

Ref: FOI/GS/ID 3357

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20 April 2017

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to No Resus Orders (DNR) in 2011 – 2016.

- 1. How many No Resus Orders were issued by your hospital in last 5 years?*
- 2. How many of these patients survived and were thus discharged from your hospital in same above period?*
- 3. Have you a pro forma No Resus Order checklist which you use to see whether patient should be given No Resus Order, please send me a copy?*
- 4. What percentage of your SpR or Specialist Registrars are on the General Medical Council's Specialist Register?*

1. Maidstone and Tunbridge Wells NHS Trust does not store this information electronically. The Trust has estimated that it will cost more than the appropriate limit to consider this part of your request as each patient record would need to be checked individually. The appropriate limit is specified in regulations and represents the estimated cost of one person spending 3½ working days in determining whether the Trust holds the information, locating, retrieving and extracting the information. Under Section 12 of the Freedom of Information Act 2000 the Trust is not obliged to comply with this part of your request and we will not be processing this part of your request further. The Trust follows the same policy as the other Trusts in Kent both acute and non-acute, this was agreed in 2009.

2. Please see the above response.

3. Please see the following document:

Resuscitation Policy / Not For Attempted Cardiopulmonary Resuscitation Policy and Procedures

Requested/Required by:	Standards Committee
Main author:	Resuscitation Committee Chair Senior Resuscitation Officer Contact Details: Ext. 24450
Document lead:	Resuscitation Committee Chair
Directorate:	Critical Care
Speciality:	Theatres and Anaesthetics
Supersedes:	Resuscitation Policy / Not for Attempted Cardiopulmonary Resuscitation Policy (Version 4.0: October 2011 / Version 4.1: December 2013)
Approved by: 2014	Resuscitation Committee, 8 th September
Ratified by:	Standards Committee, 17 th October 2014
Review date:	September 2016 or sooner at times of significant change

Requirement for document:	<ul style="list-style-type: none"> • Resuscitation Council (UK) Guidance national Standard
Cross references:	<ol style="list-style-type: none"> 1. British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. (2007). <i>Decisions relating to cardiopulmonary resuscitation</i>. Available at: www.bma.org.uk 2. Mental Capacity Act 2005 3. Withholding and Withdrawing life-prolonging treatments: Good Practice in Decision Making – General Medical Council - August 2002/Revised 2007 4. Human Rights Act 1998 5. Sandroni C, Nolan J, Cavallaro F, Antonelli M. In-hospital cardiac arrest: incidence, prognosis and possible measures to improve survival. <i>Intensive Care Med</i> 2007;33:237-245. 6. Nolan JP, Laver SR, Welch CA, Harrison DA, Gupta V, Rowan K. Outcome following admission to UK intensive care units after cardiac arrest: a secondary analysis of the ICNARC Case Mix Programme Database. <i>Anaesthesia</i>. 2007;62(12):1207-16 7. Joint statement on decision related to cardiopulmonary resuscitation from RCN, BMA and Resuscitation Council (UK) 2007 8. GMC guide, Treatment and Care towards the end of life. May 2010 9. Ewer MS, Kish SK, Martin CG, Price KJ, Feeley TW. Characteristics of cardiac arrest in cancer patients as a predictor of survival after cardiopulmonary resuscitation. <i>Cancer</i>. 2001;92(7):1905-12. 10. Wallace SK, Ewer MS, Price KJ, Feeley TW. Outcome and cost implications of cardiopulmonary resuscitation in the medical intensive care unit of a comprehensive cancer center. <i>Support Care Cancer</i>. 2002 Jul;10(5):425-9. 11. Arawwawala D, Brett SJ. Clinical review: beyond immediate survival from resuscitation-long-term outcome considerations after cardiac arrest. <i>Crit Care</i>. 2007;11(6):235. 12. de Vos R; de Haes HCJM; Koster RW; de Haan RJ. Quality of Survival After Cardiopulmonary Resuscitation. <i>Arch Intern Med</i>. 1999;159:249-254 13. Resuscitation Council (UK). (2010). <i>Resuscitation Guidelines 2010</i>. Available at: www.resus.org.uk 14. Duties of a Doctor - Good Medical Practice (2006) GMC
Associated documents:	<ul style="list-style-type: none"> • Advanced Life Support 6th Edition revised January 2011 • Quality standards for cardiopulmonary resuscitation practice and training Acute Care Resuscitation Council (UK) November 2013 • Cardiopulmonary Resuscitation Standards for Clinical Practice and Training Resuscitation Council (UK) October 2004 updated June 2008 • Cardiopulmonary Resuscitation, Standards for Clinical Practice and Training, A joint statement from the RCA, RCP, ICS and RC (UK) Oct 2004. • Establishing a standard crash call telephone number in hospitals. <i>National Patient Safety Agency Alert</i>, February 2004. • European consensus guidelines on the management of neonatal respiratory distress syndrome. • A Framework for Clinical Practice at the time of Birth. British association of perinatal medicine, Oct 2008. • International guidelines 2000 – A Consensus on Science. <i>Resuscitation</i> 2000; 46:1-

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	<p><i>not attempt resuscitation (DNAR) decisions</i>'. Available at: www.resus.org.uk</p> <ul style="list-style-type: none"> • Resuscitation Council (UK). (2010). <i>The legal status of those who attempt Resuscitation</i>. Available at: www.resus.org.uk • Resuscitation Council (UK). (2011). <i>Immediate Life Support. (3rd edition)</i>. Available at: www.resus.org.uk • Resuscitation Council (UK). (2011). <i>Advanced Life Support (6th edition)</i>. Available at: www.resus.org.uk • Resuscitation Council (UK). (2008). <i>Standards for Clinical Practice and Training</i>. Available at: www.resus.org.uk • Maidstone and Tunbridge Wells NHS Trust. <i>Consent to Examination or Treatment, Policy and Procedure for [RWF-OPPPES-C-SM5]</i> • Maidstone and Tunbridge Wells NHS Trust. <i>Care of the Dying Policy and Procedure [RWF-OPPPCSS-C-CAN2]</i> • Maidstone and Tunbridge Wells NHS Trust. <i>Core Statutory & Mandatory Risk Management Training Matrix [RWF-OWP-APP526]</i>
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Version Control:		
Issue:	Description of changes:	Date:
1.0	Combined policies	Feb 2005
2.0	Policy revision and separation of procedures to conform to new Trust format.	May 2007
3.0	Policy Revision, linking policy to procedure and updating terminology	Nov 2009
3.1	Amendment to Appendix 4l and 4m (age applicable)	Nov 2009
3.2	Added Appendix 11 (Hypothermia Guidelines)	Apr 2010
4.0	Updated National Guidelines change of Hospital configuration	Oct 2011
4.1	No amendments - Standards Committee granted extension of review date	December 2013
5.0	Policy review and revision	September 2014

