

Policy Document

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University Hospitals
of North Midlands
NHS Trust

Resuscitation Policy

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Statement on Trust Policies

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed 

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1. INTRODUCTION

- 1.1 This resuscitation policy fully supports the Quality Standards for Cardiopulmonary resuscitation practice and training set out by the Resuscitation Council, UK (2013, updated 2017) and Care Quality Commission regulations and by incorporating the key findings and recommendations from the NCEPOD report – Time to Intervene (2012).
- 1.2 This version supersedes any previous versions of this document.
- 1.3 This policy applies to all University Hospital North Midlands (UHNM) sites, inclusive of Royal Stoke Hospital and County Hospital.
- 1.4 Cardiopulmonary resuscitation (CPR) is undertaken in an attempt to restore breathing and spontaneous circulation in a patient in cardiac/respiratory arrest. CPR is a relatively invasive medical treatment and it is therefore essential to identify patients for who cardiopulmonary arrest represents a terminal event in their illness. The Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) section of this policy (Section 8) is to ensure that CPR is only initiated for patients when it is appropriate and in their best interests.
- 1.5 This policy should be read in conjunction with the following documents:
 - Policy No. C43 “Trust Policy and Procedure for Obtaining Consent “
 - Policy No. MM03 “Trust Policy for the Storage, Prescription, Supply and Administration of Medicines”
 - Policy No. RM07 “An Organisation-wide Policy for the Management of Untoward Incidents including SUIs”
 - Policy No. HR53 Statutory & Mandatory Training Policy
 - Policy No. Re01 “Multidisciplinary Health Records Policy”
 - Policy No. HS03 “Safer Manual Handling Policy”
 - The Bedside Clinical Guidelines Partnership Medical Guidelines
 - The Bedside Clinical Guidelines Partnership Nursing Guidelines

2. POLICY STATEMENT

- 2.1 The provision of an effective resuscitation service for patients who suffer cardiopulmonary arrest must be an operational priority. The performance of this service has wide ranging implications with respect to training, standards of care, risk management and clinical governance. This policy/strategy incorporates current national guidance for resuscitation in accordance with Resuscitation Council, UK, 2015 guidelines.
- 2.2 The Trust has a duty of care to provide an effective resuscitation service and to ensure that all relevant staff are trained appropriately and regularly updated, to a level compatible with their expected degree of competence.
- 2.3 Purpose of the policy is to provide guidance on the planning and implementation of a high quality and robust resuscitation service within the organisation and to ensure that:
 - Prompt, safe, early and appropriate CPR and defibrillation occurs within the Trust.
 - Management of anaphylaxis follows Resuscitation Council (UK) guidelines.
- 2.4 Adherence to the specifications outlined within this policy is necessary to ensure that a system is in place to facilitate rapid access, irrespective of location, to appropriately trained personnel and essential emergency equipment.
- 2.5 This policy will always be applicable in the absence of any DNACPR decisions.

2.6 An overarching statement which is applicable to policy can be found on the Trust Policies Intranet page.

3. SCOPE

This policy applies to all staff that have patient contact both permanent and temporary or contracted staff (please see sections five and six for individual roles and levels of responsibility). There is a requirement for all clinical staff to achieve a level of competence in CPR skills appropriate to their role.

4. DEFINITIONS

Newborn Life Support (NLS)	Newborn Life Support involves keeping the baby warm, maintaining the baby's airway and mask inflation and ventilation. The baby is stabilised where necessary until the neonatal team arrives.
Basic Life Support with Airway Adjuncts (BLS)	A combination of external chest compressions and ventilations incorporating the use of bag valve mask devices, pocket mask and oropharyngeal airways.
In Hospital Resuscitation (IHR)	An extension of Basic Life Support with Airway Adjuncts to incorporate the use of automated external defibrillation
Immediate Life Support (ILS)	A Resuscitation Council (UK) Course, incorporating Recognition of the deteriorating patient, airway management skills including laryngeal mask airway insertion, the use of a manual Defibrillator, ALS Algorithm, reversible causes of cardiac arrest and the administration of first line resuscitation drugs.
Approved Advanced Life Support Trust Programme (ALS)	An extension of In hospital Resuscitation incorporating airway management skills including supraglottic airway device insertion, the use of a manual Defibrillator, ALS Algorithm, reversible causes of cardiac arrest and the administration of first line resuscitation drugs.
Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)	A Do Not Attempt Cardio-pulmonary Resuscitation order indicates that in the event of a cardiac arrest, CPR will not be initiated. DNACPR decisions are the overall responsibility of the consultant/GP in charge of the patient's care. Attempts at CPR will not be commenced when it is felt that a patient would not survive or when it is not the patient's wishes. It is emphasised that a DNACPR decision does not prevent other forms of treatment being provided.
Anaphylaxis	Anaphylaxis is an acute life-threatening hypersensitivity reaction and should be considered when there is an acute onset, life-threatening airway and/or breathing and/or circulation problem particularly if skin changes are present.
Automated Defibrillator (AED)	External The defibrillator itself analyses the cardiac rhythms and advises whether a shock is indicated or not and selects the appropriate energy levels. AED's allow staff to defibrillate prior to arrival of more expert help. They can also be used on paediatric patients.
Non-clinical Staff	A member of staff whose job description does not include direct patient care. Some staff in this group need to attend annual resuscitation training if their role includes patient contact without clinical staff immediately available e.g. reception; portering and security staff.

5. ROLES AND RESPONSIBILITIES

5.1 Trust Board and Chief Executive

The Trust Board have a responsibility to:

- Ensure systems, policies and procedures are in place to provide an effective and appropriate resuscitation service.
- Provide a suitable infra-structure which is required to establish and continue support for these activities.

5.2 Quality and Safety Forum

- Monitoring compliance with this policy through the receipt and review of minutes of the Resuscitation Working Group, ensuring that actions are taken where issues are identified.
- The receipt of the Cardiac Arrest Audit, NEWS Audit and DNACPR Audit.
- The receipt of Divisional Resuscitation training compliance and Adverse Incident Reports

5.3 Resuscitation Working Group

The Resuscitation Working Group is responsible for:

- The review of national legislation and guidance in relation to Resuscitation
- Addressing local implications of such guidance and informing the Group of issues to be reviewed
- Maintaining an up to date and accurate risk register with associated action plan; progress against which, will be monitored by the Group
- Reviewing outcome of local reviews and where necessary, making recommendations to address any gaps identified
- Monitoring compliance with training.
- Monitoring adverse incident reports and reflecting any findings as part of the improvement plan
- Reviewing findings from audit projects and reflecting any findings as part of the improvement plan
- Providing assurance to the Quality and Safety Forum that the standards within this policy are being complied with, through the submission of minutes of each meeting.
- Advising on the composition of the resuscitation team and its role.
- Providing guidance to the provision of appropriate equipment throughout the hospital both for the resuscitation of patients and for training purposes.
- Approving the Resuscitation Policy prior to approval by the Quality and Safety Forum
- Escalating any issues of concern to the Deteriorating Patient Group
- Sharing best practice
- Ensuring implementation and adherence to national resuscitation guidelines and standards
- Defining the role and composition of the resuscitation team
- Ensuring that resuscitation equipment for clinical use is available and ready for use
- Planning adequate provision of training in resuscitation
- Preparing and implementing a policy on resuscitation decisions.

5.4 Senior Resuscitation Officer

The Senior Resuscitation Officer (SRO), who is a full member of the resuscitation working group and is accountable to the Chairman of the working group, is responsible for:

- Co-ordinating the teaching and training of staff in resuscitation techniques.
- Ensuring that all resuscitation equipment in clinical use is maintained to an appropriate standard through an agreed rolling programme of audit.
- Ensuring continued self-education in resuscitation skills and protocols.
- Co-ordinating participation in trials relating to resuscitation both locally and nationally.
- Ensuring that the documentation and audit of all cardiopulmonary arrests is carried out utilising the agreed Trust Cardiac Arrest Audit proforma.
- Attending cardiopulmonary arrests regularly and providing feedback to staff as part of their continuing training in resuscitation.

- Providing input into the investigation and action planning around resuscitation related adverse incidents in liaison with the Quality, Safety and Compliance Department.

5.5 Resuscitation Teams

5.5.1 The composition and roles of the resuscitation teams within UHNM, which can be found at Appendix 7, varies on the different hospital sites that make up the Trust. Within The Royal Stoke and County Hospitals, help is summoned from the Resuscitation Teams within the hospitals via the emergency bleep number, [REDACTED] for all adult cardiac arrests.

5.5.2 The Resuscitation Team is responsible for:

- Attending all cardiopulmonary arrests within their designated area of responsibility in response to a cardiac arrest call.
- Ensuring they are appropriately trained, maintaining a level of competence appropriate to each individual's employed role.
- Identifying the Team Leader.

The Resuscitation team will be summoned by using the universal number [REDACTED]. The precise location of the patient must be communicated promptly and clearly to the switchboard operator.

If an anaesthetist is required at the arrest they will be summoned using the universal number [REDACTED], the call centre will then fast bleep the anaesthetist using the procedure at Appendix 8.

5.5.3 The **Resuscitation Team Leader** is responsible for:

- Directing and co-ordinating the resuscitation attempt; this will normally be a doctor.
- Communicating with those responsible for the further care of the patient if the resuscitation process is successful.
- Ensuring the decision to stop resuscitation is made in consultation with team members (with the Team Leader making the final decision).
- Ensuring that, at the conclusion of the resuscitation process, information must be passed to relatives in an appropriate environment.
- Ensuring that all the relevant documentation including the cardiac arrest audit form is completed as soon after the conclusion of the resuscitation as possible.

5.6 Resuscitation Team Bleep Holders

Resuscitation Bleep Holders are responsible for:

- At RSUH, on receiving the resuscitation team bleep you are to contact the call centre on Ext: [REDACTED] to inform them that you have received the bleep and to test it.
- At County Hospital, the bleep will be tested at 10.00hrs and 22.00hrs. Bleep holders are to acknowledge the test by pressing the red button on the bleep itself.
- You must ensure you are aware of your area of responsibility and how to get to all Wards and Departments within that area of responsibility.
- You must attend all cardiac arrests within your area of responsibility unless leaving your current location would create a life threatening situation.
- At the conclusion of each resuscitation attempt an electronic cardiac arrest audit form must be completed on iPortal and if the attempt is unsuccessful the verification must be documented within the patient's notes.
- At the conclusion of a resuscitation attempt the information from the defibrillator must be transferred using the Wi-Fi transfer mode on the device.
- You must physically hand the bleep and access card to the next person on call. You remain responsible for cardiac arrest cover until the bleep is physically handed over and therefore must remain on site until the handover has been completed.
- At RSUH, the batteries in the bleep must be changed every Monday morning and when required.
- At County Hospital, the bleep must be returned to call centre for charging and swapped for a replacement as soon as low battery is indicated.

