# Resuscitation Policy

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<th>Document Title</th>
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<tr>
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<td>NTW(C)01</td>
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<tr>
<td>Lead Officer</td>
<td>Medical Director</td>
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<td>Dr Claud Regnard - Consultant in Palliative Care Medicine, Dorothy Matthews - Macmillan Clinical Nurse Specialist Palliative Care, Dennis Davison - Service Manager, Kevin Crompton - Senior Clinical Trainer, Lynn Gibson - Physiotherapist Manager</td>
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## Review and Amendment Log

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<td>Apr 15</td>
<td>Reviewed documentation updated accordingly within section 1-11, 13, 15-16, 18-20, 22-23, 26; Standard Appendices A, B and C; Apps 5a and 5g</td>
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1 INTRODUCTION

1.1 The purpose of this policy is to provide clear guidance on emergency medical response for all staff within Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW).

2 PURPOSE

2.1 This policy will ensure that all staff are trained and regularly updated to achieve a level of clinical skills relating to resuscitation relevant to role and job description. The policy is designed to ensure a robust infrastructure across the Trust in response to medical emergencies and as such has implications with respect to Duty of Care, Training, Standards of Care, Risk Assessment and Clinical Governance.

3 DUTIES AND RESPONSIBILITIES

3.1 The Chief Executive on behalf of the Trust retains ultimate accountability for the health, safety and welfare of all service users, carers, staff and visitors; however key tasks and responsibilities will be delegated to individuals in accordance with the content of this policy.

3.2 Medical Director and Executive Director of Nursing and Operations are required to:-

- Ensure that all Medical and Nursing staff are aware of this policy and other policies and guidance which relate to this policy
- Ensure that adequate training is given to allow medical and nursing staff to implement this policy safely
- To inform Senior Management if the policy is not being implemented or adhered to in service areas / within the Trust

3.3 All staff are required to:-

- Ensure that they are aware of the content of this policy and supporting policies
- Ensure that they attend the appropriate level of training for their staff group on a yearly basis
- Ensure that they abide by there governing bodies professional code of practice at all times
4 Abbreviations used within this policy

- Basic Life Support (BLS)
- Immediate Life Support (ILS)
- Safety and Sustainability of Medical Devices and Resuscitation Medical Devices Group (SSMDRG)
- The Medicines Management Committee (MMC)
- Physical Health and Wellbeing Group (PHWG)
- Prevention and Management of Violence and Aggression (PMVA)
- Resuscitation Council UK (RCUK)
- Automated External Defibrillators (AED)
- Electro Convulsive Therapy (ECT)
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
- Deciding Right (DR)

5 STANDARDISATION OF EQUIPMENT

5.1 All resuscitation equipment will reflect Resuscitation Council UK 2010 Guidelines and be standardised across the Trust.

5.2 The choice of all emergency equipment will be decided upon by the SSMDRG.

5.3 All Immediate Life Support (ILS) emergency resuscitation equipment will be located within a red ‘grab bag’. Additional items such as AED, Suction unit, extra oxygen cylinder and pulse oximeter will be clearly located at designated areas to enable effective and timely response as and when required.

5.4 All Grab Bags should contain the following equipment: Airways, Oxygen cylinder, Non-re-breathe Oxygen mask, Bag-valve-mask.

5.5 All AED’s will have standardised generic features that include:

- Automated function
- Voice prompted actions
- Biphasic shock administration
- Shock sequence in line with Resuscitation Guidance 2010

5.6 The following AED support equipment: scissors, razor, spare electrodes pads, spare battery and manual will also be checked on a daily basis.

- Please Note:
  - The Phillips FR2 AED units will contain this equipment within the AED case
  - The Cardiac Science G3 units will have the support equipment located in the Grab-Bag
5.7 Frequency of Checks

5.7.1 AED units will be checked for effective charging on a daily basis

5.7.2 Grab Bag content (including adrenaline auto-injector) will be checked weekly. Please refer to the Trust’s NTW(C)38 Pharmacological Therapy Policy, practice guidance note – PPT-PGN-13 – Acute Management of Anaphylaxis

5.7.3 Pulse Oximeters will be checked on a daily basis

5.7.4 All suction equipment will be checked on a daily basis

5.7.5 All ILS equipment must be in good working order, have a valid expiry date, therefore all items must be checked as indicated and immediately replenished following an incident / use.