Policy statement for

Resuscitation Policy / Not For Attempted Cardiopulmonary Resuscitation Policy

- CPR is not appropriate in all patients who die in hospital.
- The default states all patients will be for resuscitation unless it is clearly documented otherwise.
- A patient's resuscitation status should be recorded on a Resuscitation Status form and this should be kept in the patient's active set of notes.
- Each Acute hospital has a Resuscitation Team who can be called using the national emergency number 2222.
- Standard national and international guidelines for the management of cardiopulmonary arrest (Including Peri & Post arrest) should be followed.
- An audit form must be completed by the team at each cardiac arrest and sent to the Resuscitation Office – compliance with this will be audited to maintain and enhance standards of care.
- Trust Resuscitation Officers are responsible for teaching and training resuscitation techniques.
- The Resuscitation Committee is responsible for resuscitation issues within the Trust and will report to the Trust Standards Committee.
- All Trust Staff with clinical patient contact should attend yearly Basic Life Support training sessions as specified on the training matrix. All clinical staff who are part of the Cardiac Arrest Team or who have the potential to be part of the Cardiac Arrest Team should have had Advanced Life Support training appropriate to their specialty.
- The Trust will facilitate specialist resuscitation training.
- The Trust has a leaflet 'Cardiopulmonary Arrest – Choices about resuscitation'. This is available on all wards, to inform patients and relatives about CPR and how decisions are made.

Resuscitation / Not For Attempted Cardiopulmonary Resuscitation Procedure

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1.0 Introduction and scope

These procedures set out the response to a clinical emergency and the statutory and mandatory training processes for all staff.

2.0 Definitions

The diagnosis of cardiac arrest is made if the adult patient or victim is unresponsive and not breathing normally unaided. In a child the definition is that the child is unresponsive, not breathing normally and has an absent or inadequate pulse.

3.0 Duties

All staff having direct clinical patient contact have a responsibility to ensure they are suitably trained and competent to recognise and care for patients who have suffered a Cardiopulmonary Arrest and that they follow best practice as outlined in **5.0 Procedure for Cardiopulmonary Resuscitation**.

4.0 Training / competency requirements

(See also section 5.12 and Appendix Seven).

- 4.1 Clinical Trust staff with patient contact should undergo at least yearly resuscitation training to a level compatible with their expected clinical responsibilities.
- 4.2 Doctors, nursing staff and professions allied to medicine (e.g. physiotherapists, radiographers and occupational therapists) should all have basic life support training. These staff should be encouraged to recognise patients 'at risk' of cardiac arrest and summon appropriate help early. (e.g. ILS or ALERT)

- 4.3 Trust hospitals will have a separate Paediatric Resuscitation Team. At least one member of the Paediatric Resuscitation Team should have undertaken training in Advanced Paediatric Resuscitation. All staff with regular commitments to paediatric resuscitation teams should also attend national paediatric resuscitation courses as appropriate e.g. European Paediatric Life Support (EPLS), Advanced Paediatric Life Support (APLS), Paediatric Life Support (PLS) and Newborn Life Support (NLS).
- 4.4 Nursing staff should have training to a standard compatible with their level of experience and expected duties within hospital.
- 4.5 Extended nursing roles in resuscitation are to be encouraged. These include the use of airway adjuncts, rhythm recognition, defibrillation and administration of specific drugs. While the use of automated external defibrillators (AEDs) or shock advisory devices (SADs) should become a standard training requirement for nursing staff in non-acute out of hospital areas, it is noted that full capability defibrillators may be required for inpatients to manage peri-arrest and post-arrest rhythms that require synchronised cardioversion and for transcutaneous pacing. Nurses in ITU, CCU and A&E may use all types of defibrillator for which they have been appropriately trained and certified. (Refer Medical Devices Policy & Medical Devices Training Policy)
- 4.6 Clinical staff that have patient contact should have clear, unambiguous guidelines for dealing with the collapsed patient in their work area/ hospital.
- 4.7 New clinical members of staff will have resuscitation training incorporated into their induction programme.
- 4.8 The Senior RO (delegated to the other ROs) has the primary role for organising and coordinating training of Trust staff. The ROs should encourage assistance from other areas within the hospital e.g. anaesthetic department.
- 4.9 Specific training for cardiac arrests in special circumstances (e.g. paediatrics, newborns, pregnancy and trauma) will be provided for the relevant medical and nursing staff working in these specialties.
- 4.10 All hospital based resuscitation training should be repeated and reassessed at regular intervals. Training is for a fixed period of time only, with regular updates at intervals determined by the Resuscitation Committee, currently annually for clinical staff. Doctors and Consultants should attend Basic Life Support Training yearly. The requirement for training should be documented in yearly appraisals and Personal Development Plans as part of Best Practice.

4.11 Mandatory training

Please also refer to the Training Matrix, available from the Learning & Development Department.