The individual Resuscitation Team's areas of responsibility are defined in Appendix 7.

5.7 Associate Director (AD)/Clinical Director (CD)/Associate Chief Nurse (CAN)

Are responsible for ensuring that staffs are booked on to and attend appropriate resuscitation training as defined in appendix 11.

Are responsible for ensuring that all areas have appropriate resuscitation equipment and that equipment is checked and maintained as per trust policies.

Will ensure that there is compliance with all audit recommendations, requirements and action plans.

Ensure that decisions related to a patients resuscitation status are conducted following national guidance and recorded on the appropriate documentation. If the patient lacks capacity also ensuring that the capacity assessment is documented within the medical record.

5.8 Matrons

Those who take responsibility for a clinical area are expected to demonstrate the same degree of competence as those acting under their direction. They should know the required skills of other grades of staff in order to support them in their duties.

Are responsible for ensuring that Ward / Departmental compliance reports are presented at Directorate/ Divisional Governance Meetings.

5.9 Department managers; Sisters/Charge Nurses

5.9.1 Must ensure that a member of staff is available to assist the arrest team at each cardiac arrest in their clinical area.

5.9.2 Must establish a ward/departmental routine for checking and documentation of resuscitation equipment checks. Compliance is audited by the staff in the clinical audit department and fed back to the resuscitation department and department managers

5.9.3 Are responsible for taking action to ensure compliance if stock is missing or in need of repair.

Responsible for releasing staff to attend resuscitation training, in accordance with the requirements identified in appendix and monitoring attendance.

They should establish systems to ensure that all non-attendees of CPR training are followed up. Staff who do not attend training are identified on the ESR system.

5.10 Individual Practitioner

All practitioners should be aware of the general principles relating to resuscitation and are advised to refer to Appendix 1 of this policy for further information.

5.10.1 It is each individual practitioner's responsibility to be accountable for his or her own actions and ensure that they are confident and competent to initiate Cardiopulmonary Resuscitation

It is each individual's practitioners responsibility to attend Resuscitation Training annually at a level required by their individual job role.

5.10.2 It is the responsibility of the individual to initiate Cardiopulmonary Resuscitation unless there is a prior documented decision not to resuscitate the patient or by direct instruction from the consultant or registrar responsible for that patient's care.

5.10.3 To use the National Early Warning Scoring system (NEWS) to identify adult patients at risk of suffering a cardio respiratory arrest.

- Vital Pac should be used on all inpatient areas to facilitate the regular measurement and recording of early warning scores. In areas where Vital Pac is not available the observations must be recorded on the paper version at appendix 13
- For all patients requiring monitoring, there must be clear instructions as to the type and frequency of observations required. Where 'track and trigger' systems are used the initial frequency of observations should be stated clearly by the admitting doctor.
- The early warning scores will be used to initiate the NEWS Escalation Strategy, this will ensure that patients receive appropriate treatment at the appropriate time.

5.11 Paediatrics

5.11.1 The Trust has a separate Paediatric Resuscitation Team responsible for cardiopulmonary arrests involving children as special conditions apply when resuscitating children both in the aetiology of cardiopulmonary arrest and in the techniques of resuscitation. It is imperative that experienced personnel who are aware of the special needs are present at the resuscitation attempt.

5.11.2 At least one member of the Paediatric Resuscitation Team should possess a qualification in Advanced Paediatric Resuscitation. All staff with regular commitments to paediatric resuscitation should attend national paediatric resuscitation courses e.g. European Paediatric Life Support (EPALS), Advanced Paediatric Life Support (APLS), internally or externally. A specialised Paediatric Anaesthetist can be called if required on [REDACTED] stating "Paediatric Anaesthetist".

5.11.3 Ethical issues are especially difficult when resuscitating a child and consideration should be given to the care of relatives who may be present. A member of staff should be delegated to stay with them and liaise with the team on their behalf.

5.11.4 The use of paediatric resuscitation charts and drug dosing aides is essential. In circumstances where the weight is not known (such as in the emergency department) a method of calculating drug dosages from length or age should be available and utilised.

5.12 Newborn Resuscitation

Newborn resuscitation training will be provided for all relevant neonatal/paediatric staff groups. Midwives will be provided with basic life support training to reflect their role as initiators of intervention. A list of those identified staff groups are in Appendix 10. Any baby that requires resuscitation whilst being cared for in the Maternity Department should be resuscitated using the Newborn Life Support compression to ventilation ratios unless it is a primary cardiac event, when paediatric ratios should be considered.

6. EDUCATION, TRAINING AND PLAN OF IMPLEMENTATION

6.1 Training Strategy

The strategy for resuscitation training shall embody the statements and guidelines published by the Resuscitation Council (UK) and the European Resuscitation Council, incorporating the most recent updates to these guidelines. An outline of the Training Needs Analysis for the levels of CPR training required can be found at Appendix 11.

Education and training should be recorded within staff personal record, ideally within ESR.

6.2 All staff who as part of their clinical duties carry a cardiac arrest bleep and attend cardiac arrests as part of a Resuscitation Team or are required to routinely resuscitate critically ill patients (e.g. Anaesthetists, Intensivists or ED doctors) require training annually to an approved Advanced Life Support (ALS) Trust programme, see Appendix 9 for details.

6.3 Nursing staff working in any emergency portal of entry to the hospital, or theatre recovery are required to attend a Resuscitation Council (UK) Immediate Life Support (ILS) Course annually.

- 6.4** Other doctors, registered nurses in areas other than Emergency Entry Portals, midwives, allied health professionals, clinical support workers, porters and admin staff with patient contact, require In Hospital Resuscitation training annually. This minimum training standard may be raised to the Immediate Life Support (ILS) or Advanced Life Support (ALS) level, in those clinical areas where high risk or critically ill patients are cared for.
- 6.5** Additionally, hospital and community midwives undertake newborn basic life support calling for advanced support from the neonatal team or by calling 999 in the community when necessary.
- 6.6** Basic Life Support BLS training with airway adjuncts can be made available to non-clinical staff as identified by the Divisional Management Team or Directors of Corporate Services functions.
- 6.7** All new personnel, where required, entering employment within the Trust and who cannot supply evidence of prior training will attend resuscitation training as part of their induction program either corporately or locally.

7. MONITORING AND REVIEW ARRANGEMENTS

C09 Resuscitation Policy Monitoring Table					
Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or department responsible for the monitoring	Frequency of the monitoring activity	Group/committee/forum which will receive the findings/monitoring report	Committee/individual responsible for ensuring that the actions are completed
Requirement for a documented plan for vital signs monitoring that identifies variables to be measured and frequency	NEWS Audit	Corporate Audit Programme	Yearly	Quality and Safety Forum	Resuscitation Working Group
Use of NEWS to recognise patients at risk of deteriorating	NEWS audit	Corporate Audit Programme	Yearly	Quality and Safety Forum	Resuscitation Working Group
Do not attempt cardio-pulmonary resuscitation orders (DNACPR)	DNACPR audit	Corporate Audit Programme	Yearly	Quality and Safety Forum	Resuscitation Working Group
How the organisation documents that resuscitation equipment is checked, stocked and fit for use	Resuscitation equipment Audit	Resuscitation Officer	Rolling programme at least yearly	Resuscitation Working Group	Resuscitation Working Group
Compliance of resuscitation	ESR Business Intelligence	Ward / Departmental	Rolling Programme	Directorate / Divisional	Quality and Safety Forum

training		Managers		Governance Groups	
Adverse Incident Reports	DATIX	Ward / Departmental Managers	Rolling Programme	Directorate / Divisional Governance Groups	Quality and Safety Forum

7.1 Review Arrangements

This document will be reviewed every 3 years or whenever national policy or guideline changes are required to be considered (whichever occurs first), primarily by the Resuscitation Officer.

8. GUIDELINES

8.1 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)

8.1.1 Correct documentation of the decision to DNACPR is essential for considered patient care a Standard Operating Procedure is available at Appendix 16 to clarify the minimum requirements expected from staff involved in the process.

8.1.2 The organisation has developed DNACPR Guidelines which comply with the guidance issued by the British Medical Association (BMA)/ Royal College of Nursing (RCN)/Resuscitation Council (UK) (2016) and the recommended standards issued in the Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians, the Intensive Care Society and the Resuscitation Council (UK) standards for clinical practice.

8.1.3 Prolonging a patient's life usually provides a health benefit to that patient. Nevertheless, it is not appropriate to prolong life at all costs with no regard to its quality or to the potential burdens of treatment for the patient. The decision to use any treatment should be based on the balance of burdens, risks and benefits to the individual receiving the treatment, and that principle applies as much to cardiopulmonary resuscitation (CPR) as to any other treatment. The responsibility for making the decision rests with the most senior clinician currently in charge of the patient's care, although they may delegate the task to a Registrar or Specialty Doctor or Nurse Consultant.

8.1.4 Health care professionals as a whole must understand that patients can remain for active treatment but that in the event of a cardiac arrest CPR attempts may be futile. Providing active treatment is not a reason not to consider and document what should happen in the event of a cardiac arrest. A DNACPR order applies solely to cardiopulmonary resuscitation and does not affect any other aspect of treatment. Healthcare professionals should ensure that a DNACPR decision is not allowed to compromise the quality of care for any patient.

8.2 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. Blanket policies that deny CPR to groups of patients, for example to all patients in a hospice or nursing home or to patients above a certain age, are considered unethical and are probably unlawful. Decisions or policies that discriminate in favour of, or against people with defined disabilities would be unlawful under the Equality Act (2010).

Adherence to the Mental Capacity Act (2005) is a legal requirement and should always be referred to when considering DNACPR orders and Advanced Decisions. Appendix 12 outlines the key points from the Mental Capacity Act (2005).

8.3 Advanced Care Planning

8.3.1 If there is a risk of cardiac or respiratory arrest it is desirable to make decisions about CPR in advance whenever possible. The Decision-Making Framework is at Appendix 14. There should

be a full clinical assessment of the chances of a successful outcome. Advance care planning should be undertaken only by those who have the necessary training and experience. Ensuring that discussion takes place about CPR and a decision is made in advance, where possible, as this is preferable to 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.

8.3.2 CPR status must be considered and recorded for all acute admissions, ideally during the initial admission process and definitely at the initial consultant review when an explicit decision should be made, and clearly documented (for CPR or DNACPR). When, during the initial admission, CPR is considered as inappropriate, consultant involvement must occur at that time. Are we adding cardiopulmonary resuscitation and Do not

8.3.3 If patients decide that they do not wish to have CPR attempted, this should be documented carefully in the medical record, unless these records are signed by patients and the signature is witnessed, they are unlikely to meet the legal criteria for a valid advance decision and so some patients may prefer to make a formal, written advance decision following the criteria stipulated in the Mental Capacity Act 2005.