5.7.6 The Ward Manager or designated person is responsible for ensuring checks are undertaken and the appropriate documentation is complete

5.7.7 The Ward Manager or delegated other will also ensure that all staff have a clear understanding of the equipment contained within the grab bag and how to use it.

5.7.8 Qualified staff will be responsible for undertaking the check; they should use this as an opportunity to promote awareness of the equipment for their support worker colleagues

5.7.9 All resuscitation equipment checks must be completed using the identified check list documentation (see Appendices 5a-5g - Resuscitation Equipment check list).

5.7.10 Please Note: some services, for example ECT may have additional equipment due to service need/speciality. It is the responsibility of the local managers to ensure that all additional equipment / medication are checked in accordance with Appendices 5a-5g and as per Trust’s NTW(C)17 Medicines Management Policy.

5.8 Location of Equipment

5.8.1 Via the SSMDRG and PHWG, the Trust will identify and prioritise the location of Automated External Defibrillators (AED) Trustwide, taking into consideration:

- Specialist treatment departments such as Electro Convulsive Therapy (ECT)
- Inpatient services where there is a potential for physical interventions or rapid tranquillisation and seclusion
- Locally identified medical risk factors
- Area of high volumes of ‘throughput’ of people
5.8.2 It is the responsibility of the Ward Manager to ensure that the location of equipment is clearly displayed, all staff are familiar with the location of equipment and that it is accessible at all times.

5.9 **ECT Departments**

5.9.1 Anaesthetists will be the only designated staff to operate manual defibrillators situated within ECT Departments as part of the service level agreement in conjunction with ECT delivery.

5.9.2 All NTW staff involved in ECT will be trained to ILS level and have access to AED equipment, only staff trained in the use of manual defibrillators should operate them.

5.10 **Trust Locations with Crash Team Support from Acute Hospitals**

5.10.1 In specific designated sites within the Trust there are some units/wards that have access and support from Acute Hospitals Crash Team, these areas will have a locally developed process to summons the Team, this is usually by dialling 2222 Crash Team Response system. In this case the AED will be different from those allocated within the Trust; the AED units will have ECG screens and Manual override facility, these will only be utilised by the crash team.

5.11 **Checking of the Crash Trolley Equipment (Only Applicable to certain areas)**

5.11.1 In specific designated areas that access the crash team which utilise a ‘Crash Trolley’, the nurse in charge within the respective NTW ward/department will be responsible to maintain checks, reorder equipment and identify any problems.

5.11.2 Staff will use the acute hospital paperwork for crash trolley checks.

5.11.3 If required Trust staff can receive training to maintain crash trolley checks directed by the Acute Hospital Resuscitation Officer

5.12 **Equipment Safety**

5.12.1 All electrical equipment will be checked prior to distribution as recommended by the Trust wide Resuscitation and Medical Devices Group and as per requirements of the Trust policies, NTW(O)20 - Health and Safety and NTW(C)21 – Medical Devices.

5.12.2 If staff notice equipment is damaged or has not been PAT tested they should liaise with the Estates manager and remove the item from use until it is safe to use, replacement equipment should be identified via Clinical Nurse Manager as required to maintain safe delivery of service in relation to ILS.
5.13 Emergency Drugs

15.3.1 The MMC and SSMDRG will decide upon emergency drug choice and standardisation across the Trust. The only drug currently designated as an emergency drug is adrenaline 1 in 1000 for anaphylaxis. This will be available as pre-filled Adrenaline Auto Injector in all grab bags. Please see NTW(C)38, practice guidance note – PPT-PGN 13 Acute Management of Anaphylaxis. All medication previously identified as emergency drugs will be kept as standard ward stock and managed in the usual manner (see NTW(C)17 - Medicines Policy).

15.3.2 In areas that utilise orange emergency boxes, local procedures must satisfy the NTW(C)17 - Medicines Policy.

6 TRAINING

6.1 The Trust will ensure that all staff has access to appropriate levels of training, it is the responsibility of each Group Director to ensure staff attend. Levels of training are identified in the training needs analysis available on the Trust Intranet page under the Training link. Training needs should be identified during annual Joint Development and Review (JDR): refer to the Trust's policy NTW(HR)09 – Staff Appraisal (non-medical) which includes Practice Guidance Notes (PGNs).