- **Adult Basic Life Support – Mandatory once a year including DNACPR awareness**

Clinical and Medical staff involved in patient care

- **Paediatric Basic Life Support – Mandatory once a year**
Clinical and Medical Staff involved in Paediatric Care
- **Newborn Basic Life Support – Mandatory once a year**
Clinical and Medical Staff (including midwives) involved in Neonatal and Newborn Care
- **Adult Advanced Life Support – Mandatory every 4 years**
Those taking the lead decision making role in the Adult Cardiac Arrest Team
- **Paediatric Advanced Life Support (EPLS or APLS) – Mandatory every 4 years**
Those taking the decision making role in the Paediatric Cardiac Arrest Team

4.12 Optional training

- **Immediate Life Support – Yearly certification**
Clinical and Medical staff working in Adult areas where patients are at risk of Cardiac Arrest, but are not necessarily part of the Cardiac Arrest Team.
(Resuscitation Council (UK), (RC (UK)) certification.)
- **Paediatric Immediate Life Support – 1 year Certification**
Clinical and Medical Staff working in Paediatric areas where patients are at risk of Cardiac Arrest, but are not necessarily part of the Cardiac Arrest Team.
(Resuscitation Council (UK), (RC (UK)) certification)
- **Adult, Paediatric and Newborn study days**
Tailor-made study days for the remainder of the Clinical and Medical staff who feel they do not need to attend specific RC (UK) or ALSG study days, but need to update their practice and guidelines. Can be held during Clinical Governance sessions.

4.13 Courses available within the Trust

- Advanced Life Support
- European Paediatric Life Support
- Immediate Life Support
- Paediatric Immediate Life Support
- All certificated by either Resuscitation Council (UK) or the Advanced Life Support Group
- Advanced Trauma Life Support Course available from Tunbridge Wells Hospital Education Centre

5.0 Procedure for cardiopulmonary resuscitation

SECTION 1 – PATIENTS FOR ATTEMPTED CPR

5.1 Prevention of cardiopulmonary arrest

A track and trigger system (Patient At Risk Score) is in place to identify patients who are at risk of becoming critically ill and therefore at risk of cardiopulmonary arrest.

A patient charting system that facilitates the regular measurement and recording of early warning scores should be in place to identify patients at risk. The track and trigger system includes actions to be undertaken by clinical teams according to their patient at risk score.

Please refer to Critical Care Outreach Services operational procedure.

Training in the recognition of peri-arrest patients is a joint responsibility between Critical Care Outreach Services and the Resuscitation Training department.

5.2 Indications for summoning the cardiac arrest team are

- Discovery or presentation of a patient/casualty with no breathing or signs of life.
 - Discovery or presentation of a patient/casualty with imminent cardiopulmonary arrest
- Discovery or presentation of a patient whose condition has suddenly deteriorated

5.3 Calling the Resuscitation Team

5.3.1 The Resuscitation Team is summoned to cardiopulmonary arrests by dialling the local arrest team number and stating:

- Cardiac arrest and in case of children state paediatric arrest
- Exact location of patient / casualty including site. No abbreviations
- Local cardiac arrest numbers are stated in [Appendix 4.a](#)

5.3.2 Team members for each hospital site are detailed in [Appendix 4.a](#), and roles of the team leader are given in [Appendix 4.g](#).

5.3.3 Special conditions apply when resuscitating victims of trauma, both in the aetiology of cardiopulmonary arrest and in the techniques of resuscitation. Best practice is that trauma patients continue to be managed by the trauma team even if a cardiac arrest occurs, and it is their responsibility to call for assistance from the cardiac arrest team if needed.

5.4 Initiation of resuscitation in clinical areas

5.4.1 In the event that any individual requires the assistance of the cardiac arrest team, the member of staff 'rescuer' who finds them should contact the cardiac arrest team following appropriate assessment of the patient's airway, breathing and signs of life, the team is contacted via switchboard.

5.4.2 The cardiac arrest team is contacted by dialling the national hospital arrest number 2222 on the internal telephone system.

5.4.3 All employees within Maidstone and Tunbridge Wells NHS Trust should be aware of the local arrangement for contacting emergency help. (Please refer to [appendix 4.a](#))

5.4.4 In a clinical area of the hospital it is unlikely that the 'rescuer' will be alone in a department. When more than one rescuer is present then roles should be prioritised. While one rescuer contacts the cardiac arrest team and collects the resuscitation trolley the other should commence CPR using chest compressions only. When a second rescuer arrives initiation of bag valve mask ventilation should occur using a ratio of 30 compressions to 2 ventilations.

As further rescuers arrive, the defibrillator should be connected and Immediate Life Support interventions should occur.

5.4.5 In the event of the initial rescuers being competent in defibrillation, assessment of the cardiac rhythm and potential defibrillation should occur as soon as possible rather than wait for the cardiac arrest team.

5.5 Paediatrics

5.5.1 Special conditions apply when resuscitating children, again in the aetiology of cardiopulmonary arrest and in the techniques of resuscitation. Best practice is that paediatric staff who are experienced in those conditions are present at the resuscitation attempt.

5.5.2 When resuscitating a child in cardiac arrest the Team Leader should ideally have training and expertise in paediatric resuscitation. Special knowledge of the equipment required, doses of drugs used and the differences in both aetiology and treatment are appropriate. This should be facilitated, wherever possible, by having a specific paediatric resuscitation team.

5.5.3 If a child's weight is not readily available, Formulae based on the child's age over the age of 1 year or, specific paediatric resuscitation charts which are based on the length of a child, can be used to estimate appropriate drug doses and other interventions.

5.5.4 Ethical issues are especially difficult when resuscitating a child and consideration should be given to the care of relatives who may be present. An appropriate member of staff should be delegated to stay with them and liaise with the team on their behalf. Refer to Paediatric Algorithms, [Appendices 4.d & 4.e](#)

5.6 Neonates

5.6.1 Special conditions apply when resuscitating neonates, again in the aetiology of cardiopulmonary arrest and in the techniques of resuscitation. Best practice is that personnel who are

experienced in these conditions are present at the resuscitation attempt.

- 5.6.2 When resuscitating a neonate in respiratory/cardiac arrest the Team Leader should ideally have training and expertise in neonatal resuscitation. Special knowledge of the equipment required, doses of drugs used and the differences in both aetiology and treatment are appropriate. This should be facilitated, wherever possible, by having a specific neonatal/paediatric resuscitation team.
- 5.6.3 Drug doses and other interventions should be based on the actual or estimated weight of the baby specific paediatric resuscitation charts which are based on the length of a child, can be used.
- 5.6.4 Ethical issues are especially difficult when resuscitating neonates and consideration should be given to the care of parents who will most likely be present. An appropriate member of staff should be delegated to stay with them and liaise with the team on their behalf. Refer to Neonatal Algorithm, [Appendix 4.f](#)

Resuscitation at the threshold of viability (22- 26 weeks gestation).