8.4 Communicating DNACPR Decision to Patients

8.4.1 In relation to decisions about CPR the courts have stated that there should be a presumption in favour of patient involvement and that there needs to be convincing reasons not to involve the patient. When a clinical decision is made that CPR should not be attempted because it will not be successful, and the patient has not expressed a wish to discuss CPR, careful consideration should be given as to whether or not to inform the patient of the decision. In most cases a patient should be informed, it should also be established at this time whom the patient wishes to be informed of the decision and this should be documented on the DNACPR form. For some patients, information about interventions that would not be clinically successful will be unnecessarily burdensome and of little or no value. An assessment should be made of how much information the patient wants to know. Information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team. If a second opinion is requested, this should be arranged, whenever possible. Clinicians should document the reason why a patient has not been informed of a DNACPR order if the decision is made not to inform the patient. Clinicians may be asked to justify their decision. If the patient lacks capacity and has appointed a welfare attorney whose authority extends to making these clinical decisions, or if a court has appointed a deputy or guardian with similar authority to act on the individual's behalf, this person should be informed of the decision and the reason for it. The mental capacity assessment to support the fact that the patient does not have capacity, should be documented in the medical notes.

8.4.2 The health care team will agree upon the best approach for communicating with the patient given their particular circumstances to ensure the patient is treated with respect and dignity. The clinician should give consideration to the appropriateness of giving the patient and relatives a copy of the "Decisions Relating to Cardiopulmonary Resuscitation".

8.4.3 Any discussions with the patient about whether to attempt CPR and any anticipatory decisions should be documented, signed and dated in the patient's health record. If a DNACPR decision is made and there has been no discussion with the patient because they have indicated a clear desire to avoid such discussion, this must be documented in the health record and the reasons must be recorded.

8.5 Children and Young People

8.5.1 It is recognised widely that medical decisions relating to children and young people ideally should be taken within a supportive partnership involving patients, their families and the health care team. The views of children and young people must be taken into consideration in decisions about attempting Cardiopulmonary Resuscitation.

8.5.2 Competent young people are entitled to give consent to medical treatment, and where they lack competence it is generally their parents who make decisions on their behalf. In England refusal of treatment by competent young people 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 competent young person refuses treatment, the harm caused by violating the young person's choice must be balanced against the harm caused by failing to treat.

8.5.3 Usually agreement will be reached about whether CPR should be attempted if the patient suffers respiratory or cardiac failure. If disagreement persists despite attempts to reach agreement, legal advice should be sought. Parents cannot require doctors to provide treatment contrary to their professional judgement, but doctors will try to accommodate parents' wishes as far as is compatible with protecting the child's interests.

8.6 Recording Decisions

Once the discussions are completed the resuscitation decision must be clearly recorded in the patient's medical and nursing records. If the patient lacks capacity to be involved in the decision making process, then the mini MCA form found at appendix 17, must be completed and placed in the medical notes. For Paediatric patients, The Child and Young Persons Advance Care Plan to record the decision making about attempting Cardiopulmonary Resuscitation found at Appendix 18 will be used.

The DNACPR order and reviews are written in the medical notes using the UHNM and CHC DNACPR document at Appendix 15 by the doctor making the decision. Boxes 1-5 on the form must be filled out appropriately. If the patient has not been involved in the decision-making process the precise reasons as to why they have not been involved must be documented in Box 3. The document must then be signed and the name and job title must be printed, if the person making the decision is NOT the Consultant then Box 6 needs to be completed. If the person making the decision is the Consultant they should complete Box 7, if Box 6 has been completed the Consultant should endorse the decision by completing Box 7 as soon as possible after the decision has been made. The Red bordered DNACPR document must be placed prominently in the front of the patient's medical notes. The Grey bordered DNACPR document should then be placed in the medical notes at the chronological point the decision was made. The Red bordered copy is the patient copy and will travel with the patient on discharge, the grey bordered copy remains the hospital file copy and remains within the notes.

8.7 Presumption In Favour Of CPR When There Is No DNACPR Decision

If no explicit decision has been made in advance about CPR and the express wishes of the patient are unknown and cannot be ascertained, there should be a presumption that health professionals will make all reasonable efforts to attempt to revive the patient in the event of cardiac or respiratory arrest. There may be some situations in which CPR is commenced on this basis, but during attempted resuscitation further information comes to light that makes continued CPR inappropriate. That information may consist of a DNACPR order or a valid and applicable advance decision refusing CPR in the current circumstances, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued attempted resuscitation would be inappropriate.

8.8 Requests for CPR Where It Will Not Be Effective

Neither patients, nor those close to them, can demand treatment that is clinically inappropriate. If the healthcare team believes that CPR will not re-start the heart and breathing, this should be explained to the patient in a sensitive way by experienced senior clinicians. If the patient does not accept the decision and requests a second opinion, this should be arranged whenever possible. Similarly, if those close to the patient do not accept a DNACPR decision in these circumstances, despite careful explanation for its basis, a second opinion should be offered.

8.9 Requests for CPR Where the Burdens May Outweigh the Benefits

Doctors cannot be required to give treatment contrary to their clinical judgment, but should be willing to consider and discuss patients' wishes to receive treatment. Where attempted CPR has a reasonable chance of successfully re-starting the heart and breathing for a sustained period, and patients have decided that the quality of life that can reasonably be expected is acceptable to them, their wish for CPR should be respected. If the doctor responsible for a patient's care feels unable to agree to the patient's expressed wishes for attempted CPR, or where there is lack of agreement within the healthcare team, a second opinion should be sought. Transfer of the patient's care to another doctor or team can be considered if there is still a lack of agreement and it is feasible. In exceptional circumstances, where there is ongoing disagreement, it may be necessary to seek legal advice.

If CPR may be successful in re-starting the patient's heart and maintaining breathing for a sustained period, the benefits of prolonging life must be weighed against the potential burdens to the patient. A decision that CPR will not be attempted, on best interest's grounds, because the burdens outweigh the benefits should be made only after careful consideration of all relevant factors, discussion with the patient, or those close to patients who lack capacity. Attempts should be made to discuss a patient's CPR status, where possible, with members of the medical and nursing team involved in the patient's care, including those involved in a patient's primary and secondary care.

8.10 Readily Reversible Causes

Some patients for whom a DNACPR decision has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking, in such situations CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances. In addition to readily reversible causes, it may be appropriate to temporarily suspend a decision not to attempt CPR during some procedures, if the procedure itself could precipitate a cardiopulmonary arrest. DNACPR decisions should be reviewed in advance of the procedure. Ideally this should be discussed with the patient, or their representative if they lack capacity, as part of the consent process. If a patient wishes an advanced decision refusing CPR to remain valid during a procedure or treatment that increases the risk of or induces cardiorespiratory arrest (e.g. cardiac surgery), this may significantly increase the risks of the procedure or treatment. If a clinician believes that the procedure or treatment would not be successful with the DNACPR order still in place, it would be reasonable not to proceed. Others will request that the DNACPR decision is suspended temporarily. The time at which the DNACPR decision is reinstated should also be discussed and agreed.

If a decision to restrict the type or extent of CPR that is to be applied in specific circumstances is made, any such decision must be thought through clearly on the basis of the balance of risks, burdens and benefits to the individual patient. If a decision is made to restrict the nature or extent of CPR for an individual the reasons justifying that restriction should be documented fully in the patient's health record, and detailed instructions on the implementation of the decision should be recorded by the healthcare professional making the decision and communicated effectively to all members of the healthcare team caring for the patient.

8.11 Review

The nurse in charge of the ward has a duty to keep the medical staff informed of any changes in the patient's condition and must do so if the patient's resuscitation status could be affected.

Decisions about CPR must be reviewed regularly and especially whenever changes occur in the patient's condition or in the patient's expressed wishes. It is important to note that patients' ability to participate in decision-making may change with changes in their clinical condition. It is not necessary to discuss CPR with the patient each time the decision is reviewed. Where a patient has previously been informed of a decision and it subsequently changes, they should be informed of the change of decision and the reason for it. The review must be conducted by the most senior clinician and recorded in the medical notes with date, time, printed name and signature.

If a patient is admitted to the hospital with a Community DNACPR order then the resuscitation status must be reviewed at the first Consultant review and documented on Trust documentation. Until the review has been conducted the patient's DNACPR order remains valid. Patients attending outpatient departments with a DNACPR order should not be resuscitated in the event of a cardiac arrest.

If there is a change in the patient's condition and the DNACPR order is rescinded, the decision must be written prominently in the medical notes by the doctor making the decision. The word "RESCINDED" and the date of the decision must be written at the point in the medical record of the original decision, ensuring that the original information is not obscured. The DNACPR proforma is to be removed from the medical notes and destroyed. The nurse in charge is to update the nursing records and inform all other members of the health care team of the change in status.

8.12 Communicating Decisions To Other Healthcare Providers

If a patient with a DNACPR decision is discharged, the red bordered DNACPR document must remain with the patient. A copy of the grey bordered DNACPR document form must be emailed to the receiving GP, with the date, time and destination recorded in the medical notes and the original document form placed back in the medical record. The Resuscitation status of the patient must be communicated to the community nursing team or nursing home prior to discharge and the ambulance service when booking the transport to ensure the seamless transition of patient care. (Appendix 16 SOP 1)

9. REFERENCES

Mental Capacity Act (2005) Department of Health

National Health Service Litigation Authority (2012/13) NHSLA Risk Management Standards for Acute Trusts

Resuscitation Policy. Health Services Circular (HSC) 2000/028. London. Department of Health

Resuscitation Council (UK) (2016) Decisions Relating to Cardiopulmonary Resuscitation. A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. <http://www.resus.org.uk/pages/DNACPR.pdf> [online]

Resuscitation Council (UK) (2013 Revised 2017) Quality Standards for Cardiopulmonary Resuscitation Practice and Training. Acute Care – Quality Standards. <https://www.resus.org.uk/quality-standards/acute-care-quality-standards-for-cpr/> [online]

Resuscitation Council (UK) (2015) Resuscitation Guidelines 2015. <http://www.resus.org.uk/pages/guide.htm> [online]

Resuscitation Council (UK) (2009) Guidance for Safer Handling during Resuscitation in healthcare settings <http://www.resus.org.uk/pages/safehand.pdf> [online]

The Emergency Treatment of Anaphylactic Reactions Guidelines for healthcare providers. January 2008 (annotated 2012) <http://www.resus.org.uk/pages/reaction.pdf> [online]

NCEPOD Report Time to Intervene <http://www.ncepod.org.uk/2012cap.htm> [online]

