assessment of the patient's condition and the likely outcome of CPR; when no previous DNACPR decision is in place; and when it is not possible to find out the patient's views. In these circumstances, CPR should be attempted, unless you are certain you have sufficient information about the patient to judge that it will not be successful. (GMC, 2010)

14.13. ROLES and RESPONSIBILITIES OF BTUH CLINICAL STAFF

14.13.1 The EoE regional DNACPR policy and its forms / appendices are relevant to all clinical staff across all sectors and settings of care including primary, secondary, independent, ambulance and voluntary. It applies to all designations and roles. It applies to all people employed in a caring capacity, including those employed by the local authority or employed privately by an agency.

14.13.2 If a DNACPR decision is made for a BTUH patient, Basildon and Thurrock University Hospital NHS FT defines the ***Healthcare Professional completing such a DNACPR form*** as Middle Grade Doctor or above.

Review and endorsement by responsible senior clinician**,** the form must be countersigned by a Consultant within 24 hours; it is the Consultants responsibility to decide if the DNACPR decision is indefinite or if it is to be reviewed on a specific documented date on the form.

Please note that if the review date has passed and it has NOT been reviewed the person is for full cardiopulmonary resuscitation. If a review does occur a new form must be completed, the expired form must be cancelled see section 14.16.

Consultants must review the Healthcare Records at the time of the review and/or endorsement of DNACPR decision, to ensure that documentation of discussions with patients/relatives/ Lasting Power of Attorney for health and welfare (LPAs) is evident or if it has not been discussed the reasons why must be fully documented, and if not what the communication plan is.

Patients transferred to the care of another Consultant or if admitted with a current valid DNACPR decision, the Consultant must acknowledge in the Health Care Records their agreement with the decision, or cancel the decision with an explanation.

Please note that advanced decisions to refuse medical treatment and Lasting Power of Attorney does not apply to patients under 18 years of age. See section 15.2. For the legal aspect for persons under 18 years old.

14.13.3 Patients who have made a decision that they would not want CPR should inform, where able, those looking after them that there is a valid documented DNACPR decision about themselves and where this can be found.

14.14 DOCUMENTATION & COMMUNICATON EXPECTATIONS OF BTUH CLINICAL STAFF

14.14.1 The form will stay with the person. However, whilst under the care of Basildon and Thurrock University Hospital NHS FT current and valid DNACPR forms must be kept in the front of the patients Health Care Records.

If a patient is to be discharged home with a DNACPR form, the original form must be given to patient /carers to take with them on discharge. A copy must be retained in the Healthcare Records.

The DNACPR decision must be included on the E-discharge and/or discharge summary to inform GP's and other external agencies.

14.14.2 During ambulance transfer between healthcare settings and home, the form should go with the patient and ambulance service staff should abide by the DNACPR decision. Where the facility exists, and the patient gives consent, the DNACPR status should be recorded on ambulance service databases. (EoE, 2011)

14.14.3 Following transfer between healthcare settings, DNACPR decisions remain valid but should be verified as soon as possible by the clinician with overall responsibility for the person's care. (EoE, 2011)

14.14.4 Confidentiality - If the individual has the capacity to make decisions about how their clinical information is shared their agreement must always be sought before sharing this with family and friends. Refusal by an individual with capacity to allow information to be disclosed to family or friends must be respected. Where individuals lack capacity and their views on involving family and friends are not known, clinicians may disclose confidential information to people close to them where this is necessary to discuss the individual's care and is not contrary to the individual's best interests. (EoE, 2011)

14.15 SITUATIONS WHERE THERE IS A LACK OF AGREEMENT

14.15.1. A person with mental capacity may refuse any treatment from a doctor or nurse even if that refusal results in death and any treatment carried out against their wishes is technically an assault. In these circumstances, Individuals should be encouraged to make an ADRT.

14.15.2 Should the person refuse CPR, this should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual and possibly their relatives, has taken place.

14.15.3 A verbal request to decline CPR is not legally binding; however it should not be ignored and does need to be taken into account when making a best interest decision. The verbal

request needs to be documented by the person who it is directed to and any decision to take actions contrary to it must be robust, accounted for and documented.

14.15.4 Individuals may insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Sensitive discussion with the person should aim to secure their understanding and acceptance of the DNACPR decision. Ongoing patient education, a period of time for reflection and opportunities for discussion will often result in agreement.

14.15.5 In the case of disagreement a second medical opinion should be sought. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice should be sought.

14.16 CANCELLATION OF A DNACPR DECISION

14.16.1 If the person's clinical condition changes, the decision may be made to cancel or revoke the DNACPR decision. If the decision is cancelled, the form should be crossed through with 2 diagonal lines in black ball-point ink and the word 'CANCELLED' written clearly between them, dated and signed by the healthcare professional.

If the patient requires a review of the DNACPR decisions a new form must be completed and the old form should be cancelled as above.

14.16.2 It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to **all parties** informed of the original decision. Electronic versions of the DNACPR decision must be cancelled as per guidance above.

14.17 SUSPENSION OF DNACPR DECISION

14.17.1 In some circumstances there are reversible causes of a cardio-respiratory arrest these are either pre-planned or acute and the individual should receive treatment, unless intervention in these circumstances has been specified.