Although neonatologists use the term resuscitation it is rarely practised with newborns in the sense that it is understood with adults. Newborn infants who do not breathe sufficiently need gentle assistance to make the transition from placental to pulmonary gas exchange which improves the heart rate. Decisions are required for infants at the threshold of viability about non initiation or limitation of aggressive treatment including transfer to intensive care which are made on a best interest's basis following consultation with parents or carers. If circumstances preclude discussion before birth the physician (Paediatrician) has the responsibility to made an assessment of the infants condition at birth and then a judgement as to whether or not to initiate resuscitation. In cases of uncertainty the physician should err on the side of resuscitation in order to assess the infants response to the intervention provided and to discuss the prospects for survival. The parents' wishes though significant are not overriding and the treating physician continues to have an independent responsibility to provide appropriate treatment to the newborn. [Appendix4.I](#)

Department of Paediatrics

GUIDELINES RELATING TO THE BIRTH OF PRETERM BABIES.

If delivery between 23+0 and 26+6 weeks gestation is extremely likely at **Tunbridge Wells Hospital or Maidstone**, the mother should be considered for transfer to a centre with a major neonatal intensive care unit. The decision to transfer rests with the consultant obstetrician. In case transfer is deemed inappropriate by the obstetric team, the Paediatric Consultant on call must be informed about the impending delivery as soon as possible.

Following review of data at Maidstone, all mothers with singleton pregnancies less than 30 weeks should be transferred to Tunbridge Wells. This gestation limit goes up to 32 weeks for multiple births.

Both parents (if father present) should be counselled antenatally by a senior Paediatrician, preferably the consultant (for deliveries at 26 weeks and under). They should explain possible outcomes based on the most recent data available. Epicure study results with 6 years follow up data are attached. Following discussion a management plan should be formulated, documented in the notes and communicated to family, neonatal, midwifery and obstetric staff.

Guidelines for management of babies less than 26 weeks:

These guidelines assume that the fetal heart has been heard during labour and that a live delivery is therefore anticipated. It would not be appropriate for a paediatrician to attend an anticipated stillbirth or late fetal loss except in exceptional circumstances.

a) <22+6 weeks gestation:

Currently resuscitation at this gestation is experimental and should only take place under controlled circumstances in tertiary centres. It is therefore inappropriate within this Trust. Paediatrician might attend delivery on special request from the parents or obstetricians.

b) >23+0 weeks gestation:

The most senior paediatrician available (usually the consultant) should attend the birth with another doctor and a neonatal nurse in order to assess the babies condition and decide if intensive care management should be instituted. In the best interests of the baby a decision not to start resuscitation is an appropriate approach particularly if the parents have expressed this wish. In case discussion with parents has not happened, decision to institute intensive care should rest on the condition of baby at birth and heart rate response to initial ventilation breaths.

Neither external cardiac massage nor adrenaline has been shown to improve survival in low birth weight babies and rarely appropriate below 25 weeks gestation.

Intubation and surfactant guidelines:

All viable babies under 27+6 weeks of gestation should be intubated at delivery. Surfactant should be administered in the delivery suite if the senior doctor is confident about endotracheal tube position. Very active babies delivered at 28 weeks or above may not require intubation, in which case

nasal CPAP should be commenced as soon as possible. All intubated babies should be given surfactant .

References:

1. Thames regional perinatal group guideline:
<http://www.bapm.org/documents/publications/immature.pdf>.
2. Neurologic and developmental disability at six years of age after extremely preterm birth.
N Engl J Med. 2005 Jan 6;352(1):9-19.
3. European consensus guidelines on the management of neonatal respiratory distress syndrome.
J Perinat Med. 2007;35(3):175-86.
4. Nasal CPAP or intubation at birth for very preterm infants.
N Engl J Med. 2008 Feb 14;358(7):700-8. Erratum in: N Engl J Med. 2008 Apr 3;358(14):1529.
5. The Management of Babies born Extremely Preterm at less than 26 weeks of gestation
A Framework for Clinical Practice at the time of Birth. British association of perinatal medicine, Oct 2008.

Summary of outcomes up to six years of age among children born alive at different gestations (based on Epicure 1 data from babies delivered in UK in 1995).

Outcome	22 wks	23 wks	24 wks	25 wks
Showed signs of life at birth	138(100%)	241(100%)	382(100%)	424(100%)
Died in delivery room	116(84%)	110(46%)	84(22%)	67(16%)
Survived to discharge from hospital	2(1%)	26(11%)	100(26%)	186(44%)
Survived to the age of 6 years	2 (1%)	25(10%)	98(33%)	183(43%)
Survived at 6 yrs without severe or moderate disability	1(0.7%)	8(3%)	36(9%)	86(20%)

Note: Epicure 2 data for preterm babies delivered in UK in 2006 is awaiting publication.

5.7 Maternal

5.7.1 Special conditions apply when resuscitating pregnant women, again in the aetiology of cardiopulmonary arrest and in the techniques of resuscitation. The priority must be the mother, and the cardiac arrest team must be called.

5.7.2 When the cardiac arrest call is made to switchboard the caller must ask for the obstetrician, paediatrician and anaesthetic registrar to be paged to the arrest as well as the Resuscitation Team.

5.7.3 Peri-mortem caesarean section may have to be undertaken early on in the resuscitation attempt (Resuscitation Council guidelines recommend within 5 minutes of CPR from 23 weeks gestation onwards).

5.8 Resuscitation in Accident & Emergency

The largest group of cardiac arrests within A&E are the continuation of pre-hospital cardiac arrests. The survival from pre-hospital cardiac arrest is very poor but despite this it is inappropriate to stop resuscitation following a brief assessment in an ambulance. Therefore, where an ambulance crew is undertaking CPR, a period of advanced life support within A&E is required.

5.9 Relative witnessed resuscitation

5.9.1 Relatives may remain during a resuscitation attempt. This is common during paediatric resuscitation although this is unusual during resuscitation of the adult patient.