6.2 All training will be ratified through the SMDRG.

6.3 The SSMDRG will provide lead advice and support.

6.4 All training provision will reflect National Guidelines and Resuscitation Council UK 2010.

6.5 Trust staff will undergo regular resuscitation and medical emergency response training to a level compatible with their clinical responsibilities, expected roles and experiences.

6.6 All staff will be able to access the emergency services using the indicated medical emergency number system: 9-999 ‘blue light’ paramedic service or 2222 Crash Team response.

6.7 The following resuscitation training structure will be available within NTW training programme:

- Medical emergency response awareness through Trust/local induction
- Basic Life Support (BLS) Adult
- Basic Life Support (BLS) Infant/Child
- Immediate Life Support (ILS) Adult
- Immediate Life Support (ILS) Child

6.8 There will also be unit/service user specific sessions available that combine the above such as Adult ILS with Infant/Child components.

6.9 Basic Life Support (BLS) and Immediate Life Support (ILS) training requires annual updates.
6.10 It is mandatory for all medical staff to attend CPR at ILS level.

6.11 All medics on rotation into NTW Trust will have the medical emergency response covered within their induction process.

6.12 Although NTW does recognise prior learning of medics within RCUK resuscitation training programme, it is mandatory for them to attend an ILS update session to familiarise them with NTW equipment and medical emergency response.

6.13 It is mandatory for all nursing staff to attend BLS training as a minimum on an annual basis.

6.14 All nursing staff working within inpatient services where physical intervention, rapid tranquillisation and seclusion could potentially be used must be trained to ILS level as part of their PMVA training. This will also include dangers of physical intervention/positional asphyxia and medical risk factors such as: Compartment syndrome, Sickle Cell Anaemia, pregnancy and relevant underlying medical conditions and drug use. PMVA training will also include use of pulse oximetry.

6.15 All nursing staff involved with Electro-Convulsive Therapy (ECT) will be trained in ILS on a 6 monthly basis. The Trust will at all times aim to reflect the National Electro-convulsive therapy accreditation standards (NECTAS).

6.16 All nursing staff working in areas that have known; associated or potential medical risk factors will access training at ILS level.

6.17 All qualified staff involved in the potential use of rapid tranquillisation will adhere to the Trust policy, NTW(C)02 - Management of Rapid Tranquillisation and receive appropriate training.

6.18 The medical emergency number and procedures will be outlined during all resuscitation training sessions.

6.19 The medical emergency procedure and equipment location will be outlined in all local ward or department induction.

6.20 All flu vaccinators will receive annual updates in CPR (ILS), Anaphylaxis and specific vaccination training.

6.21 Training records will be kept using both hard copy and computer based formats. Paper based records will include:

- Course attendance
- Contents
- Standards
- Outcomes
- Assessment
- Evaluation (electronic)
6.22 Staff can identify training details by using the training matrix located on the Trust intranet on the Training link below

6.23 Levels of training are identified in the training needs analysis and are included within the Training Guide which can be accessed via this link

http://nww1.ntw.nhs.uk/services/index.php?id=3796&p=2780

7. DECISION MAKING

7.1 The Department of Health states:

“It is a general legal and ethical principle that valid consent must be obtained before starting treatment, physical investigation or providing personal care” (DOH).

7.2 All patients/clients have a right to receive accurate information about their condition and intended treatment. It is the responsibility of individual practitioner proposing to carry out the treatment to ensure that the patient/client understands what is proposed (NMC 2002).

7.3 This policy also reflects principles under the Human Rights Act 1998 with particular reference to:

- Article 5: The right to liberty and security of person
- Article 8: The right to privacy
- Article 10: Confidentiality

7.4 The term “consent” refers to the service user’s agreement for a health professional to provide care, or agreement to participate in education or research. Service users may indicate consent non-verbally, orally or in writing. Consent will need to be gained for the procedure, research and any educational/supervisory purpose.

