Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 6889

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11 August 2021

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 Do Not Resuscitate Policies or Procedures.

You asked:

Please send any Do Not Resuscitate Policies or Procedures the Trust have.

Trust response:

Please find below the Resuscitation Policy / Do Not Attempt Cardiopulmonary Resuscitation Policy and Procedures together with the applicable appendices.

Resuscitation Policy / Do Not Attempt Cardiopulmonary Resuscitation Policy and Procedures

Target audience:	All Trust Staff
Author:	Resuscitation Committee Chair **Contact details:** Ext 24361
Other contributors:	Senior Resuscitation Officer **Contact details:** Ext. 24450
Owner:	Medical Director
Division:	Surgery
Directorate:	Critical Care
Specialty:	Theatres and Anaesthetics
Supersedes:	Resuscitation Policy / Not for Attempted Cardiopulmonary Resuscitation Policy (Version 5.0: September 2014)
Approved by:	Resuscitation Committee, 12th November 2018
Ratified by:	Policy Ratification Committee, 13th December 2018
Review date:	December 2022 or sooner at times of significant change

Document history

Requirement for document:	Resuscitation Council (UK) Guidance National Standard
Cross references (external):	1. British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2014) Decisions relating to cardiopulmonary resuscitation. 2. HM Government (2005) Mental Capacity Act 2005 3. General Medical Council (2010) Treatment and care towards the end of life: Good Practice in Decision Making. 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. Intensive Care Med 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. Anaesthesia. 2007;62(12):1207-16 7. 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. Cancer. 2001;92(7):1905-12. 8. 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. Support Care Cancer. 2002 Jul;10(5):425-9. 9. Arawwawala D, Brett SJ. Clinical review: beyond immediate survival from resuscitation-long-term outcome considerations after cardiac arrest. Crit Care. 2007;11(6):235. 10. de Vos R; de Haes HCJM; Koster RW; de Haan RJ. Quality of Survival After Cardiopulmonary Resuscitation. Arch Intern Med. 1999;159:249-254 11. Resuscitation Council (UK). (2015). Resuscitation Guidelines 2015. 12. Duties of a Doctor - Good Medical Practice (2013) GMC 13. The Queen On The Application Of David Tracey (Personally And On Behalf Of The Estate Of Janet Tracey (Deceased)) Appellant And Cambridge University Hospitals NHS Foundation Trust (2014) 14. Elaine Winspear (Personally and on behalf of the estate of Carl Winspear, Deceased) and City Hospitals Sunderland NHS Foundation Trust (2015) 15. Advanced Life Support 7th Edition revised January 2016 16. Quality standards for cardiopulmonary resuscitation practice and training Acute Care Resuscitation Council (UK) November 2013 17. Establishing a standard crash call telephone number in hospitals. National Patient Safety Agency Alert, February 2004. 18. European consensus guidelines on the management of neonatal respiratory distress syndrome. Neonatology 2013;103:353–368 19. A Framework for Clinical Practice at the time of Birth. British association of Perinatal Medicine, Oct 2008.

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46. Decisions relating to cardiopulmonary resuscitation. Br Med Assoc [Internet]. 2016; Available from: https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Associated documents (internal):

- Cardiopulmonary Arrest, Choices about resuscitation [LARGE PRINT LEAFLET] [RWF-OPLF-PPS101]
- Cardiopulmonary Arrest, Choices about resuscitation [STANDARD PRINT LEAFLET] [RWF-OPLF-PPS100]
- Care of the Dying Policy and Procedure [RWF-OPPPCSS-C-CAN2]
- Consent to Examination or Treatment, Policy and Procedure for Treatment [RWF-OPPPES-C-SM5]
- Core Statutory & Mandatory Risk Management Training Matrix [RWF-OWP-APP526]
- Medical Devices Policy and Procedure [RWF-OPPPCS-NC-EST2]
- Standard Operational Procedure for the Critical Care Outreach Service at Maidstone and Tunbridge Wells Hospitals [RWF-THT-IC-GUI-1]

Keywords:	Resuscitation	CPR	DNACPR
	Audit	Training	

Version control:		
Issue:	**Description of changes:**	**Date:**
5.0	Policy review and revision	September 2014
6.0	Policy review and revision	December 2018

Summary for

Resuscitation Policy / Do Not Attempt Cardiopulmonary Resuscitation Policy and Procedures

- Cardiopulmonary Resuscitation (CPR) is not appropriate for all patients who die in hospital.
- The default state is that the resuscitation status of **all** patients must be considered, no matter their age or illness and this decision-making process must be documented.
- Following this consideration, the patient will be for resuscitation unless it is clearly documented otherwise and a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form has been completed.
- Completed DNACPR forms should be kept at the front of the patient's active healthcare records for the duration of their admission.
- Each acute hospital has a Resuscitation Team who can be called using the national emergency number 2222.
- National and international guidelines for the management of cardiopulmonary arrest (including peri and post arrest) should be followed.
- An audit form **must** be completed by the team at each cardiopulmonary arrest or peri-arrest and sent to the Resuscitation Training 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 Directorate Governance Committee.
- All Trust Staff with clinical patient contact should attend annual Basic Life Support (BLS) 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 (ALS) 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.

Contents

1.0 Introduction, purpose and scope

These procedures set out the response to a clinical emergency and the statutory and mandatory training processes for all clinical staff, involved in the care of both adult and paediatric patients.