5.9.2 Reluctance to allow a relative to witness resuscitation usually reflects the discomfort of the resuscitation team. Properly prepared and supported relatives can find comfort in witnessing resuscitation attempts. It must be remembered that resuscitation procedures are regularly shown in the media and the relative may have themselves attempted CPR prior to arrival at hospital.

5.9.3 Currently, Resuscitation Council (UK) guidelines suggest it may be beneficial to allow relatives to witness resuscitation attempts if they so wish. However, the following should be considered - if requested by a family member of an adult patient and the following criteria are met:

- safety of relatives can be ensured (e.g. defibrillation)
- sufficient space so that the relative can witness proceedings without impeding the smooth running of the resuscitation attempt
- the person requesting to stay is a close relative/partner and is over 18 years of age
- Relatives may be asked to leave if obstructing the resuscitation attempt.

THEN:

- **Obtain the consent of the cardiac arrest team leader. However, there must be a sound reason for refusal of permission.**
- **Allocate a senior team member to stay with the relative. This person should be empowered to explain what is happening and why.**
- **Allow relative to leave at any time.**
- **Do not leave the relative alone during active resuscitation.**

5.10 Patient transfer and post-resuscitation care

The immediate post-resuscitation phase is characterised by high dependency and clinical instability. Most patients require appropriate critical care expertise. 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.

- 5.10.1 Continuity of care during this period is vital. Senior staff may need to be involved prior to transfer. Referral to an appropriate specialist 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 specifically delegated care to an appropriate colleague. 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 inappropriate delays do not occur. This is the responsibility of the senior staff present, in conjunction with the clinician responsible for clinical care.
- 5.10.2 Equipment for transfer, including drugs, should be readily accessible and appropriate monitoring equipment should be provided. It may be sensible to liaise early with the ambulance service if inter-hospital transfer is likely. Critical Care Transfers should follow the appropriate guidelines from the Kent & Medway Critical Care Network.
- 5.10.3 Appropriately trained and experienced staff should accompany a patient being transferred. Relatives should be informed of the transfer of the patient.

5.11 Actions following cardiac arrest

An audit form must be completed by the cardiac arrest team leader, or person delegated by such, and sent to the site Resuscitation office.

5.12 Training

(See also section 4.0)

All clinical staff who have patient contact are required to be competent to perform basic life support whenever called upon to do so. These staff require annual updates.

The Resuscitation Training Department will facilitate resuscitation training via:

- Annual mandatory training days - available for clinical staff
- Specific trainings/updates in clinical areas as identified by the Resuscitation Committee
- Resuscitation Officers will keep records of attendance at trainings, and follow-up non-attendees in conjunction with Human Resources.

- Basic Life Support course attendance certificates are a required part of staff appraisal documentation.
- Advance Life Support training in all its forms, appropriate to the staff members normal work area, should be facilitated by the Trust.

5.13 Resuscitation Team ([Appendix 4.a](#))

Refer to above appendix for listings of Team members across the Trust.

5.14 Resuscitation equipment ([Appendix 4.h](#))

Refer to above appendix for listings of requirements and responsibilities for equipment, drugs and checking of both.

5.15 Audit

5.15.1 Audit of both the process and outcome of resuscitation attempts is essential. It is the responsibility of the Resuscitation Committee, supported by the clinical audit department, to ensure that this occurs and to keep the Quality and Standards Committee informed of any issues that arise from it that cannot be resolved by the Resuscitation Committee alone. The trust will use the national standard Utstein Template for auditing resuscitation attempts (European Resuscitation Council).

5.15.2 Accurate data from all resuscitation attempts should be kept for audit, training and medico-legal purposes. During the resuscitation, one team member should document events. The Team Leader should ensure that an accurate record of the resuscitation attempt has been recorded before leaving the resuscitation scene.

The team leader must also ensure a Trust audit form has been completed and the form sent to the Resuscitation office at either Tunbridge Wells Hospital or Maidstone Hospital.

5.15.3 Any critical incidents or significant deficiencies must be promptly recorded and reported in accordance with the Trust's risk management policy and reviewed by the Resuscitation Committee.

5.15.4 The resuscitation process should ideally include periods of 'debriefing' after resuscitation attempts. This allows staff time to reflect on events that occurred and provides the opportunity to discuss matters of concern. Counselling for staff is available.

5.15.5 Audit of the process of resuscitation should include the availability, and performance of the members of the team, the standard and reliability of equipment used and the ongoing care of the patient in the post resuscitation phase. This should include patient transport as well as the actual resuscitation attempt. Evaluation of training needs and development requirements must also be included.

The Resuscitation Committee should ensure that the following audits are completed:

- The availability and use of equipment
- The availability of arrest and peri-arrest drugs
- All cardiac arrests using the Utstein template
- Resuscitation decisions / NFACPR (Mandatory)
- Cardiopulmonary arrest outcomes
- Critical incidents leading to cardiopulmonary arrest or occurring during the arrest
- Other health and safety issues
- Random selection of patients to ensure the correct resuscitation decision documentation is completed

Where audit has identified deficiencies, steps must be taken to improve performance.

5.15.6 Compliance with mandatory training in CPR will be monitored by the Workforce Development & Learning Committee.

SECTION 2 – PROCEDURE FOR MAKING A NOT FOR RESUSCITATION DECISION

NHS South East Coast Adult Do Not Attempt Cardiopulmonary Resuscitation Policy (DNACPR) V.6.3 july2010

5.16 Summary

- This policy applies to all health providers in Kent and Medway.
- The decision making framework and DNACPR form provides the basis for CPR decision making in the previous NHS South East Coastal region and is based on the guidance given in the Joint Statement from the BMA, Resuscitation Council (UK) and the RCN (2007)¹
- A DNACPR order documented on the standard red form is therefore valid in all health care settings including during transfer from one setting to another across the South East Coast NHS region. It should be respected by all healthcare professionals.
- CPR should not be delivered where:
 - CPR is not likely to restart the patient's heart and breathing
 - Restarting the patient's heart and breathing would provide no worthwhile or sustainable benefit.
 - CPR is not in accord with the sustained wishes of a patient with capacity for that decision or that of a properly appointed Lasting Power of Attorney
 - A valid and applicable advance decision to refuse life-sustaining treatment has been made.
 - A previous order not to resuscitate is valid and applicable.
- The health care professional making the decision needs to be competent to answer three questions when approaching CPR decision making
 - Is a cardiac arrest likely?