7.5 For the consent to be valid the service user must have capacity to make that particular decision. The Mental Capacity Act 2005 details assessment of capacity and best interest decisions. The service user should firstly be assumed as having capacity to make decisions if the person’s capacity is in question an assessment must be carried out and documented. A person is unable to make a decision for themselves if they are unable to:

- Understand the information relevant to the decision
- Retain that information
- Use or weigh that information as part of the process of making the decision
- Communicate their decision (whether by talking, using sign language or any other means).
If a person does not have the capacity to consent to this procedure a ‘best interests’ decision must be made by the person carrying out the procedure. This must consider any advanced decision or advanced statement made by the person. Any decision must be in the best interests of the service user and follow the principles of the least restrictive option possible. Best interest decision must also be documented. For further advice on consent/capacity please consult the Trust policy, NTW(C) 05 - Consent to Examination or Treatment.

8. DECISIONS RELATING TO RESUSCITATION

- The Trust will adopt the principles of the 2014 guidelines from the British Medical Association, Resuscitation Council and Royal College of Nursing: October 2014

8.1 Decisions about CPR must be made on the basis of an individual assessment of each patient’s case and documented evidence of best interests / DNACPR must be available, in the absence of any DNACPR documents the patient must receive CPR to preserve life as outlined in Professional Governing Bodies Guidance. It is not the sole decision of the responder either not to commence CPR or to end CPR they must commence and continue CPR until guidance / support is received from emergency services.

8.2 Advance care planning, including making decisions about CPR, is an important part of good clinical care for those at risk of cardiorespiratory arrest.

8.3 Communication and the provision of information are essential parts of good quality care.

8.4 It is not necessary to initiate discussion about CPR with patients if there is no reason to believe that a patient is likely to suffer a cardiorespiratory arrest.

8.5 Where no explicit decision has been made in advance there should be an initial presumption in favour of CPR.

8.6 Where the expected benefit of attempted CPR may be outweighed by the burdens, the patient’s informed views are of paramount importance. If the patient lacks capacity those close to the patient should be involved in discussions to explore the patient’s wishes, feelings, beliefs and values using the Best Interests process of the Mental Capacity Act.

8.7 If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision refusing CPR, this should be respected.

8.8 A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision does not override clinical judgement in the unlikely event of a reversible cause of the patient’s respiratory or cardiac arrest that does not match the circumstances envisaged.

8.9 DNAR decisions apply only to CPR and not to any other aspects of treatment.
DECISION MAKING PROCESS


"All DNACPR forms can be accessed via the following link; the original version should be used as photocopies cannot be accepted by NEAS"
http://www.nescn.nhs.uk/common-themes/deciding-right/regional-forms/

9.1 Consequences of the new guidelines:
- A professional’s view of quality of life must not be used in making CPR decisions
- Teams or departments should not be assessing CPR status in all patients
- The only patients who should be asked to consent for CPR are those who have the capacity for this decision and in whom a cardiac or respiratory arrest is anticipated and in whom CPR could be successful
- In the absence of a CPR decision, there is an initial presumption in favour of CPR.
- A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) does not override clinical judgement if the health professional believes the arrest is from reversible causes. However, for this to work, the circumstances of the anticipated arrest must be clearly documented
- A bedside assessment of the circumstances is essential, even if a CPR decision is in place and regardless of whether it is for CPR or DNACPR. Putting CPR decisions in place to avoid such an assessment is no longer appropriate
- If an arrest is anticipated and CPR could be successful the patient must be asked for consent regarding CPR. If the patient wants this, CPR must be given in the event of an arrest even if the clinical team believe the burdens will outweigh the benefits

9.2 Decisions Relating to CPR Issues for Consideration: Children and Young People
- The advice on CPR decisions in Section 9 applies to children and adults. In addition:
  - In England, Wales and Northern Ireland, consent to from a person with parental responsibility or a court may override a competent young service user's decision
  - Where there is serious disagreement between the family and health team, legal advice should be sought.
  - In Scotland it is likely that neither parents nor the courts are entitled to override a competent young person’s refusal of treatment
10 COMMUNICATION WITH THE SERVICE USER

10.1 Obtaining consent about CPR is a very different process to effective communication. Only a small minority of Trust patients will have consented for CPR (see Section 9), but all should receive effective communication, which may include a discussion about CPR if this is what they wish. This may arise as part of the general discussion regarding service user’s care, however, information should not be forced on an unwilling recipient or if they indicate that they do not wish to discuss such an issue.

10.2 Discussions regarding the advisability or otherwise of attempting CPR are highly sensitive, individualised and complex and should be undertaken by senior, experienced members of the medical team, supported by the senior member of the nursing team.