14.17.2 Pre-planned: Some procedures could precipitate a cardiopulmonary arrest for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc; under these circumstances the DNACPR decision should be reviewed prior to procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people including the patient, if appropriate, will need to take place.

This is essential before proceeding with anaesthesia and surgery.

Three options are available:
Option one: DNACPR decision is discontinued.
Surgery and anaesthesia are to proceed with cardiopulmonary resuscitation (CPR) to be used if cardiopulmonary arrest occurs.

Option two: DNACPR decision is to be modified.
This permits the use of drugs and techniques commensurate with the provision of anaesthesia.

Option three: No changes to the DNACPR decision.
Under most circumstances this option is not compatible with the provision of general anaesthesia for any type of surgical intervention.

All agreed DNACPR management must be documented within the healthcare records, and any discussions with the patient, proxy decision maker, and relatives or carers. The DNACPR management options must be communicated to all of those staff involved with the patients care from peri-operative until post operative care on the ward.

Please note for patients in **Endoscopy** their DNACPR decision will be suspended during the period immediately before, during and after the procedure.

14.17.3 Acute: Where the person suffers an acute, unforeseen, but immediately life threatening situation such as anaphylaxis or choking, CPR would be appropriate while the reversible cause is treated.

14.18 DEFINITIONS

14.18.1 Cardio Pulmonary Resuscitation (CPR) Interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs.

14.18.2 Cardiac Arrest (CA) is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness, and apnoea or agonal gasping respiration. In simple terms cardiac arrest is the point of death.

14.18.3 Mental Capacity Act - 2005 (MCA) was fully implemented on 1 October 2007. The aim of the Act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards.

14.18.4 Mental Capacity - An individual over the age of 16 is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary.
Individuals are deemed to lack capacity if they are unable to do one of the following:

- understand the information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate the decision, whether by talking or sign language or by any other means.

Please also refer to the Trust Mental Capacity Act 2005 for further information.

14.18.5 Advance Decision to Refuse Treatment (ADRT) a decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding for healthcare staff.

14.18.6 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) refers to not making efforts to restart breathing and / or the heart in cases of respiratory / cardiac arrest. It does not refer to any other interventions / treatment / care such as fluid replacement, feeding, antibiotics etc.

14.18.7 Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA). The Mental Capacity Act (2005) allows people 18 and over, who have capacity, to make a Lasting Power of Attorney by appointing a Personal Welfare Attorney who can make decisions regarding health and wellbeing on their behalf, once capacity is lost.

14.18.8 A Court-appointed deputy (CAD) Appointed by the Court of Protection (Specialist Court for issues relating to people who lack capacity to make specific decisions) to make decisions in the best interests of those who lack capacity

14.18.9 Advance Care Plan. A plan which allows the individual to express and record wishes about future care in the final months of life.

14.19 Where to get help in the Trust regarding DNACPR orders, LPA and ADRT

If there are any disputes or uncertainties in relation to any DNACPR issue, advice should be sought the Trust's Legal Department (ext 3252) during normal office hours, or from the On-Call Manager out of hours, who will have access to the Trust's solicitors.

15. DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FOR CHILDREN /YOUNG PERSON UNDER 16 YEARS

15.1 INTRODUCTION

The child/young person has the right to die in peace and with dignity.

There will be some cases where attempted resuscitation following cardio-respiratory arrest is not in the child/young person's best interests, because the potential burdens are likely to outweigh any possible benefits.

These cases should be identified on admission to Hospital. A multi disciplinary meeting of all of those involved in the care of child's/young persons should take place in order to ensure all involved in care provision are aware of the proposed treatment plan and/or ceiling of treatment.

A "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) for children/young person under 16 years decision only relates to attempting CPR and does not relate to any other on-going treatment or care the patient is receiving. Clinical treatments such as giving oxygen and clearing the airway by suction should still be given when appropriate.

It should be noted that where a child/young person dies and when the death was not foreseen in the preceding 24 hour period, irrespective of whether a DNACPR decision has been reached, then the family/carers will be subject to a sensitive enquiry under the Child Death Review.

15.2. Making a decision

15.2.1 Any decision must be made on an individual basis. "Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, their families and the healthcare team" (UK Resuscitation Council 2007).

If the child or young person is under the care of a consultant at a tertiary centre, all discussions around DNACPR must be communicated and involve the child or young persons paediatric consultant at that centre and consideration given to seeking advice from the palliative and symptom control team at that centre.

An individual assessment must be made in each case as to whether it is necessary or appropriate to involve the child/young person in making the decision. Whilst in some cases the child/young person might be informed there may be cases where this is inappropriate. National guidance suggests that "where CPR may re-start the heart and breathing for a sustained period

but there are doubts about whether the potential benefits outweigh the burdens, the views of the child or young person should be taken into consideration in deciding whether it should be attempted" (UK Resuscitation Council 2007).