- Is an attempt at CPR likely to be successful?
- Has the patient the capacity to be involved in decision making?
- The health care professional making the decision should be competent to undertake discussion of end of life issues including CPR with patients and those close to them.
- The final responsibility for decision-making lies with the patient's consultant or GP depending on the patient's location. Good practice requires discussion with the multi-disciplinary team.
- The policy allows for suitably trained senior nurses and other health care professionals to complete the DNACPR form
- This policy should be read in conjunction with the Mental Capacity Act (2005).²
- A DNACPR decision does not mean 'Do not treat'. It only impacts on whether or not resuscitation procedures should be commenced following cardiac arrest and is individual to that patient.
- Inappropriate resuscitation is potentially as significant as failing to attempt resuscitation. It can cause harm and suffering and could be regarded as a form of assault. However, the presumption should be in favour of CPR in the absence of a previous clear decision, a valid and applicable advance decision to refuse treatment or incontrovertible contraindications.

5.17 CPR decision making: who can make the decision

The overall responsibility for DNACPR decisions rests with the most senior clinician currently in charge of the patient's care. In the majority of cases this will be the consultant or GP. However, they may delegate this responsibility to another registered medical practitioner. In certain settings an experienced nurse may be the senior clinical decision maker. Examples include nurse consultants or senior clinical nurses working in palliative care who have undergone appropriate training, subject to local discussion and agreement.

Nurses will undertake a training programme and competency assessment as part of an extended role. The programme and competencies will be in line with those agreed by the NHS South East Coast End of Life (EoL) Clinical Advisory Group.

There are five different situations in which a DNACPR decision needs to be considered depending on the likelihood of success of CPR and the capacity of the patient.

When attempts at CPR have a reasonable chance of success and the patient has capacity for decision making

- It is not necessary to initiate discussion about CPR with a patient if there is no reason to believe that the patient is likely to suffer a cardiorespiratory arrest.
- Patients should however be given as much information as they wish about their situation including information about resuscitation. It is the

professional's responsibility to find out how much the patient wishes to know or can understand.

- Written information on CPR should be available for all patients and their families. (see Appendix 4)
- If a patient with capacity refuses CPR this must be respected.
- Patients should be encouraged to complete an Advanced Decision to Refuse Treatment or appoint a Lasting Power of Attorney if they have specific requests for their future care.

When attempts at CPR have a reasonable chance of success and the patient is assessed as not having capacity for decision-making

The decision remains the responsibility of the consultant or GP responsible for the patient's care taking into account the following:

- If a patient lacking capacity has a valid and applicable advance decision refusing CPR this should be respected.
- Any properly appointed lasting power of attorney should be consulted.
- In the absence of these, those close to the patient should be involved in discussions to explore the patient's wishes, feelings, beliefs and values.
- For patients who are un-befriended an IMCA must be involved.
- Relatives or friends should never be placed in a position in which they feel they are making a DNACPR decision for the patient unless they have been appointed as the patient's personal welfare attorney under a Lasting Power of Attorney (LPA)².

When attempts at CPR have little or no chance of success and the patient has capacity for decision-making.

- Whilst patient's informed views are of great importance, where the expected benefit of attempted CPR may be outweighed by the burdens the GMC has stated that "there is no obligation to give treatment that is futile or burdensome" This applies to CPR.³
- If CPR is futile, the NHS Trust Employer will support a justifiable and appropriately documented decision of a healthcare professional not to attempt CPR.
- Discussions should take place between healthcare professionals, the patient and family about the patient's condition and future prognosis and a DNACPR form completed. The Patient or their representative must be informed that a decision has been made.

When attempts at CPR have little or no chance of success and the patient lacks capacity for decision making.

- The decision remains the responsibility of the consultant or GP responsible for the patient's care.
- Discussions are required to secure understanding of the decision by those close to the patient.
- For un-befriended patients there is a need to appoint an IMCA

When no CPR decision has been taken and the situation is clearly palliative

- There may be occasions when due to unavoidable circumstances a Health Professional who is unable to contact a doctor immediately, makes a decision based on their knowledge of the patient, the patient's circumstances and the patient's wishes, not to commence CPR.
- The Employer will support any appropriate decisions made by the health professional in these circumstances. However such decisions must be incontrovertible and very clearly documented.
- This only applies in emergency situations and health professionals should do everything possible to contact either the GP or consultant or their deputy. If they are unable to do so then they must document the reasons for this in the patient's medical records.

5.18 Discussion of CPR decisions

- For any patient a decision needs to be made regarding:
Who to include in the discussion about CPR
What to cover in the discussion about CPR
- It is not necessary to burden a patient or relevant others with a CPR discussion where a cardiac or respiratory arrest cannot be anticipated.
- The Association for Palliative Medicine in UK and Ireland and the National Council for Palliative Care have jointly stated that "there is no ethical obligation to discuss CPR with those palliative care patients for whom such treatment, following assessment, is judged to be futile". In this situation discussion with the patient and family should aim to secure understanding of the poor prognosis and likely future palliative management.
- The responsible health professional should initiate the process at the appropriate time. This may be delegated to other members of their team including senior nurses and other health care professionals who have been suitably trained.
- See [Appendix Eight](#) for examples of how to address the discussion

5.19 The DNACPR form, the DNACPR Decision Record and communication with other healthcare professionals.

If a 'DNACPR' decision is made, the senior health care professional must complete the DNACPR form.

The DNACPR form is in 3 parts and carbonated, one with a red border. This is the DNACPR active form, the second part with a grey border which is the Decision Record and the third part also grey bordered should be sent to Resuscitation Training for audit purposes.

The NHS South East Coast End of Life Clinical Advisory Group has agreed that The Resuscitation Council red bordered model DNACPR form will be the preferred form for recording the decision and will be used South East Coast wide in all settings.

The red edged form, which requires an ink signature, will be considered the active document and will be considered the patient's "property". The form needs to move with the patient when transferring from one care setting to another, for example from hospital to home so that Out of Hours (OOH) services and ambulance services can see the signed form if necessary.