11 INFORMATION PROVIDED TO SERVICE USERS

11.1 Written information regarding resuscitation policies should be included in general literature provided within healthcare establishments. The purpose is to demystify the process by which decisions are made and should be seen as part of advance care planning. Such information should reassure the service user of their part in the decision making process and should make it clear that for most service users, the question may not arise. Such information must be handled sensitively with an appreciation of the individual’s health status and capacity to understand.

11.2 The Trust will adopt the principles of the Planning for Your Future Care - A Guide EOLC Programme (2009). It will be the responsibility of the senior nurse or lead practitioner to order and locate this information within their respective areas.

11.3 The views of all members of the medical and nursing team including those involved in the service user’s primary care and people close to the service user are valuable in forming the decision. In all cases, there must be due regard to service user confidentiality. Once made, all decisions must be communicated effectively to the relevant professional.

11.4 Involving the individual with capacity is the default when making CPR decisions. This applies even if CPR cannot work. However, this information must be delivered as part of a shared dialogue over time. For individuals who lack capacity for this decision, their opinion and that of any parent, partner or family are key to the Mental Capacity Act best interest process.

12 RESPONSIBILITY FOR DECISION MAKING

12.1 In an adult without capacity for CPR decisions, the overall responsibility for decision-making in relation to CPR and DNACPR orders rests with the Consultant or GP in charge of the service user’s care. He or she should be prepared always to discuss the decisions for an individual with other healthcare professionals involved in the service user’s care. The importance of teamwork and good communication is paramount at all times and must reflect the service user’s wishes. Where care is shared such as between hospital and general practice, the doctors involved should discuss the issue with each other, and with other members of the healthcare team.
12.2 Healthcare professionals must use their best judgement bearing in mind the clinical condition of the individual service user. Such decisions must be based on reliable up-to-date clinical guidelines.

12.3 Any decision must be made on an individual service user basis and reflect the Human Rights Act.

13. INVOLVING RELATIVES

13.1 Subject to the wishes of the service user who has the right to confidentiality, medical staff will take reasonable steps to inform partners or relatives when decisions to not resuscitate are contemplated or have been made. In the case of children, the parents would be part of the decision-making process.

13.2 Doctors have the authority to act in their service user’s best interest where consent is unavailable. Unless to do so would be contrary to the service user’s interest, people close to the service user should be kept informed about the service user’s health and be involved in the decision making in order to reflect the service user’s views and preferences. It should be made clear that their role is not to make decisions on behalf of the service user. Relatives and others close to the service user should be assured that their views on what the service user would want will be taken into account in the decision-making, but they cannot insist on treatment or non-treatment.

13.3 The Mental Capacity Act requires a specific process to decide a person’s best interests:

- **Appoint a decision maker** (usually after an interdisciplinary team discussion) who should consider the following **as a minimum**:
  
  - Is an IMCA needed for a person aged 16yrs or more? If there is no one who knows the individual well, you must consider instructing an Independent Mental Capacity Advocate (IMCA) and receive a report from an IMCA. However this must not delay urgent treatment
  
  - Have you avoided making assumptions merely on the basis of the individual’s age, appearance, condition or behaviour?
  
  - Have you identified all the things the individual would have taken into account when making the decisions for them? Consider that the individual may have a ADRT or Advance Care Plan made when they had capacity
  
  - Have you considered if the individual is likely to have capacity at some date in the future and if the decision can be delayed until that time?
  
  - Have you done whatever is possible to permit and encourage the individual to take part in making the decision?
o Where the decision relates to life sustaining treatment, have you ensured that the decision has not been motivated in any way by a desire to bring about their death?

o Has consideration been given to the least restrictive options for the individuals including restricting their rights?

o Consult others (within the limits of confidentiality) this may include an LPA, IMCA or Court Appointed Deputy as well as factors such as emotional bonds, family obligations that the person would be likely to consider if they were making the decision?

o Having considered all the relevant circumstances, weigh up all factors in order to inform the decision/action to be taken in the best interests of the individual

14. CONFIRMATION BY CONSULTANT

14.1 The decision to not attempt resuscitation will be discussed at the next available opportunity with the Consultant or GP in charge of the service user’s care. Once again, the aim is to make decisions in advance and where this has not occurred, there will be an initial presumption in favour of resuscitation

15. DOCUMENTATION OF DECISION NOT TO ATTEMPT RESUSCITATION : (DNACPR)

15.1 This will be recorded on the DNACPR form developed within the Deciding Right regional guidance which has been adopted by NTW.