"Young people with capacity are entitled to give consent to medical treatment, with the exception to donating a kidney, or tattooing. Where they lack this capacity, it is generally those with parental responsibility who make decisions on their behalf. **Refusal of treatment by competent young people up to the age of 18 is not necessarily binding upon doctors since the courts have ruled that consent from people with parental responsibility, or the court, still allows doctors to provide treatment. Where a young person with capacity refuses treatment, the potential harm caused by violating the young person's choice must be balanced against the harm caused by failing to give treatment" UK Resuscitation Council (2007). Although patients over 16 years of age are presumed to have capacity to make a decisions for themselves unless there is evidence to the contrary, they are unable to make a legally binding advance decision under the terms of the Mental Capacity Act, until they reach the age of 18.**

15.2.2 SITUATIONS WHERE THERE IS A LACK OF AGREEMENT

"Usually, it is possible to reach agreement on whether or not CPR should be attempted if a child or young person suffers respiratory or cardiac arrest. If there is disagreement between the patient, those with parental responsibility and the healthcare team despite attempts to reach agreement, legal advice should be sought. Parents cannot require doctors to provide treatment contrary to their professional judgement, but doctors should try to accommodate parents' wishes where there is genuine uncertainty about the young person's best interests. If legal advice is required, this should be sought in a timely manner" (UK Resuscitation Council 2007). See section 15.7.

"The responsibility for making a DNACPR decision rests with the most senior clinician currently in charge of the patients care" (UK Resuscitation Council 2007). This will be the Paediatric or Neonatal Consultant.

There should be a presumption in favour of attempting resuscitation unless a decision has been clearly documented in the Health Care Records.

15.3 Recording a decision

A DNACPR form must be completed. If a DNACPR decision is made for a BTUH patient, Basildon and Thurrock University Hospital NHS FT define ***Healthcare Professional making this DNACPR order*** as Paediatric Registrar or Consultant. If a Registrar needs to make a DNACPR decision the child's Paediatric Consultant or on-call Paediatric Consultant must be informed of this decision.

The form must be countersigned and **reviewed by a Consultant within 24 hours**; it is the Consultants responsibility to decide when to review on a specific documented date on the form.

The Consultants must review the Healthcare Records at the time of the DNACPR decision, to ensure that documentation of discussions with patients/parents/legal guardians is evident or if it has not been discussed the reasons why must be fully documented, and if not available what the communication plan is.

Reasons for the decision and the persons involved in making the decision should be recorded in the child's/young person's Health Care Records.

The completed form must be filed in the front of the patient's Health Care Records.

If there are any disputes or uncertainties in relation to any DNACPR issue see Section 15.7

15.4 Communicating Decisions

Decisions should be made & communicated to all members of the multidisciplinary team ideally through a case review meeting, which would involve the child's Tertiary Centre if appropriate. Information about the decision can also be communicated through a letter from the Consultant Paediatrician to relevant health care professionals.

15.5 Reviewing a decision

The Consultant Paediatrician must state on the form how often a review must be a carried out. Decisions about resuscitation should be reviewed regularly and also in the light of changes in the child's/young person's condition, treatment and wishes.

This should include a review before any anaesthetic or procedure where cardio-respiratory arrest is a risk.

Following a review of a decision:
Should the child/young person continue to be 'not for resuscitation' the existing form will need to be signed and dated by the paediatric doctor reviewing the decision. The reasons for this decision must also be clearly documented in the child's/young person's Health Care Records.

Should the child/young person now be for active resuscitation no form is necessary. The old form must be cancelled by crossing through with two diagonal lines in black ball point and "CANCELLED" written clearly between the lines and then signed and dated by the doctor cancelling the order. This should then be filed appropriately within the Health Care Records.

If the patient requires a review of the DNACPR decisions a new form should be completed and the old form should be cancelled as above.

15.6 Discharge and re admittance to hospital

When a child/young person is discharged with a DNACPR form, the original form must be given to the person who has parental responsibility to take with them on discharge. A copy must be retained in the Healthcare Records

On all subsequent readmissions to hospital the DNACPR status of that child or young person should be reviewed by either their own consultant or the consultant on service that week. And this communicated to all members of the team caring for that child or young person.

15.7 Where to get help in the Trust regarding DNACPR orders

If there are any disputes or uncertainties in relation to any DNACPR issue, advice should be sought the Trust's Legal Department (ext 3252) during normal office hours, or from the On-Call Manager out of hours, who will have access to the Trust's solicitors.

16. AUDIT STANDARDS OF RESUSCITATION

All audits listed below are compiled by the Resuscitation Service these audits are to ensure that the Trust is provided with adequate assurance that the Resuscitation Policy is being adhered to. Any deficiencies identified will require evidence of recommendations and actions will be developed and the changes implemented. This is in line with NHSLA Risk Management Standards – 2011/12 Standard 4 – Criterion 7: Resuscitation Level 3 (3.4.7) with particular relation to Do Not Attempt Resuscitation Orders. The Resuscitation Service will report this to the Resuscitation Strategy Group, to ensure best practice is followed. Clinical Audit outcomes will be reported in the Trust's Annual Clinical Governance Report.