The grey Decision Record is part of the care record and should remain in the notes of the originator. This form can then be used to communicate the decision to others involved in the patient's care including the ambulance service, GP/OOH service and Hospices. This may be by fax or other timely means.

While only the red form is the active version, the presence of a grey decision record form in the care record should inform the healthcare professionals' decision making if the Red form is not available at a future time.

In care settings where medical and nursing records are not combined the grey Decision Record should be copied and placed in the nursing record.

In all healthcare locations there should be clearly defined responsibility for ensuring the decision is properly recorded and conveyed to all those who need to know it, this may be defined by local or internal policy.

The decision should be handed over from one nursing shift to the next as a matter of routine practice.

Transferring patients

On transfer from one care setting to another the active red form should travel with the patient. The grey DNACPR Decision Record should remain in the originator's notes.

When transferring a patient home (or to a facility with no patient record system) the red DNACPR form should be attached to the accompanying discharge letter.

Forms completed in hospital or hospices should be reviewed before the patient is discharged to the community.

Recording and communicating in hospital

The overall responsibility for DNACPR decisions rests with the consultant in charge, however good practice would support a multidisciplinary decision making approach.

Decisions should be made by the most senior member of the clinical team available and ratified by the consultant or his deputy at the earliest opportunity. Local policy will dictate which members of the senior clinical team can sign the form. Where this is a senior nurse they will be assessed as DNACPR competent practitioners against South East Coast NHS region wide competencies.

Recording and communicating in the community

- Where the decision is made in the community it should be recorded in the GP's notes and nursing notes, any palliative care notes and communicated to the hospital consultants. The decision should be recorded on the standard red DNACPR form which should remain with the patient.

Other services that may need to be informed of the decision may include Out of Hours GP and nursing teams, the ambulance service, community nurses, palliative care services and specialist nursing teams involved with the patient. The grey DNACPR Decision Record can be used to communicate to other services, either by fax or electronically. It should be filed in the originators healthcare record.

- ***In the community a senior nurse professional may initiate the discussion and if the patient decides they would not wish attempts to be made at CPR this should be recorded on the DNACPR form and a second signature obtained from a senior doctor/GP with whom the patient should be offered the opportunity of further discussion.***
- In a nursing home a doctor can make the decision and complete the form which should then be witnessed by the senior nurse.
- In the community the 'DNACPR' order can be valid with a single signature from a senior nurse who has undertaken training in accordance with the regionally agreed competency criteria. Nurses who have undertaken this training will be supported by their organisation through the governance structure. While training is mandatory to allow nurses to undertake the role of signatory it is up to each individual organisation to decide if they wish to allow nurses to do so. However where a nurse is a signatory in one setting it will be recognised across care settings due to the unified nature of the competency criteria.
- In an emergency, out of hours, the doctor on call may undertake the decision. Whilst a DNACPR form completed by the on-call doctor is valid without a second signature it is good practice for the second signature to be completed subsequently by a healthcare professional who knows the patient.
- A verbal DNACPR order is not valid. Only orders correctly documented are valid. If the order is not appropriately documented a correct form should be completed to avoid inappropriate CPR attempts. (See 5.17– where no CPR decision had been taken and the situation is clearly palliative).

5.20 Review of DNACPR decisions

- Where the clinical circumstances and patient's condition are likely to change decisions about CPR need to be reviewed regularly. The responsible clinician, depending on the general health status of the patient, should determine the frequency of this.
- Where a patient has a long-term stable condition it is good practice for a regular patient review by members of the health-care team to take

place. This is an opportunity to review resuscitation status decisions where appropriate.

- If uncertainty exists a member of the health-care team should seek advice from a senior colleague (and potentially a legal representative of the care provider).
- Reviews should be carried out by the GP or Consultant in charge of the patient's care and should include other medical and nursing staff as well as the patient and their relatives where appropriate.¹

Cancelling DNACPR decisions

If the 'DNACPR' order is cancelled the form should be removed from the front cover of the notes, crossed through with two lines and highlighted with the instruction 'This order is cancelled', signed, dated and filed normally. A suitable entry must also be made in the patient's record and all relevant agencies informed. Any copies of the order should also be crossed through, signed and dated when the agencies are informed of the cancellation.

SECTION 3 - STANDARDS

- 5.21 Log of all cardiac arrests from the switch board data of all emergency calls made an reconciliation with audit forms received.
- 5.22 Audit forms will be completed after each cardiac arrest and reports compiled by the Resuscitation Training department reported quarterly to Resuscitation committee and Quality and Standards Committee.
- 5.23 All staff with patient clinical contact will have BLS training annually as a minimum standard many specific roles will require more advanced skills as laid out in training matrix.
- 5.24 All key members of the cardiac arrest team must have had ALS training
- 5.25 Where patients have had status changed, this must be checked with the consultant
- 5.26 All patients who die in hospital must have either a cardiac arrest form or a DNACPR resuscitation form
- 5.27 All resuscitation trolleys will be checked daily by the ward staff and this compliance will be monitored on a monthly basis by the Resuscitation Training team.

6.0 Monitoring and audit plan

The Trust Resuscitation Committee is responsible for:

- Writing and reviewing the Trust Resuscitation Policy
- Operational policies governing cardiopulmonary resuscitation and resuscitation decisions
- Implementing and monitoring policies for training in cardiopulmonary resuscitation and provision of appropriate equipment

- Ensuring that guidelines for the resuscitation of people in cardiopulmonary arrest are implemented effectively and adhere to national guidelines and standards
- Monitoring liaison between all components of the resuscitation team, including portering staff and switchboard operators
- Determining appropriate Monitoring Facilities, Equipment and Drugs used in Resuscitation
- Advising the Divisions on the provision of appropriate equipment throughout the Trust for actual resuscitation and for training

Audit of resuscitation outcomes and practice used in resuscitation events.

6.1 Monitoring minimum requirements

The Lead Resuscitation Officer and Chair of the Resuscitation Committee and main author will be responsible for monitoring compliance with this policy on behalf of the Trust.