FOI REF 044-1920

APPENDIX 1 - GENERAL PRINCIPLES OF RESUSCITATION

1 Post-Resuscitation Care

- 1.1 In all areas, patients not admitted to a bed and where there are no in-patient beds a cardiac arrest call should be initiated to activate the relevant Resuscitation Team, within the main, Lyme and Trent buildings and at County Hospital the Resuscitation team will transfer the patient to the Emergency Care Centre. In the West Building, Oncology and Maternity Centres an emergency call must be also placed with the Ambulance Service. This is to allow for the transportation of the patient in the post arrest phase of the resuscitation to the Emergency Care Centre.
- 1.2 The immediate post-resuscitation phase is characterised by high dependency and clinical instability Consultant input is required in the immediate post arrest period to ensure that decision making is appropriate and that the correct interventions are undertaken. Most patients require either coronary care or intensive care treatment. Facilities for ongoing care of the patient may not be available at the location of the cardiac arrest and transfer of the patient may be necessary.
- 1.3 Continuity of care during this period is vital. Senior staff may need to be involved prior to transfer. When appropriate, referral to specialists (e.g. cardiologist or an intensivist) should be made. It is the responsibility of the Team Leader at the resuscitation to ensure that the transfer of care from one group of clinicians to another is both appropriate and efficient. The Team Leader should not leave the patient until this has occurred unless he/she has delegated care to another appropriate colleague.
- 1.4 The patient's condition should be stabilised as far as possible prior to transfer, but this should not delay definitive treatment. Careful co-ordination is required to ensure that no delays occur. This is the responsibility of the transfer team leader but tasks may be delegated to appropriately trained staff.
- 1.5 Equipment for transfer, including drugs, should be kept readily accessible and appropriate monitoring equipment should be provided. It may be necessary to liaise with the ambulance service provider as transfers may occur between hospitals and within hospital.
- 1.6 A patient being transferred should be accompanied by staff appropriately trained in the safe transfer of patients. Relatives should be informed of the transfer of the patient but should not expect to travel with the patient.

2 Resuscitation Equipment, Replenishment and Cleaning

- 2.1 All areas with clinical responsibility for Adult patients are to have standard adult resuscitation equipment stored on a standard trolley as in Appendix 2.

All resuscitation trolleys must be maintained in a state of readiness at all times. To ensure this, daily checks must be made of the following:

- Defibrillator
- Suction and oxygen apparatus
- Items on the top and sides of the trolley
- The tamper proof seal must be checked to ensure it is intact and matches the number recorded at the last complete check.

The full contents of the resuscitation trolley must be checked on a weekly basis and as soon as possible following conclusion of a resuscitation event. It is the Ward/departmental manager's responsibility to ensure that the equipment is checked and in a state of readiness for use. If this responsibility is delegated to the person in charge of a specific shift and the check is not completed, it is that individual's responsibility to identify that the check has not been completed, record the failure to check the trolley in the Ward or departmental diary and formally pass the responsibility to the person in charge of the next shift at handover.

- 2.2** Each adult resuscitation trolley is to have a standard adult resuscitation drug box as in Appendix 3 for use during cardiopulmonary arrests and may have any additional drugs specifically required in that clinical area. Second line emergency drugs are to be available in specified locations throughout the Trust as per Appendix 3.
- 2.3** All areas with clinical responsibility for paediatrics are to have standard paediatric resuscitation equipment stored on a standard trolley as in Appendix 4.

All resuscitation trolleys must be maintained in a state of readiness at all times. To ensure this, daily checks must be made of the following:

- defibrillator
- suction and oxygen apparatus
- items on the top and sides of the trolley
- the tamper proof seal must be checked to ensure it is intact and matches the number recorded at the last complete check.

The full contents of the paediatric resuscitation trolley must be checked on a weekly basis and as soon as possible following conclusion of a resuscitation event. It is the Ward/departmental manager's responsibility to ensure that the equipment is checked and in a state of readiness for use. If this responsibility is delegated to the person in charge of a specific shift and the check is not completed, it is that individual's responsibility to identify that the check has not been completed, record the failure to check the trolley in the Ward or departmental diary and formally pass the responsibility to the person in charge of the next shift at handover.

- 2.4** Each paediatric resuscitation trolley is to have a standard paediatric resuscitation drug box as in Appendix 5 for use during cardiopulmonary arrests and may have any additional drugs specifically required in that clinical area.
- 2.5** All areas with clinical responsibility for neonates are to have standard neonatal resuscitation equipment stored on a standard trolley as in Appendix 6 and checked on a daily basis and as soon as possible following conclusion of a resuscitation event.
- 2.6** Disposable items should be replenished at the earliest opportunity from the central storage areas. Non-disposable items should be de-contaminated/cleaned in accordance with both the manufacturers' recommendations, the infection control policy and re-instated to the trolley as soon as is practical.

3 Manual Handling

- 3.1** In situations where the collapsed patient is on the floor, in a chair or in a restricted/confined space the Safer Manual Handling Policy, Policy Number HS03, must be followed to minimise the risks of manual handling and related injuries to both staff and the patient.
- 3.2** Please also refer to the Resuscitation Council (UK) advisory document "GUIDANCE FOR SAFER HANDLING DURING RESUSCITATION IN HOSPITALS"

4 Cross Infection

- 4.1** 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 therefore advisable that direct mouth-to-mouth resuscitation be avoided and the patient ventilated with a Pocket Mask or Bag Valve Mask Device.
- 4.2** 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 airway protective devices are not immediately available, start chest compressions whilst awaiting a ventilation device. If there are no contraindications consider giving mouth-to-mouth ventilations, if

you are unwilling or mouth-to-mouth ventilations are not appropriate, continue with continuous chest compressions until a ventilatory device is available.

5 Anaphylaxis

The management of suspected anaphylaxis/anaphylactoid reactions should be conducted in accordance with the Resuscitation Council (UK) Guidelines for the management of anaphylaxis utilising the anaphylaxis packs held on each resuscitation trolley.

6 Defibrillation

A Defibrillator must only be operated by persons specifically trained in the use of the particular make and model of defibrillator to be used. The operation of defibrillators by nurses, midwives and Allied Health Professionals is subject to the completion of an ALS course, ILS course or successful completion of an In Hospital Resuscitation training session.

7 Procurement

The procurement of resuscitation equipment is subject to the organisations purchase requisition procedure. A list of ordering codes is available via the Resuscitation section of the Trust Intranet.

APPENDIX 2 - CHECKLIST FOR ADULT RESUSCITATION TROLLEY - 2017

THE RESUSCITATION TROLLEY REQUIRES A COMPLETE CHECK EVERY WEEK AND AFTER EACH USE. DURING OTHER TIMES THE TROLLEY CAN BE LEFT SECURE BY USING A TAMPER PROOF SEAL.

EACH DAY THE TOP OF THE TROLLEY INCLUDING DEFIBRILLATOR, OXYGEN AND SUCTION MUST BE CHECKED AND A CHECK MUST TAKE PLACE TO ENSURE THAT THE TAMPER PROOF SEAL IS IN PLACE AND IS THE SAME SERIAL NUMBER PREVIOUSLY DOCUMENTED.

Week Commencing:	Name of Ward/Department:

EXPIRY DATES OF DRUGS AND IV FLUIDS	
ITEM	EXPIRY DATE
Oxygen Cylinder – Must be ½ Full	
Anaphylaxis Pack	
0.9% sodium chloride 1000ml	
Compound Sodium Lactate Solution 1000ml	
Adult Cardiac Arrest Drug Box	

WEEK COMMENCING:	MON	TUE	WED	THU	FRI	SAT	SUN	EXPIRY
TOP OF TROLLEY TO BE CHECKED AND SIGNED DAILY								
2 x Boxes of Latex-Free Gloves (1 Medium, 1 Large)								
5 x Eye Protection Frames with 5 x sets of Eye Protection Lenses								
1 x Pocket Mask								
1 x R Series Zoll Defibrillator – Check for self-test Green Tick, mains and battery indicators.								
3 x Packets of 'Hands Off' Defibrillator Pads								
Battery Operated Suction Device								
1 x Pulse Generator Magnet								
1 x Self-Inflating Bag-Valve-Mask (Adult) with Reservoir Bag and O2 Tubing								
1 x Stethoscope								
1 x Bag of ECG Electrodes (Stored in air tight Bag/container)								
1 x E Size O2 Cylinder with Regulator and cylinder key								
1 x Sharps Bin attached to Side of the Trolley								
CONTENTS OF TROLLEY TO BE CHECKED WEEKLY AND AFTER EACH USE								
TOP DRAWER (AIRWAY)								
1 x Adult Magill Forceps								
Guedel Airways (2, 3, 4, one of each)								
Nasopharyngeal Airways (6, 7, one of each)								
I-Gel Size 4								

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C09 Resuscitation Policy

WEEK COMMENCING:	MON	TUE	WED	THU	FRI	SAT	SUN	EXPIRY
1 x Gum Elastic Bougie (Adult)								
1 x Stylet (Medium)								
1 x Airway Adapter Kit (CO 2 Sampling line)								
2 x Lubricating Jelly Sachets								
1 x Catheter Mount with 15mm Angled Connector (Sterile)								
1 x Roll 12mm Cotton Tape								
MIDDLE DRAWER (AIRWAY/BREATHING)								
1 x Yankauer Sucker								
Suction Catheters (12, 14, five of each)								
1 x Suction Connecting Tube								
1 x 'Mini-Trach' Tracheostomy Set (Portex)								
1 x Disposable Scalpel (Size 10)								
Bag-Valve-Mask Face Masks (small/3, medium/4, one of each)								
1 x 'Waters Circuit' Re-Breathing Bag								
1 x Non-Rebreathe O2 Mask / Reservoir Bag								
BOTTOM DRAWER (CIRCULATION)								
1 x Tourniquet								
5 x Clinell 2% wipes								
3 x Size 14G Cannula (Brown / Orange)								
3 x Size 16G Cannula (Grey)								
3 x Size 18G Cannula (Green)								
3 x Size 20G Cannula (Pink)								
5 x IV Dressings								
10 x 10ml Syringes								
15 x Size 21G Needles (Green)								
5 x Size 23G Needles (Blue)								
2 x 10cm x10cm Gauze Swabs								
10 x 10ml Normal Sodium Chloride 0.9% Ampoules								
2 x Arterial Blood Gas Syringes								
4 x Arterial Cannulas								
2 x Blood Administration Sets								
2 x 1000ml Sodium Chloride 0.9%								
2 x 1000ml Compound Sodium Lactate Solution								
1 x Pressure Infusion Bag								
1 x Anaphylaxis Pack								
BOTTOM OF TROLLEY								
1 x Adult Resuscitation Drug Box								
1 x Pair of Cutting Shears								
1 x Disposable Razor								
1 x Spare Self-Inflating Bag-Valve-Mask (Adult) with Reservoir Bag and O2 Tubing								

University Hospitals of North Midlands NHS Trust
C09 Resuscitation Policy

WEEK COMMENCING:	MON	TUE	WED	THU	FRI	SAT	SUN	EXPIRY
1 x Intubation Roll (see below)								
INTUBATION ROLL								
2 x Laryngoscopes with Size 3 and 4 Blades								
2 x Spare Batteries for Laryngoscopes								
Cuffed ET Tubes with 15mm Connector (6mm, 7mm, 8mm, 9mm, one of each)								
3 x KY Jelly Sachets								
1 x 20ml Syringe								
1 x Airway Adapter Kit (CO 2 sampling line)								
1 x Catheter Mount with 15mm Angled Connector (Sterile)								
1 x Length 12mm Cotton Tape (a Resus Trolley Width in Length)								
1 x Roll 5cm Blenderm Tape								
Tamper Proof Seal – Serial Number								
Printed name and Signature of Person Checking trolley								

- **Pocket Mask with O₂ connector and O₂ tubing in each bay and side room**
- **The second Adult Resuscitation Drug Box must be available on the Ward/Department.**

All of these drugs must be checked daily for stock and expiry date- if used, replacements should be obtained from pharmacy as soon as possible.