16.1 2222 Audit

Any attempt at resuscitation must be competent and in accordance with current Resuscitation Council (UK) guidelines. A standard 2222 form must be completed for all 2222 calls by the Team Leader. The white copy becomes a part of the Healthcare Records and the blue copy is sent to the Resuscitation Service

Information Collected	Frequency	Who Reported to
All 2222 calls for adults and paediatrics (excluding trauma) Data for both out-of-hospital and in-hospital cardiac arrests. This includes medical emergencies and peri-arrests. Only Basildon & Orsett Hospital are included.	Data continuously Collected Monthly snap shots. Annual Audit	Director of Nursing/Medical Director Programme Management Office Resuscitation Strategy Group Clinical Directors Heads of Nursing Clinical Effectiveness

16.2 National Cardiac Arrest Audit - NCAA

Information Collected	Frequency	Who Reported to
All 2222 calls for adults and paediatrics (excluding trauma) Data for both out-of-hospital and in-hospital true cardiac arrests. Any 2222 call where chest compressions or defibrillation has been performed is submitted into a national database. Only Basildon & Orsett Hospital are included.	Data continuously collected and inputted onto a secure system. NCAA report back to the Resuscitation Service.	Director of Nursing/Medical Director Programme Management Office Resuscitation Strategy Group Clinical Directors Heads of Nursing Clinical Effectiveness

Both of the above audits are a prerequisite of the RCUK in reference to Recommendations for Clinical Practice and Training in Cardiopulmonary Resuscitation (2008).

16.3 Do Not Attempt Cardiopulmonary Resuscitation

Information Collected	Frequency	Who Reported to
Audits of DNACPR forms and healthcare records to ensure that they are completed in line with the Resuscitation Policy. Monitoring of the implementation of this policy will be by evaluation of: • Any reported incidents or near misses relating to the policy • Consideration of any feedback received from patients, children/young people and all families who have been involved in DNAR decisions. • Experience of staff who have been involved in DNAR decisions.	Monthly retrospective audits. Bi Annual prospective audits.	Director of Nursing/Medical Director Programme Management Office Resuscitation Strategy Group Clinical Directors Consultants Matrons/Service Managers Medical Staff

This is in line with NHSLA Risk Management Standards – 2011/12 Standard 4 – Criterion 7: Resuscitation Level 3 (1-3.4.7)

16.4 Resuscitation Equipment

Information Collected	Frequency	Who Reported to
Audits that equipment is as listed in date and all listed equipment is in good working order.	All areas subject to spot-checks by resuscitation officers. Weekly checks by ward/area managers to ensure daily checks. Quarterly audits by the Resuscitation Service.	Director of Nursing/Medical Director Resuscitation Strategy Group Clinical General Managers Heads of Nursing Matrons/Service Managers Ward/Department Managers

This ensures that we are meeting the Care Quality Commission standards Essential standards of quality and safety Guidance about compliance Manage risk through effective procedures about equipment suitability 11C. People are safe because where equipment is provided as part of the regulated activity, there are clear procedures followed in practice, monitored and

reviewed. 11H. People who use services receive care, treatment and support that: Ensures equipment required for resuscitation or other medical emergencies is available and accessible for use as quickly as possible. Where the service requires it, this equipment is tamper proof.

16.5 Resuscitation Training

Information Collected	Frequency	Who Reported to
Details of all trust staff attending any Resuscitation Courses. All information collected is put onto the Resuscitation Service training records. This is then placed onto OLM.	Data continuously Collected Six-monthly Reports on attendance/Non-attendance. Education, Training & Research compile all of the training data from OLM to disseminate.	Director of Nursing/Medical Director Clinical Directors Consultants Clinical General Managers Heads of Nursing Matrons/Service Managers Ward/Department Managers Unit Training Directors and Clinical Directors

This ensures that we are meeting the Care Quality Commission standards
12B. In relation to qualifications, knowledge, skills and experience:

- Have relevant qualifications, knowledge, skills and experience to carry out their role.
- Know who they are able to contact, and how, when expert advice is needed.
- Lead effectively to ensure staff are suitable for their role

13A. People who use services benefit from sufficient staff to meet their needs because the provider:

- Can demonstrate that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of people who use services at all times.

16.6 Critical Incidents

Information Collected	Frequency	Who Reported to
All “Resuscitation-Related” Critical Incidents	Data collected by Risk Management and passed onto Resuscitation Service.	Resuscitation Service Patient Safety Resuscitation Strategy Group

All incidents will be reported to the Resuscitation Strategy Group with action plans and changes to be implemented. Lessons learnt will be disseminated as appropriate.

Where any of the above key indicators are not being met the Resuscitation Service will inform the Resuscitation Strategy Group who will determine any action required and make recommendations to the Trust.

17 APPROVAL AND IMPLEMENTATION OF THE POLICY

17.1 Approval

Approval for the policy will be through initial agreement at the Resuscitation Strategy Group before being passed to the Clinical Directors.

17.2 Implementation

The policy will be available electronically on the Trust document management system. The Resuscitation Service will highlight the policy during any resuscitation training.

REFERENCES & BIBLIOGRAPHY

British Medical Association (2005) The Mental Capacity Act 2005 - Guidance for health professionals

Department of Health The acutely or critically sick or injured child in the District General Hospital: A Team Response, October 2006

Department of Health (2009) Records management: NHS code of practice http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093027.pdf

General Medical Council (2010) -Treatment and care towards the end of life: good practice in decision making GMC May 2010 – IN FORCE JULY 2010 http://www.gmc-uk.org/Treatment_and_care_towards_the_end_of_life_0510_32609298.pdf

HMSO (2005) The Mental Capacity Act.