15.2 The forms within the link:

http://www.nescn.nhs.uk/common-themes/deciding-right/regional-forms/

cannot be photocopied and the original document must always stay with the patient irrespective of their care setting.

15.3 In addition to completing the DNACPR decision document, the details of the proposed plan in the event of a cardiac arrest will be written within service user’s notes (paper or electronic record) along with reasons that led to the decision. In addition, a record of contact with and the explanation given to relatives will also be made within the notes. The nurses must be kept informed of all decisions and ensure that the decisions made are recorded accordingly.
16. **TIME LIMITATIONS OF DECISIONS NOT TO ATTEMPT RESUSCITATION**

16.1 The DNACPR decision will usually only apply for a specific period and **must** be reviewed:

- To reflect change in condition
- On change in care setting
- Within 12 months if not reviewed earlier

Review of the decision will not be needed when death is seen as inevitable

17. **CHANGING CIRCUMSTANCES**

17.1 A significant change in a service user’s condition will prompt a review of the planned use of CPR. Also, other circumstances i.e. invasive procedures, anaesthesia or surgery may require that treatment, including CPR can be given. Any changes to status or within the decision-making process may require a review of the CPR decision –


18 **COMMUNICATION TO THE NURSING TEAM**

18.1 It is very important that once a CPR decision has been made that this is effectively communicated to the nursing team.

18.2 The Consultant or GP in charge of the service user’s care making the decision will verbally inform the Nurse in Charge of the decision and make reference to the service user’s notes where the treatment plan is recorded and the status form completed.

18.3 The Nurse in Charge will be responsible for ensuring that all nurses caring for the service user are made aware of the decision. This could be communicated at handover time(s) with a suitable entry being made in the service user’s notes accordingly.

- **Please note** – if there is no DNACPR form or no evidence regarding a CPR decision the service user concerned will be resuscitated.

18.4 If there is any change in the resuscitation status then the same process will apply.
19 TRANSPORTATION OF THE SERVICE USER WITH DNACPR decision form

19.1 Staff organising transportation of those service users with a DNACPR order must follow the policy of the North East Ambulance Service (NEAS) on transportation (Appendix 4 – North East Ambulance Service NHS Trust - Do Not Attempt Resuscitation (DNAR) Patient Transport Policy. See link below for ‘Referral form’, which is linked to Northern England Strategic Clinical Networks – scroll down to NEAS and click on ‘NEAS Deciding right flag referral’

http://www.nescn.nhs.uk/common-themes/deciding-right/regional-forms/

20 IDENTIFICATION OF STAKEHOLDERS

20.1 This is an existing policy which has undergone an early review due to major changes that relate to operational and/or clinical practice and has therefore been circulated to the following for a two week consultation period

- Senior Management Team
- Local Negotiating Committee
- Consultant Psychiatrists
- Planned Care
- Specialist Service
- Urgent Care
- Psychological Services
- Clinical Governance and Medical Directorate
- Safeguarding
- Trust Allied Health Professions Service Steering Group
- Finance, IM&T, Estates and Performance
- Staff-side
- Trust Pharmacy
- Workforce
- Communications

21 EQUALITY AND DIVERSITY ASSESSMENT

21.1 In conjunction with the Trust’s Equality and Diversity Officer this policy has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner. (See Appendix A)
22 IMPLEMENTATION

22.1 This will be implemented immediately and monitored by the SSMDRG for quality and safety during the review process. If at any stage there is an indication that the target date cannot be met, then the SSMDRG will consider the implementation of an action plan.

23 MONITORING COMPLIANCE – Please see Appendix C

23.1 The Resuscitation Council guidance states that each hospital will have a Resuscitation Committee that meets on a regular basis. The Trust wide SSMDRG will take on this role within this Trust. The person taking the lead for resuscitation on behalf of the group will be the identified lead trainer for Cardiopulmonary Resuscitation (CPR) who will provide advice as required.