Adult Resus Drug Box

6 x ADRENALINE 1 in 10,000 (1mg in 10ml)
1 x AMIODARONE 300mg in 10ml

Anaphylaxis Pack – Tamper Evident

1 held on each Resus Trolley in Circulation drawer

- ADRENALINE ampoules 1:1000 (1mg in 1ml) x2
- HYDROCORTISONE sodium succinate 100mg x2
- CHORPHENAMINE injection 10mg in 1ml x1

Emergency Drugs – kept as stock on all wards

Naloxone 400mcg/ml injection x 1 box for the treatment of opioid toxicity
Flumazenil 500micrograms/5ml injection x 1 box for the treatment of benzodiazepine overdose
Glucose 10% infusion bags for the treatment of Hypoglycaemia

Second Line Adult Emergency Drugs

- 20% Lipid emulsion 500mls infusion – held on all Theatre recovery's, A&E and Cardiac Cath Lab 1
- Lidocaine 100 mg IV- 1% 10ml glass amps (only to be held on CCU and A&E (CDU, Minors, Omnicell (A&B bay) and Resus at the Royal) A&E at County

The following second line drugs as outlined by the Resuscitation Council (UK) Quality Standards 2013 will be located throughout the Trust in strategic areas:

- Adenosine injection 6 mg/2ml 1 box
- Atropine injection – 600mcg/ml x 1 box
- Calcium chloride injection 10% x 1 10 ml pre-filled syringe
- Magnesium sulphate (2 g = 8 mmol) x 1 box of 1g/2ml (50%)
- Sodium bicarbonate 8.4% 1x 250ml bottle
- Salbutamol IV injection 5mg/5ml x 1 box

Royal Stoke Hospital	County Hospital
ED	ED
Cardiology (CCU)	Pharmacy Emergency Drug Cupboard
Theatres (Hub)	Critical Care Unit
Critical Care Pod 4	Ward 15
Ward 76 West Building	
Ward 201(EAU)	
Ward 124	
Pharmacy Emergency Drug Cupboard	
SSCU Bay 1	

APPENDIX 4 - CHECK LIST FOR PAEDIATRIC RESUSCITATION TROLLEY - MAY 2017

THE RESUSCITATION TROLLEY REQUIRES A COMPLETE CHECK EVERY WEEK AND AFTER EACH USE. DURING OTHER TIMES THE TROLLEY CAN BE LEFT SECURE BY USING A TAMPER PROOF SEAL.

EACH DAY THE TOP OF THE TROLLEY INCLUDING DEFIBRILLATOR, OXYGEN AND SUCTION MUST BE CHECKED AND A CHECK MUST TAKE PLACE TO ENSURE THAT THE TAMPER PROOF SEAL IS IN PLACE AND IS THE SAME SERIAL NUMBER PREVIOUSLY DOCUMENTED.

WEEK COMMENCING:	NAME OF WARD/DEPARTMENT:

EXPIRY DATES OF DRUGS AND IV FLUIDS	
ITEM	EXPIRY DATE
Oxygen Cylinder Must be ½ Full	
Amiodarone 300mg in 10ml pre filled syringe	
Dextrose 10% 500ml	
0.9% Sodium Chloride 500ml	
Dextrose Injection 50% in 50ml	
Diazepam PR 5mg	
Naloxone 400 microgram/ml	
Sodium Bicarbonate injection 8.4% (1mmol/1ml) 1 x 250mls	
Anaphylaxis Pack	
Paediatric Cardiac Arrest Drug Box	

WEEK COMMENCING:	MON	TUE	WED	THU	FRI	SAT	SUN	EXPIRY
TOP OF TROLLEY TO BE CHECKED AND SIGNED DAILY								
1 x R Series Zoll Defibrillator – Check for self-test Green Tick								
Hands Off Defibrillator Pads – 1 x Adult and 1 x Paediatric								
Bag-Valve-Mask Device with Reservoir and O2 tubing: 1 x Paediatric (500ml) + 1 x Adult (1500ml)								
Oxygen Mask with Reservoir bag – 1 x Adult and 1 x Paediatric								
1 x E Size O2 Cylinder with Regulator and Spanner								
ECG Electrodes: Paediatric + Adult								
Paediatric Dual Head Stethoscope x 1								
Latex Free Gloves: Size S, M, L								
Medisense-Blood Sugar Testing Kit (Orange Box)								
Battery Operated Suction Device and Liners.								
CONTENTS OF TROLLEY TO BE CHECKED WEEKLY AND AFTER EACH USE								
TOP DRAWER								
Open Circuit Ayers T – piece bag system x 1								

WEEK COMMENCING:	MON	TUE	WED	THU	FRI	SAT	SUN	EXPIRY
Bag-Valve-Mask Face Masks: Small size 3 and Medium size 4								
Oropharyngeal Airways: Sizes 000, 00, 0, 1, 2, 3, 4								
Portex 'Mini-trach' Tracheostomy set x 1								
Suction connecting tube x 1								
Suction catheters x 1 of each size 6, 8, 10, 12								
Yankauer suckers: 1 x Adult and 1 x Paediatric								
MIDDLE DRAWER								
Orange, Blue, Green needles + Butterflies x 3 each								
Disposable Tourniquets x 3								
Yellow, Blue Jelco's/ cannula plus Green Cannula's x 3 each								
Luer Lock syringes: 3 x each size 1ml, 2ml, 5ml, 10ml, 20ml + 50ml								
Intra-osseous Needles: 1 x each size 15.5 and 18 gauge								
Blenderm tape, Mefix 10cm, Tegaderm								
Needle free IV Extension set x 3								
Needle free valve / bag access spike x 1								
3-way Taps x 3, Air Inlets x2								
Chloraprep, Razor, Wool Balls, Sterile Gauze swabs.								
Sodium Chloride 0.9% 5ml and Water for Injection 5ml x 5								
NG Tubes Sizes 6 + 8 x 2 (Medicina) and pH Testing Strips								
BOTTOM DRAWER								
Amiodarone 300mg in 10ml pre filled syringe								
Dextrose 10% 500ml								
Sodium Chloride 0.9% 500ml x 2 bags								
Dextrose Injection 50% in 50ml								
Access to 1 box of Adrenaline 1:1000 Ampoules 1ml								
Access to Lorazepam 4mg /1ml Injection								
Diazepam PR 5mg								
Access to Dopamine hydrochloride 200mg/5ml								
Naloxone 400 microgram/ml								
Sodium Bicarbonate injection 8.4% (1mmol/1ml) 1 x 250mls								
Anaphylaxis Pack								
BOTTOM OF TROLLEY								
Paediatric Drug Box								
Splints/ Bandages - various sizes								

WEEK COMMENCING:	MON	TUE	WED	THU	FRI	SAT	SUN	EXPIRY
Security Tamper Seals.								
1 x Intubation Roll (see below)								
INTUBATION ROLL								
Laryngoscope Handles x 2								
Laryngoscope Blades Straight size 0, 1, 2								
Laryngoscope Blades Curved size 3, 4								
Spare Batteries for Laryngoscopes								
ET Tubes (Uncuffed) Sizes 2.5mm + 3.0mm								
ET Tubes (Cuffed) Sizes 3.5, 4, 4.5, 5, 5.5, 6mm								
ET Tubes (Cuffed) Sizes 6.5, 7, 8mm								
ET Stylets: 1 Infant (6inch), 1 Small x 1 Medium								
Catheter mount								
Magills forceps Adult + Paed								
Carbon dioxide detector								
KY jelly, Tongue depressor, Spencer wells, Scissors								
Tapes for securing ET Tube								
TAMPER PROOF SEAL – SERIAL NUMBER								
PRINTED NAME AND SIGNATURE OF PERSON CHECKING TROLLEY								

APPENDIX 5 - CONTENTS OF PAEDIATRIC RESUSCITATION DRUG BOX

PRE FILLED SYRINGES

6 x ADRENALINE 1 in 10,000 1mg in 10ml

1 x ADRENALINE 100 microgram in 1ml (1 in 10,000) 10ml Ampoule

Anaphylaxis Pack – Tamper Evident

1 held on each Resus Trolley in Circulation drawer

- ADRENALINE ampoules 1:1000 (1mg in 1ml) x2
- HYDROCORTISONE sodium succinate 100mg x2
- CHORPHENAMINE injection 10mg in 1ml x1

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APPENDIX 6 - CHECK LIST FOR NEWBORN RESUSCITATION EQUIPMENT

Week Commencing Date:	
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Available with Resuscitaire	MON	TUE	WED	THU	FRI	SAT	SUN	EXPIRY
Heater								
Stopclock								
Warm Towels x 2								
Stethoscope								
T Connector & Tubing								
Face masks sizes 0/1 & 00								
Scissors								
Yankauer sucker								
Laryngoscope								
Oropharyngeal Airways size 00, 000								
Endotracheal Tubes sizes 2.5, 3, 3.5								
Sterile Cord Scissors								
Sterile Cord Clamp								
Available in the Clinical Area								
2 Umbilical Venous catheters								
1 Sterile Umbilical Catheterisation Pack								
Epinephrine 1 in 10,000 x 2 ampoules								
4.2% sodium bicarbonate x 2 ampoules								
10% glucose in 10ml x 2 ampoules								
Sodium Chloride 0.9% 500ml								
3 Way Tap x1								
0.9% Sodium Chloride in 10mls x 5								
10 ml syringes x5								
21 Gauge needles x 5								
Black silk sutures x2								
Scalpel blades x2								
Sterile 20 gauge IV Cannula x 2								
Sterile Heparinised syringes 2ml x2								

Community Midwives

Community Midwives carry airways in their equipment at all times.