Jevon P (1999) *DNR orders, the issues* Nursing Standard, 13, 40, p.45-46

NHS East of England (2011) NHS East of England Integrated Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) http://www.eoe.nhs.uk/search.php?cx=005276822598664288136%3Au-0hfsg-ss4&cof=FORID%3A9&q=dnacpr#1037

NHS Executive (2000) Resuscitation Policy – Health Services Circular 2000/028 Department of Health.

Resuscitation Council UK (2011) Advanced Life Support Provider Manual 6th Ed. Resuscitation Council: London

Resuscitation Council (UK) (2004, Updated 2008) CPR Guidance for Clinical Practice and Training in Hospitals London: Resuscitation Council (UK) Publication

Resuscitation Council (UK) (2007) Decisions relating to Cardiopulmonary Resuscitation – A Joint Statement British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing London

Resuscitation Council (UK) (2010) Resuscitation Guidelines 2010 Resuscitation Council (UK) London.

Royal College of Paediatrics and Child Health (RCPCH) (2004) Withholding or Withdrawing Life Sustaining Treatment in Children: A Framework for Practice Second Edition http://www.rcpch.ac.uk/sites/default/files/Witholding.pdf

The Association of Anaesthetists of Great Britain and Ireland (May 2009) Do Not Attempt Resuscitation (DNAR) Decisions in the Perioperative Period http://www.aagbi.org/publications/guidelines/docs/dnar_09.pdf

Appendix A

TRAINING STANDARDS

All clinical members of staff must attend a resuscitation update on an annual basis. For staff looking after children this will include paediatric basic life support as a minimum standard.

Consultants:
Annually, all Consultants are expected to attend an in-house Resuscitation Training update. The training delivered will be tailored to their clinical speciality and experience (adult and/or paediatric), and will incorporate aspects of Advanced Life Support appropriate to their clinical needs.

It is recommended that Consultants attend a ALS course, if a specialist in Medicine and Emergency Care, Cardiology, Critical Care or seen as an expert in the field of resuscitation (team leader) and update such skills annually.

It is recommended that Consultants who have clinical contact with children attend an APLS or EPLS course, this includes Paediatrics, Medicine and Emergency Care, Cardiology, Critical Care or those seen as an expert in the field of resuscitation (team leader) and update such skills annually.

It is recommended that Consultants involved in the care of Newborns and Neonates attend a Resuscitation Council (UK) Newborn Life Support Course (NLS) and update such skills annually.

Consultants involved in Trauma Care are expected to attend an annual in-house trauma care update. In Addition it is recommended that Consultants in Trauma care hold an up-to-date Royal College of Surgeons (UK) Advanced Trauma Life Support Course (ATLS)

Registrars (ST1, ST2, ST3 ST4) and Middle Grade Doctors:
Must attend, an in-house Resuscitation Training, as part of their induction to the trust. All Specialist Registrars/Middle Grades who are Cardiac Arrest Team leaders should be in possession of a current RCUK ALS Certificate.

Must attend, an in-house Paediatric Resuscitation Training induction or update if clinically involved with children. All Specialist Registrars/Middle Grades who are Cardiac Arrest Team leaders should be in possession of a current ALSG APLS or RCUK EPLS Certificate.

It is recommended that they attend RCUK NLS course if clinically involved with newborns or neonates.

FY2 Doctors / Trust Grade SHOs:
Must attend a practical clinical induction Resuscitation Training session, and after this annual training.

If a member of the Cardiac Arrest Team, must be encouraged to attend a RCUK ALS course within their FY2 year or as soon as possible if not already a current ALS provider.

Must attend Annual Paediatric Basic Life Support training, if clinically involved with children.

Should be encouraged to attend APLS or EPLS course if an SHO Anaesthetist, SHO Paediatrician or an SHO working in the Accident and Emergency Department.Should be encouraged to attend Trauma training every four years in the form of a Royal College of Surgeons Advanced Trauma Life Support Course (ATLS), if an SHO Anaesthetist, Surgical/Orthopaedic SHO or a SHO working in the Accident and Emergency Department.

FY1 Doctors:
Will attend an Immediate Life Support Course on induction to the Trust. This will include basic life support, airway management, an overview of the ALS Algorithm and manual defibrillation.

Locum Medical Staff:
Locum staff should be as competent as the replacement role they are providing cover for and care must be exercised by the Medical Staffing Department / Personnel, the Medical Director and Departmental Leads that those locums can meet this requirement. When short term/last minute bookings are made, the risk of an otherwise competent clinician not having up to date resuscitation training needs to be balanced with the need to provide clinician cover.

Registered Nurses / Midwives / ODPs/Cardiac Physiologist:
All registered Nurses, Midwives and Allied Health Professions such as OPD, Cardiac Physiologists, Radiographers, where AED defibrillators are deployed, should attend Immediate Life Support Course or Basic Life Support & AED training.

Registered nurses working in A&E, ITU, CCU and Recovery that are band 6 and above should attend a Resuscitation Council (UK) Advanced Life Support Course (ALS Course) or Immediate Life Support course (ILS).

Registered nurses / ODPs working in areas where children are catered for must attend adult basic life support on mandatory annual training and PILS (RCUK) course annually. It is recommended that Children's Nurses and A&E Nurses that are band 6 and above, attend an advanced paediatric course such as APLS or EPLS every four years.