23.2 The SSMDRG will provide the Quality and Performance Committee with assurances in the following areas:

- Developing and maintaining standards
- Ensuring policies and procedures are in place and communicated to the relevant people
- Establishing clear lines of accountability in the procurement and maintenance of equipment
- Ensuring an appropriate programme of training is in place for relevant staff
- Monitoring the implementation of relevant NICE guidelines
- Ensuring appropriate actions occur in response to alerts
- Reviewing significant incidents reported via the NTW(O)05 – Incident Policy and ensuring appropriate action is taken
- Decontamination of Medical Devices

23.3 The SSMDRG membership will include representation from the Board of Directors as Chair of the group and will include as well as medical, nursing, pharmacy, practice development, training, clinical risk, patient safety/health and safety representatives as well as Trustwide representation that reflect specialist fields.

23.4 Monitoring and reviewing of training will be done in line with the Resuscitation Council National Guidelines.

24 FAIR BLAME

24.1 The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse incidents, although there may be clearly defined occasions where disciplinary action will be taken.
ASSOCIATED DOCUMENTATION

NTW(C)02 Management of Rapid Tranquillisation Policy
NTW(C)10 Seclusion Policy
NTW(C)16 Recognition, Prevention and Management of Aggression and Violence Policy
NTW(C)17 Medicine Management Policy
NTW(C)21 Medical Devices Policy and Practice Guidance Notes
NTW(C)23 Infection, Prevention and Control Policy; Practice Guidance Notes
NTW(C)38 Pharmacological Therapy Policy, practice guidance note
   o PPT-PGN-13 – Acute Management of Anaphylaxis

NTW(O)01 Development and Management of Procedural Documents Policy
NTW(O)05 Incident Reporting Policy
NTW(O)20 Health and Safety Policy, Practice Guidance Notes

NTW(HR)09 Staff Appraisal Policy

REFERENCES

1. British Medical Association, Resuscitation Council, Royal College of Nursing, 2014 Decisions Relating to Cardio-Pulmonary Resuscitation; A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (In press as of 29 Sep 2014)


3. British Medical Association Medical Ethics Department: www.bme.org.uk


11. Royal College of Nursing. [www.rcn.org.uk](http://www.rcn.org.uk)
# Equality Analysis Screening Toolkit

<table>
<thead>
<tr>
<th>Names of Individuals involved in Review</th>
<th>Date of Initial Screening</th>
<th>Review Date</th>
<th>Service Area / Directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christopher Rowlands</td>
<td></td>
<td>2017</td>
<td>Trust wide</td>
</tr>
</tbody>
</table>

## Policy to be analysed

<table>
<thead>
<tr>
<th>Policy or Service to be Assessed</th>
<th>Is this policy new or existing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation – V03</td>
<td>Existing</td>
</tr>
</tbody>
</table>

### What are the intended outcomes of this work?

Include outline of objectives and function aims

The purpose of this policy is to provide clear guidance on emergency response for all staff.

### Who will be affected?

e.g. staff, service users, carers, wider public etc

**Staff, Service Users**

### Protected Characteristics under the Equality Act 2010.

The following characteristics have protection under the Act and therefore require further analysis of the potential impact that the policy may have upon them

- **Disability**: NA
- **Sex**: NA
- **Race**: NA
- **Age**: NA
- **Gender reassignment (including transgender)**: NA
- **Sexual orientation**: NA
- **Religion or belief**: NA
- **Marriage and Civil Partnership**: NA
- **Pregnancy and maternity**: NA
- **Carers**: NA
- **Other identified groups**: NA

### How have you engaged stakeholders in gathering evidence or testing the evidence available?

NA

### How have you engaged stakeholders in testing the policy or programme proposals?

NA
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

NA

**Summary of Analysis** Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

NA

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups. Where there is evidence, address each protected characteristic.

<table>
<thead>
<tr>
<th>Eliminate discrimination, harassment and victimisation</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance equality of opportunity</td>
<td>NA</td>
</tr>
<tr>
<td>Promote good relations between groups</td>
<td>NA</td>
</tr>
<tr>
<td>What is the overall impact?</td>
<td>NA</td>
</tr>
<tr>
<td>Addressing the impact on equalities</td>
<td>NA</td>
</tr>
</tbody>
</table>

From the outcome of this Screening, have negative impacts been identified for any protected characteristics as defined by the Equality Act 2010?

If yes, has a Full Impact Assessment been recommended? If not, why not?