For planned deliveries at home, the midwives will carry Neopuff portable resuscitation unit; airways 00 and 000, facemasks 0/1 and 00, portable oxygen cylinder, green and white tubing, mucus extractor.

Where 999 is called by the woman in labour, an Ambulance crew is deployed, on arrival the crew make an assessment; if the birth is not imminent they will transfer the mother to the Maternity Unit. If the birth is imminent, they will request a second Paramedic Crew with neonatal resuscitation equipment and request the attendance of the midwife. If the woman has delivered and both are safe, the crew will make an assessment and decide on the need for support as described above.

Emergency Department

The Emergency Department will have a cot with towel, blanket and heated mattress available in the place of a resuscitaire.

All other equipment identified above will be kept in the Neonatal Resuscitation Box in the Emergency Department Resuscitation area.

APPENDIX 7 - CARDIAC ARREST GROUPS AT ROYAL STOKE

Group 0

Lyme Building – Surgical Wards, Infectious Diseases

Cardiac arrest cover for these areas will be provided by 1x Junior Doctor from Surgery, 1x Junior Doctor from AMU and a Surgical Nurse Practitioner.

Group 1

Medical Block – Elderly Care

Oncology Building – Oncology, Radiotherapy

Maternity Building – Adults

Cardiac arrest cover for this area will be provided by 2x Junior Doctor/ANP from Medicine (working within these Buildings).

Out of Hours this team will be supported by a Medical Nurse Practitioner

Group 2

All Clinical Areas

Anaesthetic cover will be provided via the escalation system described in Appendix 9

Group 3

Main Building

Level 2/3 – Medicine, Orthopaedics,

Cardiac arrest cover for these areas will be provided by 1 x Junior Doctor from the Neurosciences rota and 1 x Junior doctor from Orthopaedics.

Out of Hours this team will be supported by a Medical Nurse Practitioner

Group 4

Maternity Building – Neonatal

Neonatal Emergency Cover will be provided by the Neonatal team with 1x Junior Doctor and 1x Registrar

Group 5

Ground Level – Paediatrics

Paediatrics will provide cardiac arrest cover to all the paediatric areas with 1x Junior Doctor and 1x Registrar

Group 6

Ground Level/1 – AMU, Medical, Surgical and Orthopaedic Outpatients, Fracture Clinic

Trent Building – Elderly Care, AMU, Therapies

Lower Ground 1 Level – Imaging, Endoscopy and Nuclear Medicine

Lyme Building – Surgical Wards, Infectious Diseases (1 person only from this team)

Cardiac arrest cover for this area will be provided by 2 x Junior Doctor/ANP from the medical rota

Main Building/Trent: Out of Hours this team will be supported by a Medical Nurse Practitioner

Lyme Building: Out of Hours this team will be supported by a Surgical Nurse Practitioner

Group 7

Maternity Building – Obstetrics

Obstetric emergencies will remain to be provided by the Obstetric team with 1x Junior Doctor and 1x Registrar

Group 8

Level 1 – Cardiology, Cardiothoracics

Cardiac arrest cover for this area is provided by 1x Junior Doctor from Cardiology and 1x Junior Doctor from Cardiothoracics. The Cardiothoracic Registrar will attend for arrest calls to the Cardiothoracic Ward.

Out of Hours this team will be supported by both a Medical and Surgical Nurse Practitioner

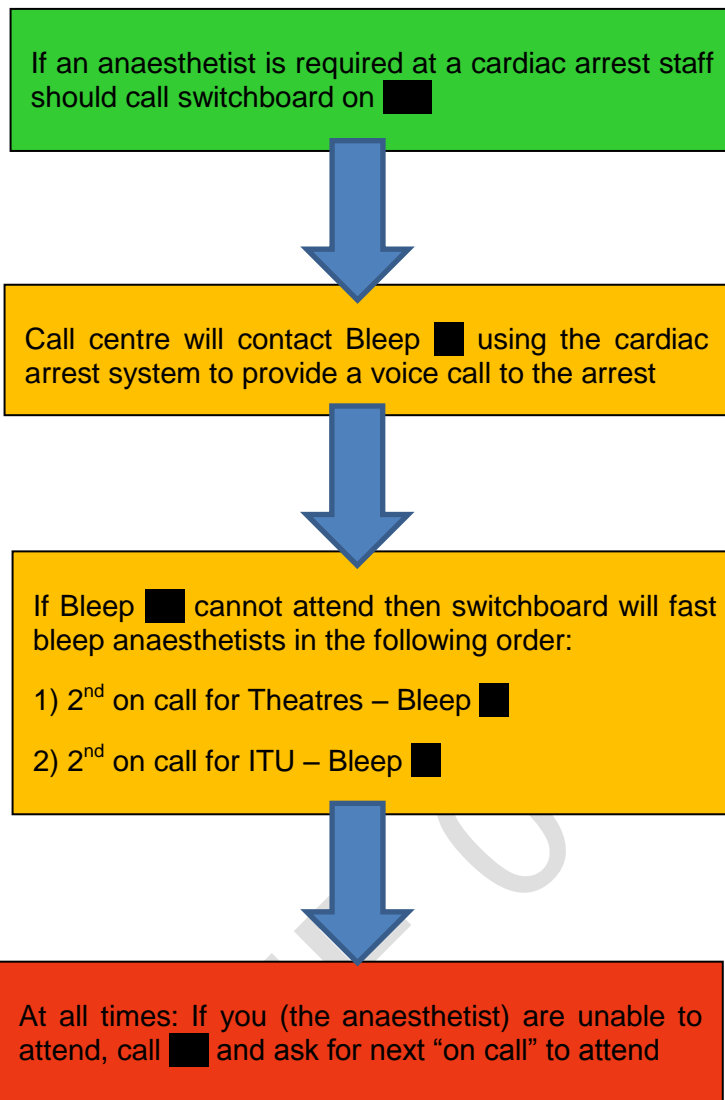
CARDIAC ARREST GROUPS AT COUNTY HOSPITAL

Cardiac arrest cover for this area will be provided by

- On-call Medical Specialist Registrar (or equivalent)
- On-call Medical F2 (or equivalent)
- On-call Medical F1 Doctor (for education)
- 1st on call Doctor for Anaesthetics
- Operating Department Practitioner (ODP)
- Resuscitation Officer (if available)

FOI REF 044-1920

APPENDIX 8 - PROCEDURE FOR CALLING ANAESTHETIST



APPENDIX 9 - APPROVED ADVANCED LIFE SUPPORT TRUST PROGRAMME

PRACTICAL STATIONS	TIMINGS
BASIC LIFE SUPPORT	30 minutes – 60 minutes
AIRWAY MANAGEMENT	15 minutes – 30 minutes
CARDIAC ARREST RHYTHMS & DEFIBRILLATION	20 minutes – 60 minutes
DRUGS AND DELIVERY	10 minutes – 30 minutes
SCENARIOS	45 minutes – 90 minutes

THE PROFILE HAS A GENERIC SYLLABUS. THE TIMINGS MAY BE ADAPTED TO FACILITATE TRAINING REQUIREMENTS OF SPECIFIC STAFF GROUPS AND SPECIALTIES ALLOWING FOR PREVIOUS KNOWLEDGE AND EXPERIENCE.

FOI REF 044-1929

APPENDIX 10 - STAFF GROUPS HAVING A RESPONSIBILITY TO RESUSCITATE NEWBORN PATIENTS

Staff Group	Mandatory	Desirable
Consultant Neonatologist	√	
F1 & F2 Paediatrics		√
SHO -Neonates	√	
SHO – Paediatrics		√
SPR - Neonates	√	
SPR – Paediatrics	√	
ANP - Neonates	√	
Midwives (Basic Life Support Training)	√	

FOI REF 044-1920

APPENDIX 11 - Resuscitation Training Needs Analysis

Staff Group ↓	Training Requirement ↓			
<i>If you feel that your staff group has not been included in the list below, please contact Resuscitation Officer on ext. 76660</i>	In Hospital Resuscitation	Immediate Life Support	Paediatric BLS/APLS	ALS
Frequency ↻:	ALL TRAINING SHOULD BE COMPLETED ANNUALLY			
Medical - F1				✓
Medical - F2				✓
Medical - CT1				✓
Medical - CT2				✓
Medical - GPVTS				✓
Medical - Obstetrics & Gynaecology	✓			
Medical – Emergency Department				✓
Medical - Anaesthetics				✓
Medical - Cardiology				✓
Medical - Respiratory Medicine	✓			
Medical Gastroenterology	✓			
Medical - Renal	✓			
Medical - Elderly Care	✓			
Medical - Stroke	✓			
Medical - Neurology	✓			
Medical - Intensive Care				✓
Medical - Cardiothoracic Surgery	✓			
Medical - General Surgery	✓			
Medical - Rehabilitation	✓			
Medical - Rheumatology	✓			
Medical - Trauma & Orthopaedics	✓			
Medical - Neurosurgery	✓			
Medical - Urology	✓			
Medical - ENT	✓			
Medical - Ophthalmology	✓			
Medical - Oral Surgery	✓			
Medical - Orthodontics	✓			
Medical - Paediatrics			✓	
Medical - Plastics	✓			
Medical - Dermatology	✓			
Medical – Genito Urinary Medicine	✓			
Medical - Histopathology				
Medical Microbiology				
Medical - Nuclear Medicine	✓			
Medical - Pathology				
Medical - Radiology	✓			

Staff Group ↓	Training Requirement ↓			
<i>If you feel that your staff group has not been included in the list below, please contact Resuscitation Officer on ext. 76660</i>	In Hospital Resuscitation	Immediate Life Support	Paediatric BLS/APLS	ALS
Medical - Haematology	✓			
Medical - Oncology	✓			
Nursing - Practitioners				✓
Nursing - Emergency Care Centre		✓		
Nursing – Acute medical Unit		✓		
Nursing – Surgical assessment Unit		✓		
Nursing – Theatre Recovery		✓		
Nursing – Adult	✓			
Nursing – Paediatric			✓	
Nursing – Dental	✓			
Midwives	✓			
Nursing Assistant	✓			
Nursery Nurse			✓	
Operating Department Practitioners	✓			
Radiographers	✓			
Physiotherapists	✓			
Occupational Therapists	✓			
Pharmacists	✓			
Dieticians	✓			
Healthcare Scientist - Clinical	✓			

How to book onto training:

All training sessions are booked via ESR.