Compliance with the following minimum requirements will be monitored thus:-

- **Duties**
All activity and any new proposals will be reported to the Trust Resuscitation Committee, and where appropriate from there reported to the Standards committee.
- **Early warning systems in place for the recognition of patients at risk of cardio-respiratory arrest**
Patient at Risk (PAR) scoring is used on all trust observation charts, scores are added for variation from normal in respiration rate, pulse and blood pressure and the score triggers a report to the staff nurse, nurse in charge or doctor depending on the raised level of score. The PAR scoring compliance is audited and reported on by the Outreach Team.
- **Post-resuscitation care**
After a successful resuscitation the patient will normally be cared for in a high dependency area ITU, HDU, or CCU this will depend on the level of airway management and support required for the patient and may be influenced by the decision to use therapeutic temperature management therapy, this decision will normally be taken by the medical registrar (team leader) in consultation with anaesthetist and Intensivist in charge of ITU. Patient must be stabilised before transfer and all immediate investigations carried out before moving the patient to their next destination. All care must be taken to ensure a safe and speedy transfer between care areas ensuring support equipment is carried to make the journey safe.

Intensive Care /High Dependency unit monitor and audit the admission care and transfer of all their patients.
- **Do not attempt resuscitation orders (DNACPR).**

The Trust will adopt the NHS South East Coast DNACPR policy as described in Section 2 – Procedure for making a Not For Resuscitation Decision (5.16 – 5.20).

The dissemination of information is the responsibility of the clinical tutors for medical training.

Audit will be the responsibility of clinical directors.

- **Process for ensuring the continual availability of resuscitation equipment**

Daily and weekly checks of Resuscitation equipment by wards and departments are audited monthly by the Resuscitation Training Team

- **Training requirements for all staff, as identified in the training needs analysis**

All clinical staff shall require a minimum of Basic Life Support updated annually some specific roles will require further training at a higher level according to the trust training needs analysis. The monitoring of compliance with mandatory resuscitation training is part of the overall mandatory training database managed by the Learning and Development team database, this measures attendance and has a call system to ensure staff are booked for a yearly update, and noting any non compliance for further action, the basic life support component is reported monthly to the Resuscitation Committee using the completeness reporting database input from each ward and department. Quarterly reports are taken from the Learning and Development database.

Any issue identified in a monitoring report will be included in subsequent monitoring reports until the issue has been satisfactorily resolved.

Process requirements

1.0 Implementation and awareness plan

- This policy and procedure should be implemented with immediate effect.
- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- All clinical staff with patient contact will be made aware of this policy as they attend annual CPR training.
- Resuscitation Officers will inform all new medical staff of the contents of the Resuscitation Policy at junior doctor induction – ongoing.

2.0 Review

The Trust Resuscitation Committee is responsible for writing and reviewing the Trust Resuscitation Policy. The document will have a two year review period, after which time the document is to be reviewed in line with the Trust policy/procedure templates.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Resuscitation Policy / Not for attempted Cardiopulmonary Resuscitation Policy and Procedures

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Lead Resuscitation Officer

By date: 30-8-14

Name: <i>List key staff appropriate for the document under consultation. Select from the following:</i>	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Chief Executive and Directors				
Director of Infection Control				
Divisional Directors				
Associate Director Operations				
Deputy Director of Nursing				
General Managers				
Matrons	30.07.14		N	
Directorate Risk Lead				
Clinical Director	30.07.14		N	
Clinical Governance Lead				
Clinical Governance Assistant	03.04.14	16.04.14	Y	Y
Senior Nurses Clinical Governance				
Head of Estates				
Director of Facilities				
Corporate Business Manager				
Head of Quality and Governance				
Risk Manager				
Quality and Patient Safety Manager				
Health and Safety Advisor				
Trust LSMS and LCFS				
Trust Fire Officer				
Trust RPA				
Trust OH Manager				
Staff Side chair				
Others				
Resuscitation Committee	30.07.14		Y	Y
Consultant Cardiologists	30.07.14		N	
Consultant Paediatricians	30.07.14		N	
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality impact assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Resuscitation Policy / Not for attempted Cardiopulmonary Resuscitation Policy and procedures
What are the aims of the policy or practice?	To ensure safe and best practice in Resuscitation and decision making processes
Identify the data and research used to assist the analysis and assessment	Quality standards for cardiopulmonary resuscitation practice and training Acute Care Resuscitation Council (UK) November 2013 Advanced Life Support 6 th Edition revised Jan 2011
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details.
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak English as a first language	No
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and	N/A

justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqlA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	Junior doctor guidelines	RWF-OWP-APP89
4a	Hospital resuscitation teams and call numbers	RWF-OWP-APP90
4b	Adult in-hospital basic life support algorithm (RC (UK) 2010)	RWF-OWP-APP91
4c	Adult advanced life support algorithm (RC (UK) 2010)	RWF-OWP-APP92
4d	Paediatric basic life support algorithm (RC (UK) 2010)	RWF-OWP-APP93
4e	Paediatric advanced life support algorithm (RC (UK) 2010)	RWF-OWP-APP94
4f	Neonatal life support guidelines (adapted using RC (UK) guidelines 2010)	RWF-OWP-APP95
4g	The Resuscitation Team Leader	RWF-OWP-APP96
4h	Resuscitation equipment	RWF-OWP-APP97
4i	The role of the Resuscitation Training Department	RWF-OWP-APP98
4j	Resuscitation Committee terms of reference	RWF-OWP-APP99
4k	Management of babies born extremely pre-term	RWF-OWP-APP100
4l	DNACPR decision record	RWF-OWP-APP101
4m	DNACPR form	RWF-OWP-APP102
5	Legal situation	RWF-OWP-APP103
6	Evidence to help identify situations when attempts at CPR are likely to be unsuccessful	RWF-OWP-APP104
7	Training and competencies	RWF-OWP-APP105
8	Examples of possible ways of introducing discussions on CPR status	RWF-OWP-APP106

9	Cardiopulmonary arrest choices about resuscitation (Patient Information Leaflet) RWF-OPLF-PPS100	RWF-OPLF-PPS100
10	Daily check of contents of resuscitation trolley	RWF-OWP-APP107
11	Guidelines for the management of therapeutic hypothermia following cardiac arrest	RWF-OWP-APP108

4. 1%