Manager's signature: Chris Rowlands Date: June 2014
## Communication and Training Check list for policies

### Key Questions for the accountable committees designing, reviewing or agreeing a new Trust policy

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this a new policy with new training requirements or a change to an existing policy?</td>
<td>Existing Policy</td>
</tr>
<tr>
<td>If it is a change to an existing policy are there changes to the existing model of training delivery? If yes specify below.</td>
<td>No change</td>
</tr>
<tr>
<td>Are the awareness/training needs required to deliver the changes by law, national or local standards or best practice?</td>
<td>National Guidance linked to Immediate Life Support</td>
</tr>
<tr>
<td>Please give specific evidence that identifies the training need, e.g. National Guidance, CQC, NHSLA etc.</td>
<td></td>
</tr>
<tr>
<td>Please identify the risks if training does not occur</td>
<td></td>
</tr>
<tr>
<td>Please specify which staff groups need to undertake this awareness/training. Please be specific. It may well be the case that certain groups will require different levels e.g. staff group A requires awareness and staff group B requires training.</td>
<td>As per Training Needs Analysis</td>
</tr>
<tr>
<td>Is there a staff group that should be prioritised for this training / awareness?</td>
<td>As per Training Needs Analysis</td>
</tr>
<tr>
<td>Please outline how the training will be delivered. Include who will deliver it and by what method.</td>
<td>Face to Face by specialist clinical trainers</td>
</tr>
<tr>
<td>The following may be useful to consider:</td>
<td></td>
</tr>
<tr>
<td>Team brief/e bulletin of summary</td>
<td></td>
</tr>
<tr>
<td>Management cascade</td>
<td></td>
</tr>
<tr>
<td>Newsletter/leaflets/payslip attachment</td>
<td></td>
</tr>
<tr>
<td>Focus groups for those concerned</td>
<td></td>
</tr>
<tr>
<td>Local Induction Training</td>
<td></td>
</tr>
<tr>
<td>Awareness sessions for those affected by the new policy</td>
<td></td>
</tr>
<tr>
<td>Local demonstrations of techniques/equipment with reference documentation</td>
<td></td>
</tr>
<tr>
<td>Staff Handbook Summary for easy reference</td>
<td></td>
</tr>
<tr>
<td>Taught Session</td>
<td></td>
</tr>
<tr>
<td>E Learning</td>
<td></td>
</tr>
<tr>
<td>Please identify a link person who will liaise with the training department to arrange details for the Trust Training Prospectus, Administration needs etc.</td>
<td>Kevin Crompton/Marc House</td>
</tr>
</tbody>
</table>
**Monitoring Tool**

**Statement**

The Trust is working towards effective clinical governance and governance systems. To demonstrate effective care delivery and compliance, policy authors are required to include how monitoring of this policy is linked to auditable standards/key performance indicators will be undertaken using this framework.

<table>
<thead>
<tr>
<th>Auditable Standard/Key Performance Indicators</th>
<th>Frequency/Method/Person Responsible</th>
<th>Where results and any associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward/department/unit can demonstrate that staff access Cardio-Pulmonary Resuscitation (CPR) training and this is compatible with the training level for their area as outlined in the Resuscitation Policy.</td>
<td>In line with individual JDR requirements, Team Managers will check Dashboards to ensure staff that they have responsibility for are appropriately trained.</td>
<td>Individual Supervision and Performance Management as per Trust Policy – NTW(HR)04 – Disciplinary. Gaps in compliance will be reported to core group quality and performance groups for development of action plan which will be monitored via the quality and performance core groups and the resuscitation and medical devices group.</td>
</tr>
<tr>
<td>Equipment is compatible with expected roles and this equates with the level identified in the Resuscitation Policy for their area.</td>
<td>Weekly checklist (App5a) completed by nominated qualified nurse via the Ward Manager.</td>
<td>Any concerns would be immediately managed and escalated through line management, if appropriate via Risk Register</td>
</tr>
<tr>
<td>All policy documentation is utilised, including: DNAR and resuscitation record forms in decisions relating to resuscitation</td>
<td>As required via a review of the clinical record by the Clinical Nurse manager</td>
<td>Monitored via individual supervision and Group Quality and Performance Committees</td>
</tr>
</tbody>
</table>

The Author(s) of each policy is required to complete this monitoring template and ensure that these results are taken to the appropriate Quality and Performance Governance Group in line with the frequency set out.