Contact Details for Further Advice:

If you would like to discuss your training needs, please contact the Resuscitation Team, who will be able to provide advice. **Contact No: Ext** [REDACTED]

APPENDIX 12 - KEY POINTS FROM THE MENTAL CAPACITY ACT (2005)

An individual who wishes to make a decision for an individual who lacks capacity must document in the medical record why capacity is in doubt and the capacity assessment process and findings.

Any decision made must be made in the best interest of the patient. A crucial part of the best interest judgement will involve a discussion with those who know the patient and those involved with the care or welfare of the patient.

The decision maker has a duty to take into account the views of anyone named by the patient as someone they want consulted, anyone involved in caring for the patient, anyone interested in the welfare of the patient including any advocate already working with the patient, an attorney appointed under a Lasting Power of Attorney and a Deputy appointed by the Court of Protection.

If the patient has no one who can be consulted (unbefriended) then an Independent Mental Capacity Advocate (IMCA) must be instructed.

An advance decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment. An advance decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity: healthcare professionals must follow the decision. If the advance decision refuses life-sustaining treatment, it must, be in writing (it can be written by someone else or recorded in healthcare notes), be signed and witnessed, and state clearly that the decision applies even if life is at risk.

APPENDIX 13 - NEWS SCORING TOOL

WARD:



OBSERVATION CHART FOR THE NATIONAL EARLY WARNING SCORE

NEWS KEY 0 1 2 3		NAME:	UNIT NO.	Chart of		
DATE				DATE		
TIME				TIME		
RESP. RATE	≥25		3		≥25	
	21-24		2		21-24	
	12-20				12-20	
	9-11		1		9-11	
	≤8		3		≤8	
SpO₂	≥96				≥96	
	94-95		1		94-95	
	92-93		2		92-93	
	≤91		3		≤91	
	Inspired O ₂ Litres/%	%	2		%	
DEVICE						
If temp <36°C Consider Sign of Sepsis	≥39°		2		≥39°	
	38°		1		38°	
	37°				37°	
	36°		1		36°	
	≤35°		3		≤35°	
If BP <90 Consider Circulatory Compromise Sepsis Heart Failure Volume Depletion	230		3		230	
	220				220	
	210				210	
	200				200	
	190				190	
	180				180	
	170				170	
	160				160	
	150				150	
	140				140	
	130				130	
	120				120	
	110		1		110	
	100		2		100	
	90		3		90	
80				80		
70				70		
60				60		
50				50		
Take a Manual Pulse - Irregular Pulse = 12 lead ECG + AF Guidelines	>140		3		140	
	130				130	
	120		2		120	
	110				110	
	100		1		100	
	90				90	
	80				80	
	70				70	
	60				60	
	50		1		50	
	40		3		40	
	30				30	
	Level of Consciousness		Alert			Alert
			V / P / U	3		V / P / U
	EARLY WARNING SCORE (NEWS)	Respiratory rate				
SATS						
O ₂ Therapy						
Temperature						
BP Systolic						
Heart Rate						
AVPU						
TOTAL NEWS						
Obs done by						
Reg Nurse						
Pain Score (0=no pain-10=worst pain poss.)						
Nausea / Vomiting						
Bowels opened (Bristol Stool Chart)						
Urine						

DEVICE CODES FOR OXYGEN DELIVERY

H2B Humified Oxygen @ 28%	V24 Venturi 24%	RM Reservoir Mask	A AIR
Also H35 H40 H60 H80 H88	Also V28 V35 V40 V60	TM Tracheostomy Mask	NC Nasal Cannulae
CP Patient on CPAP system	NIV Patient on NIV system	SM Simple Mask	OTH Other device (specify)

Version 1, Author SL, Date: Sept 2017

NSH8171

Neurological Observation Chart													
Date:													
Time													
Signature:													
eyes open	Spontaneously	4											Eyes closed by swelling = C
	To speech	3											
	To pain	2											
	None	1											
Best verbal response	Orientated	5											Endotracheal tube or tracheostomy = T
	Confused	4											
	Inapp. words	3											
	Incomp. sounds	2											
	None	1											
Best motor response	Obeys	6											Usually record the best arm response
	Localises	5											
	Flexion to pain	4											
	Abnormal flexion	3											
	Extension to pain	2											
	None	1											
GCS TOTAL													
If a patient's GCS FALLS by 2 or more CONTACT TEAM DOCTOR													
PUPILS	R	Size											s = sluggish + reacts - no reaction c eyes closed
	L	Reaction											
ARMS		Size											Record right (R) and left (L) separately if there is a difference between the two sides
		Reaction											
Limb Movement	ARMS	Normal power											
		Mild weakness											
	LEGS	Severe weakness											
		Extension											
	No response												
	Normal power												
	Mild weakness												
	Severe weakness												
	Extension												
	No response												



0	
1	Minimum 6 hourly observations
2	Minimum 4 hourly observations
3	<ul style="list-style-type: none"> Inform Registered Nurse who must assess the patient Consider Sepsis Screening Tool if appropriate Registered Nurse to consider checking blood glucose
4	<ul style="list-style-type: none"> Increased frequency of observations to a minimum of 1 hourly. Inform Registered Nurse who must assess the patient Registered Nurse to urgently inform the appropriate Nurse Practitioner/Team Doctor or Outreach Team for an urgent patient review and inform the Nurse in Charge. If there has been no response within 30 minutes, escalate further i.e. Registrar. Commence sepsis screening tool if not already done Consider Oxygen, IV access and bloods Consider 12 lead ECG Consider hourly fluid balance Consider checking blood glucose Clinical staff to consider ceiling of care and suitability for CPR
Total 5 or more Or 3 in one parameter	<ul style="list-style-type: none"> Continuous monitoring of vital signs: minimum of half hourly Inform Registered Nurse who must assess the patient Registered Nurse to immediately inform the appropriate Specialist Registrar, Nurse Practitioner/Team Doctor or Outreach Team for an immediate patient review and inform the Nurse in Charge. If there has been no response within 10 minutes, escalate further i.e. Registrar/Consultant. Commence sepsis screening tool if not already done Consider Oxygen therapy Ensure IV access and bloods Consider 12 lead ECG Consider escalation to a higher level of care Clinical staff to consider ceiling of care and suitability for CPR
Total 7 or more	

PAIN ASSESSMENT TOOL

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe Very Severe Worst Pain Possible

0 1-3 4-6 7-9 10

URINE ESCALATION MESSAGE

- Inform Registered Nurse in charge and:
- If low urine output (catheterised <30mls/hour for 6 consecutive hours or NO urine output >10 hours in un-catheterised patients) this may be AKI
- Inform medical team
- Ensure strict fluid balance chart and hourly urine measurements
- Consider a bladder scan +/- urinary catheter
- Ensure daily Urea and Electrolytes have been sent and result noted
- Ensure Trust AKI bundle is started/continued, check Urinalysis

S ituation	<ul style="list-style-type: none"> Who you are Where you are telephoning from The patient's name 	<ul style="list-style-type: none"> What is the main problem? (This is the most important aspect to attract the other person's attention immediately)
B ackground	<ul style="list-style-type: none"> Date of admission and diagnosis 	<ul style="list-style-type: none"> Relevant past medical history and treatment to date (It is imperative that this is brief, succinct and relevant)
A ssessment	<ul style="list-style-type: none"> State your assessment of the patient (For example, vital signs, national early warning score (NEWS), level of consciousness, acute confusion, medication, resuscitation status) 	
R ecommendation	<ul style="list-style-type: none"> Explain what you need Be specific about your request and the timeframe Ask if there is anything else you can do before the other staff member arrives Document the call including date, time and who you spoke to If you are worried and do not receive the response you need, you may need to escalate to a more senior clinician 	

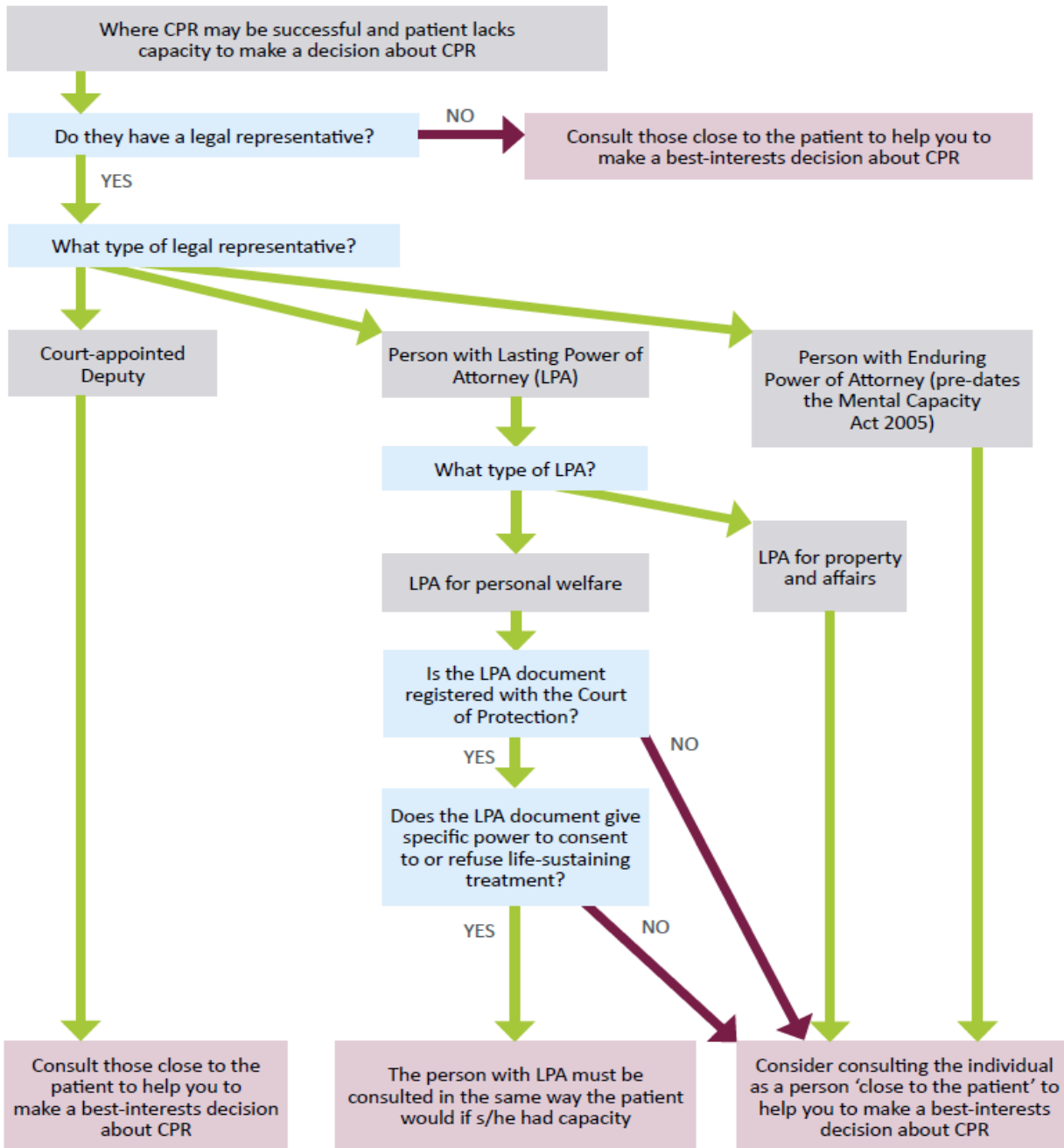
The National Patient Safety Agency (2007), National Institute of Clinical Excellence (2007)

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

APPENDIX 14 - DNACPR DECISION MAKING FRAMEWORK

Decision-making and legal representatives

ENGLAND & WALES



In all situations, where CPR will not work it should not be offered. This decision and the reasons for it should be explained carefully to those representing and those close to the patient. Where there is objection to or disagreement with this decision, a second opinion should be offered. The court may be asked to make a declaration if it is not possible to resolve the disagreement.