Registered Midwives and Neonatal Nurses caring for newborns and/or neonates must attend annual in-house Neonatal Life Support. Midwives should be encouraged to attend an accredited NLS course. It is recommended that Neonatal Nurses attend an accredited NLS course (at least six months after commencement of post). The Trust does not at present provide this course this would need to be found externally.

Registered nurses working in A&E that are Band 6 and above should attend some form of trauma training. It is recommended that Band 6 nurses and above working in A&E should be in possession of an accredited trauma course such as ATNC/TNCC. Trauma training is recommended every four years.

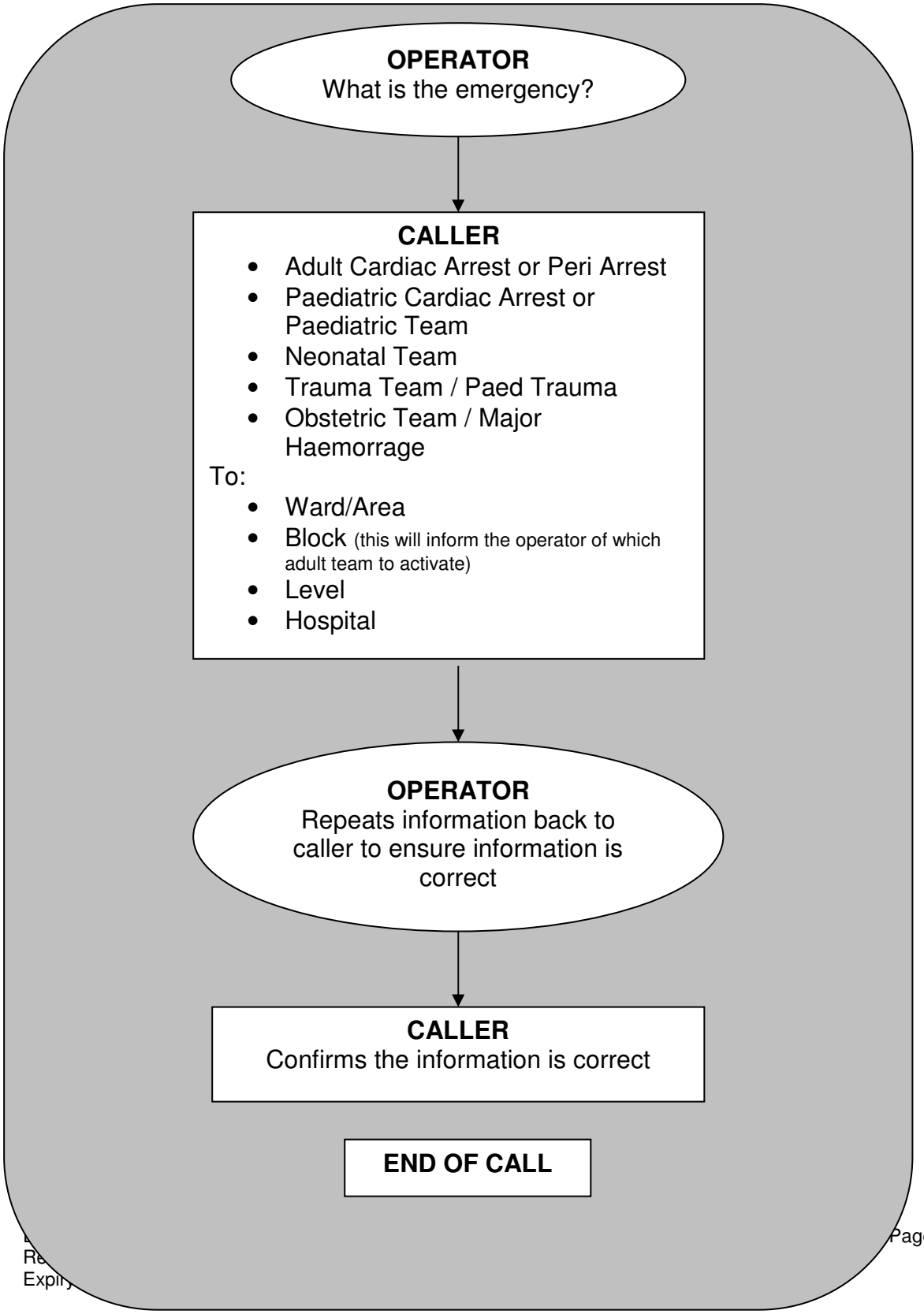
Any registered nurse or ODP that has a responsibility to respond to a major incident and be part of the mobile surgical team should receive trauma training every four years.

Other Health Care Workers:
All other staff i.e. Health Care Support Workers, Occupational Therapists, Speech Therapists, Phlebotomists and Physiotherapists, should receive Annual Basic Life Support. Registered staff working in areas where AEDs are deployed should have annual AED training

Healthcare support workers and other allied health professions that work in areas where children are catered for must receive annual paediatric basic life support training.

Appendix B

FLOWCHART FOR ALL 2222 CALLS



Operator then activates the appropriate team

Appendix C

Manual Defibrillation by Registered Healthcare Professionals.

Staff Eligible to Undertake Manual Defibrillation:

Any registered healthcare profession who have successfully completed a ALS, ILS (if taught in manual mode), APLS or EPLS course and are familiar with the Trust's Defibrillators.