University Hospitals of North Midlands	North Staffordshire Combined Healthcare			
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION				
Adults aged 18 years and over				
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.				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1</td> <td style="width: 70%;"> Does the patient have capacity to make and communicate decision about CPR? If "YES" go to box 2. If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition?" "If YES" go to box 6. If "NO" has the patient appointed a Lasting Power of Attorney for Health and Welfare or an Independent Mental Capacity Advocate to make decisions on their behalf? If "YES" they must be consulted. All other decisions must be made in the patient's best interests and comply with current law. Please refer to the DNACPR Guidelines. Go to box 2. </td> <td style="width: 25%; text-align: center;"> <input type="text" value="YES / NO"/> <input type="text" value="YES / NO"/> <input type="text" value="YES / NO"/> </td> </tr> </table>		1	Does the patient have capacity to make and communicate decision about CPR? If "YES" go to box 2. If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition?" "If YES" go to box 6. If "NO" has the patient appointed a Lasting Power of Attorney for Health and Welfare or an Independent Mental Capacity Advocate to make decisions on their behalf? If "YES" they must be consulted. All other decisions must be made in the patient's best interests and comply with current law. Please refer to the DNACPR Guidelines. Go to box 2.	<input type="text" value="YES / NO"/> <input type="text" value="YES / NO"/> <input type="text" value="YES / NO"/>
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<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">2</td> <td style="width: 95%;"> Summary of the main clinical problems and reasons why CPR would be inappropriate, Unsuccessful or not in the patient's best interests: </td> </tr> </table>		2	Summary of the main clinical problems and reasons why CPR would be inappropriate, Unsuccessful or not in the patient's best interests: 	
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<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">3</td> <td style="width: 95%;"> Summary of communication with patient (or Lasting Power of Attorney for Health and Welfare or IMCA). If this decision has not been discussed with the patient (or Lasting Power of Attorney for Health and Welfare or IMCA). Please state the reason why: </td> </tr> </table>		3	Summary of communication with patient (or Lasting Power of Attorney for Health and Welfare or IMCA). If this decision has not been discussed with the patient (or Lasting Power of Attorney for Health and Welfare or IMCA). Please state the reason why: 	
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<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">4</td> <td style="width: 95%;"> Summary of communication with patient's relatives of friends or reason why there has been no Discussion with them. </td> </tr> </table>		4	Summary of communication with patient's relatives of friends or reason why there has been no Discussion with them. 	
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<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">5</td> <td style="width: 95%;"> Names and designation of members of multidisciplinary team contributing to this decision: </td> </tr> </table>		5	Names and designation of members of multidisciplinary team contributing to this decision: 	
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<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">6</td> <td style="width: 95%;"> Healthcare professional completing this DNACPR order: Name _____ Position _____ Signature _____ Date _____ Time _____ </td> </tr> </table>		6	Healthcare professional completing this DNACPR order: Name _____ Position _____ Signature _____ Date _____ Time _____	
6	Healthcare professional completing this DNACPR order: Name _____ Position _____ Signature _____ Date _____ Time _____			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">7</td> <td style="width: 95%;"> Review and endorsement by regular senior healthcare professional Signature _____ Date _____ Time _____ <div style="border: 1px solid black; width: 100px; height: 15px; margin: 5px auto;">Further review date where appropriate</div> Signature _____ Date _____ Time _____ Signature _____ Date _____ Time _____ </td> </tr> </table>		7	Review and endorsement by regular senior healthcare professional Signature _____ Date _____ Time _____ <div style="border: 1px solid black; width: 100px; height: 15px; margin: 5px auto;">Further review date where appropriate</div> Signature _____ Date _____ Time _____ Signature _____ Date _____ Time _____	
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NSH9079				

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 18 years and over

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 Does the patient have capacity to make and communicate decision about CPR?

If "YES" go to box 2. YES / NO

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? "If YES" go to box 6. YES / NO

If "NO" has the patient appointed a Lasting Power of Attorney for Health and Welfare or an Independent Mental Capacity Advocate to make decisions on their behalf? If "YES" they must be consulted. All other decisions must be made in the patient's best interests and comply with current law. Please refer to the DNACPR Guidelines. YES / NO

Go to box 2.

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

3 Summary of communication with patient (or Lasting Power of Attorney for Health and Welfare or IMCA). If this decision has not been discussed with the patient (or Lasting Power of Attorney for Health and Welfare or IMCA). Please state the reason why:

4 Summary of communication with patient's relatives or friends or reason why there has been no Discussion with them.

5 Names and designation of members of multidisciplinary team contributing to this decision:

6 Healthcare professional completing this DNACPR order:

Name _____ Position _____

Signature _____ Date _____ Time _____

7 Review and endorsement by regular senior healthcare professional

Signature _____ Date _____ Time _____

Further review date where appropriate

Signature _____ Date _____ Time _____

Signature _____ Date _____ Time _____

FOR HOSPITAL RECORDS ONLY

Standard Operating Procedure (SOP)

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) (C09) November 2018, Version 2



The purpose of this SOP is to ensure all UHNM staff working in adult areas understand the new **DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION** documentation

This SOP links to Trust Policy C09.

For patients admitted from home with a Community DNACPR order the resuscitation status must be reviewed at the first Consultant review.

Note: The Community DNACPR remains valid until a Consultant review is completed.

The Trust carbonated DNACPR document (Appendix 1) must be completed when a DNACPR decision has been made.

If stickers are used to populate the demographic section please ensure one is used on each sheet.

Boxes 1-5 on the document must be filled out appropriately

Box 2-5 on the document must be completed unless the patient has a valid Advanced Directive

Reviews should be undertaken regularly or if condition changes and documented in accordance with the decision process and Policy C09

No.	Description of Procedural Steps
1	Box 1. Further information can be found in Registrar or above Policy C09 Resuscitation Policy Registrar or above
2	Box 2. Summary of the main clinical problems and reasons for the decision must be documented in Box 2. This must be a stand-alone statement that clearly explains why a decision has been made as this will be the only information available once the patient has been discharged. Additional information should be documented in the clinical notes. Registrar or above
3	Box 3. If the patient has not been involved in the decision making process the precise reason as to why they have not been involved must be documented in Box 3. Additional information should be documented in the clinical notes. Registrar or above
4	Box 4. Communication with Family or friends: document names and relationship to patient on the form and in the clinical notes. Registrar or above
5	Box 5. Document details of staff involved the decision making process. Continue documentation in the clinical notes if necessary Registrar or above
6	Box 6. If the person completing Box 6 is NOT the Consultant, the person completing this section must print all of their details requested in box 6. The Consultant must then endorse by completing box 7. Registrar or above
7	Box 7. If the decision has been made by the Consultant, they should complete box 7 as soon as possible after the decision has been made. Consultant only
8	Once the DNACPR form has been completed the Red bordered DNACPR document must be placed prominently in the front of the patients medical notes. The Red bordered copy is the patient copy and must travel with the patient on discharge. Consultant only
9	The patient's DNACPR status should be communicated at handover and when a patient is transferred. Medical/Nursing Staff

No.	Description of Procedural Steps
10	<p>The Grey bordered DNACPR document must be placed in the medical notes at the chronological point the decision was made.</p> <p>The Grey bordered copy is the hospital file copy and remains within the notes on discharge.</p> <p>Nursing Staff</p>
11	<p>If the DNACPR order is rescinded, the decision must be documented in the notes. The DNACPR proforma is to be removed from the medical notes and destroyed. Nursing staff to update nursing records and inform nursing staff.</p> <p>Medical/Nursing Staff</p>
12	<p>If the patient is discharged from Hospital the Red Bordered form is removed from the notes and a scanned copy should be Emailed to the GP.</p> <p>The original copy is to be given to the patient/carers or shown to the Ambulance crew if being discharged/transferred via ambulance.</p> <p>Patient / carers should be advised to keep the form in a safe prominent place at home.</p> <p>Patient /carers should be advised to make any Health care professionals aware of the form and to bring it with them if re-admitted.</p> <p>Nursing Staff</p>

APPENDIX 17 - MINI MCA FORM

(to support Do Not Attempt Cardio-pulmonary Resuscitation decision)

Name of Patient:		
Unit Number:		
I believe that the patient has an impairment of, or a disturbance in the functioning of the mind or brain , which may affect their ability to make this decision. This is due to or appears to be due to:		
Under each heading please select either Yes or No and record a brief rationale.		
In relation to the decision around Do Not Attempt Cardio-pulmonary Resuscitation, the person was able to:-		
1. Understand the information relevant to the decision.		
Does the person have a general understanding of the decision they need to make and why they need to make it? (Including the reasonable foreseeable consequences of deciding one way or another, or of failing to make the decision).		
Yes :	No :	Please circle one.
2. Retain the information long enough to make a decision.		
(The fact that a person is able to retain the information for a short period only does not prevent them from being regarded as able to make the decision).		
Yes:	No:	Please circle one.
3. Use or weigh the information to make a decision.		
(Degree of awareness and insight, evidence of reasoning processes).		
Yes:	No:	Please circle one.
4. Communicate the decision.		
(To produce a response, not necessarily verbal, that indicates choice, in any way recognised by the assessor).		
Yes:	No:	Please circle one.
Has the person been assessed as lacking capacity for this decision? Yes No		
Please circle one.		
Clinician Name:		Date:
Clinician Signature:		

APPENDIX 18 - The Child and Young Persons Advance Care Plan

The Child and Young Persons Advance Care Plan (Purple Pages) to record the decision making about attempting Cardiopulmonary Resuscitation is to be used for documentation. This can be found via the intranet.

http://uhns/media/488239/141008%206b_ACP_Policy_2012.14-29.pdf

FOI REF 044-1920