The eligible staff above must update skills annually by completing an ILS or PILS course. It is the responsibility of the healthcare professional to ensure that these skills are kept up to date.

Regulations Regarding Manual Defibrillation:

This relates to external manual defibrillation for ventricular fibrillation and pulseless ventricular tachycardia.

All manual defibrillation attempts must be performed in accordance with the current RCUK guidelines as specified by the Resuscitation Service.

Eligible staff must be willing and competent to undertake this procedure.

Appendix D – DNACPR Adults aged 16 years and over Form

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over
In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR)
All other appropriate treatment and care will be provided

NHS
East of England

Name:
Address:

Date of birth: / /
NHS number:

Date of DNACPR order:
/ /

Reason for DNACPR decision (tick one or more boxes and provide further information)

☐ CPR is unlikely to be successful [i.e. medically futile] because:

☐ Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:

☐ Patient does not want to be resuscitated as evidenced by:

Record of discussion of decision (tick one or more boxes and provide further information)

Discussed with the patient / Lasting Power of Attorney [welfare]? Yes ☐ No ☐
If 'yes' record content of discussion. If 'no' say why not discussed.

Discussed with relatives/carers/others? Yes ☐ No ☐
If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.

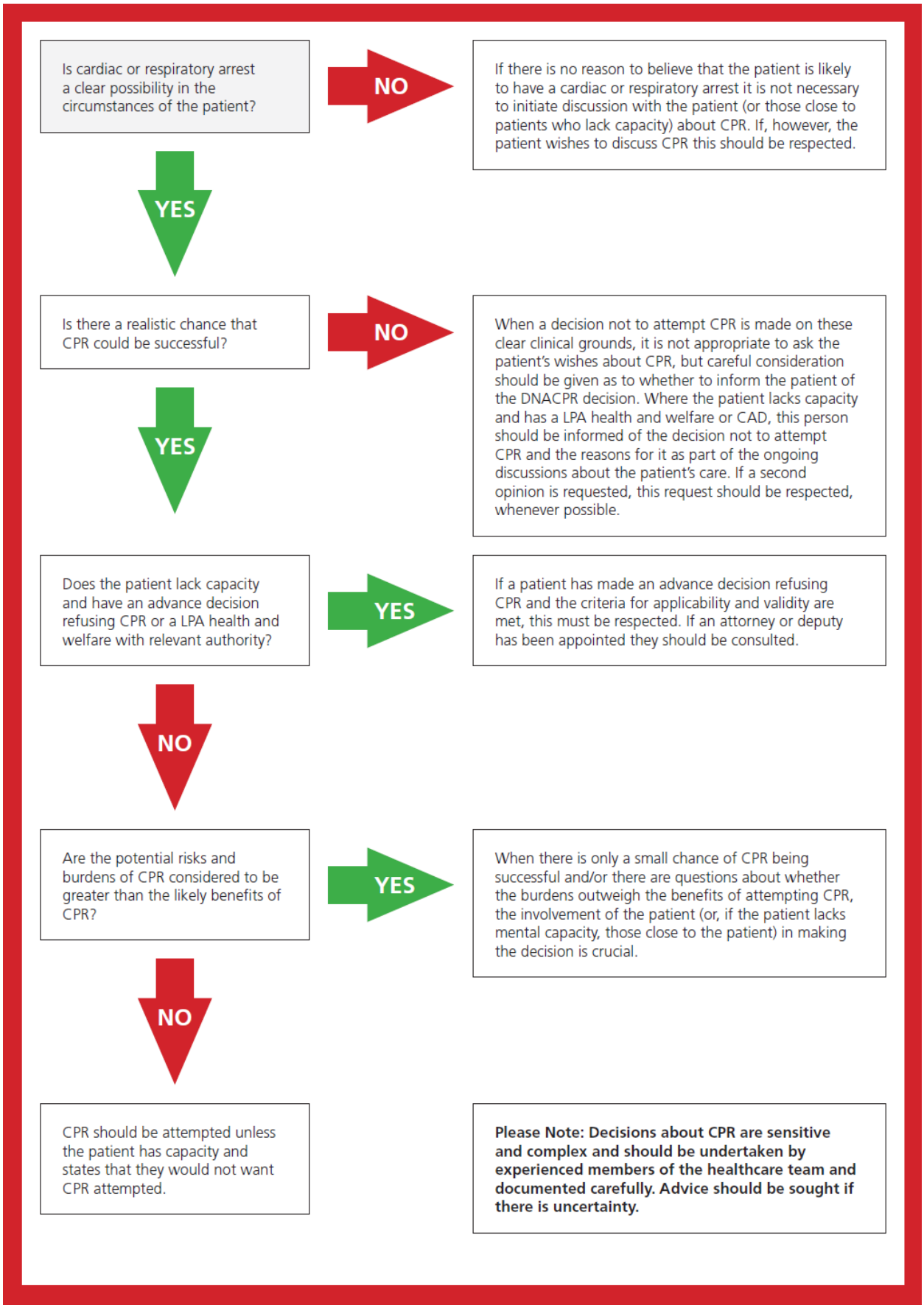
Discussed with other members of the health care team? Yes ☐ No ☐
If 'yes' record name, role and content of discussion. If 'no' say why not discussed.

Healthcare professional completing this DNACPR order

Name: Signature:
Position: Date: / / Time:

Review and endorsement by responsible senior clinician

Name: Signature:
Position: Date: / / Time:
Is DNACPR decision indefinite? Yes ☐ No ☐ If 'no' specify review date: / /



Appendix E – DNACPR Children less than 16 years of age Form

Valid on day of printing ONLY

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Children less than 16 years of age

DNARpaed.1(June 2009)

Basildon and Thurrock University Hospitals NHS
NHS Foundation Trust

Name _____

Address _____

Date of birth _____

NHS or hospital number _____

Date of DNACPR order:

/ /

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1 **1a. Does the child have capacity to make and communicate decisions about CPR?** If "YES" go to 1b. If "NO" go to 1c. — YES / NO

1b. Has the child been involved in the decision making process of this order? Now go to 1c. — YES / NO

1c. Have the child's parents (or those holding legal parental responsibility) been consulted and agreed to the application of this order? If "YES" go to box 2. — YES / NO

1d. Has a Court made an order in respect of this decision? If "YES" go to 1e. — YES / NO

If the answers to both 1c and 1d are "NO", legal advice must be taken before proceeding. All other decisions must be made in the child's best interests and comply with current law.

1e. Date, time, location and name of Judge/Court making order:

2 **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the child's best interests:**

3 **Summary of communication with child. If this decision has not been discussed with the child state the reason why:**

4 **Name of person(s) holding parental responsibility and summary of communication with them:**

5 **Names of members of multidisciplinary team contributing to this decision:**

6 **Healthcare professional making this DNACPR order:**

Name _____ **Position** _____

Signature _____ **Date** _____ **Time** _____

7 **Review and endorsement by most senior health professional:**

Signature _____ **Name** _____ **Date** _____

Review date (if appropriate)

Signature _____ **Name** _____ **Date** _____

Appendix E – DNACPR Children less than 16 years of age guidance notes

This form should be completed legibly in black ball point ink
All sections should be completed

- The patient's full name, date of birth and address should be written clearly.
- The date of writing the order must be recorded.
- This order will be regarded as "INDEFINITE" unless it is clearly cancelled or a definite review date is specified.
- The order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and "CANCELLED" written clearly between them, signed and dated by the healthcare professional cancelling the order.

1. Child's capacity: Parental responsibility and decisions

- ☐ Record the assessment (using Fraser guidelines) of the child's capacity in the clinical notes.
- ☐ If the child is noted to have capacity but not included in the decision process a detailed, reasoned explanation for this decision should be included in the clinical notes and summarised in section 3.
- ☐ Record all discussions with those holding parental responsibility in the notes. Document all action points discussed with a clear indication of the absence or presence of parental agreement. Any disagreements that cannot be resolved should be discussed with your Trust's legal department for advice before completing this order.
- ☐ Record all communications with the courts.
- ☐ The date, time and name of the Court must be recorded in section 1e where the Court has been involved or made a formal ruling on the application of this Order. A copy of the order should be filed in the patient's health record.

2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the child's best interests

Be as specific as possible.

3. Summary of communication with child…

If this decision was not discussed with a child with capacity summarise the reason why this was inappropriate (Full detail should be recorded in the clinical notes). Otherwise state clearly what was discussed and agreed.

4. Summary of communication with persons holding parental responsibility

Whether or not the child has capacity their legal guardians (i.e. persons with parental responsibility) must be consulted. If the child has capacity and has been consulted great care must be taken to ensure that discussions do not compromise the clinician-child relationship. If the child and their guardians are not in agreement a legal opinion should be sought.

State the names and relationships of guardians with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

5. Members of multidisciplinary team…

State names and positions. Ensure that the DNAR order has been communicated to all relevant members of the healthcare team.

6. Healthcare professional completing this DNAR order

This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available.

7. Review / endorsement …

The decision should be discussed with and endorsed by the most senior healthcare professional responsible for the child's care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.

DNARpaed.1 (June 2009)

Appendix F Cardiac arrest or cardiovascular collapse caused by local anaesthetic:

The AAGB&I recommend that 20% lipid emulsion (Intralipid) be available to treat cardiovascular collapse, arrhythmias and cardiac arrest caused by local anaesthetic. The 20% lipid emulsion will be available wherever patients receive **large** doses of local anaesthetic.
Intralipid is available from:

- Colne Ward
- Theatres Drug Room DGH
- Delivery Suite

The Association of Anaesthetists of Great Britain and Ireland have produced treatment guidelines.

Management of Server Local Toxicity
http://www.aagbi.org/sites/default/files/la_toxicity_2010_0.pdf

Management of Server Local Toxicity – Accompanying Notes
http://www.aagbi.org/sites/default/files/la_toxicity_notes_2010_0.pdf

Appendix G Algorithms for Resuscitation Guidelines (2010)

Below are hyperlinks to the RCUK website, please note these algorithms are available on the Hub go to departments find Resuscitation Service

Adult Basic Life Support

Adult choking algorithm

AED algorithm

In-hospital resuscitation

Adult Advanced Life Support

Bradycardia algorithm

Tachycardia algorithm

Paediatric Basic Life Support

Paediatric FBAO treatment

Paediatric Advanced Life Support

Newborn Life Support

Anaphylactic reaction - Initial treatment

Anaphylaxis Algorithm