2.0 Definitions / glossary

Term	Definition
Advance decision	An advance decision is a decision that may be made by a patient to refuse specific types of treatment at some time in the future.
Automated External Defibrillators (AEDs) Shock Advisory Device (SAD)	A defibrillator where the machine decides on the patient's rhythm and decides whether an electric shock is appropriate as well as the level of shock to be used.
Cardiopulmonary arrest	The diagnosis of cardiopulmonary arrest is made if the adult patient or victim is unresponsive, not breathing normally without aid and has an absent pulse. In a child the definition is that the child is unresponsive, not breathing normally and has an absent or inadequate pulse.
Cardiopulmonary Resuscitation (CPR)	A life-saving emergency procedure that involves ventilating and applying external chest compressions to a victim of cardiopulmonary arrest in an effort to restore spontaneous ventilations and circulation.
Continuous Positive Airway Pressure (CPAP)	A form of positive airway pressure ventilation, which applies mild air pressure on a continuous basis to keep the airways continuously open in people who are not able to breathe spontaneously on their own.
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)	A completed form declaring that a patient should not receive cardiopulmonary resuscitation if they suffer cardiopulmonary arrest, a decision made by the patient's senior clinician or by the patient themselves.
Independent Mental Capacity Advocate (IMCA)	IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options.
Lasting Power of Attorney (LPA)	A legal document that lets a person to appoint one or more people to assist them to make decisions or to make decisions on their behalf.
National Early Warning Score (NEWS2)	A track and trigger scoring system which uses physiological changes to monitor deterioration in a patient and alert staff to appropriate actions.
Rescuer	The person attempting to provide CPR to the casualty.

Term	Definition
Team leader	The role in a resuscitation team that must be undertaken by any member of the team who has an Advanced Life Support qualification. Local circumstances may indicate that this role be rotated through the team..

3.0 Duties

All staff with direct clinical patient contact have a responsibility to ensure that 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 section 5.0 Procedure and duties of more senior clinicians.

4.0 Training / competency requirements

(See also section 5.12 and Appendix 4i)

4.1 Training is tailored to European Resuscitation Council and Resuscitation Council (UK) guidelines.[31]

4.2 The Community Trust provides training for all Band 7 clinical staff (or above) involved in resuscitation decisions to enable them to become accredited in discussion of resuscitation issues and completion of resuscitation status forms.

4.3 Medical practitioners will have the agreed competencies if they are deemed fit to practice.

4.4 Nurses and Band 7 clinical staff assessed as DNACPR competent practitioners may sign a DNACPR order.

4.5 DNACPR awareness sessions should be provided for other staff as appropriate.

4.6 Clinical Trust staff with patient contact should undergo at least yearly resuscitation training to a level compatible with their expected clinical responsibilities.

4.7 Doctors, nursing staff and professions allied to medicine (e.g. physiotherapists, radiographers and occupational therapists) should all have Basic Life Support (BLS) training. These staff should be encouraged to recognise patients 'at risk' of cardiac arrest and summon appropriate help early. (e.g. Immediate Life Support (ILS) or Acute Illness Management (AIMs) courses).

4.8 Trust hospitals 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 Advanced Life Support (EPALS), Advanced Paediatric Life Support (APLS), Paediatric Immediate Life Support (PILS), Paediatric Life Support (PLS) and Newborn Life Support (NLS).

4.9 Nursing staff should have training to a standard compatible with their level of experience and expected duties within the hospital.

4.10 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 Emergency Department (ED) may use all types of defibrillator for which they have been appropriately trained and certified. (Refer Medical Devices Policy and Procedure)

4.11 Clinical staff who have patient contact should have clear, unambiguous guidelines for dealing with the collapsed patient in their work area / hospital.

4.12 New clinical members of staff will have resuscitation training incorporated into their induction programme.

4.13 The Lead Resuscitation Officer (delegated to the other Resuscitation Officers) has the primary role for organising and coordinating training of Trust staff. The Resuscitation Officers should encourage assistance from other areas within the hospital e.g. anaesthetic department.

4.14 Specific training for cardiopulmonary arrests in special circumstances (e.g. paediatrics, newborns, pregnancy and trauma) will be provided by the Resuscitation Training team for the relevant medical and nursing staff working in these specialties.

4.15 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. All doctors, including consultants, should attend BLS training yearly. The requirement for training should be documented in yearly appraisals and personal development plans as part of best practice.

4.16 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**
  All clinical staff involved in patient care.
- **Paediatric Basic Life Support – mandatory once a year**
  All clinical staff involved in paediatric care
- **Newborn Basic Life Support – mandatory once a year**
  Clinical staff involved in neonatal and newborn care
- **Adult Advanced Life Support – mandatory every four years**
  Those taking the lead decision making role in the Adult Cardiac Arrest Team
- **Paediatric Advanced Life Support (EPLS or APLS) – mandatory every four years**

Those taking the decision making role in the Paediatric Cardiac Arrest Team

4.17 Optional training

- **Immediate Life Support – annual certification**
  Clinical 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 – annual certification**
  Clinical staff working in paediatric areas where patients are at risk of cardiac arrest, but who are not necessarily part of the Cardiac Arrest Team.(RC(UK) certification)
- **Adult, paediatric and newborn study days**
  Tailor-made study days for the remainder of the Clinical staff who feel they do not need to attend specific RC(UK) or Advanced Life Support Group (ALSG) study days, but need to update their practice and guidelines. These can be held during Clinical Governance sessions.

4.18 Courses available within the Trust

- Advanced Life Support (ALS)
- European Paediatric Advanced Life Support (EPALS)
- Immediate Life Support (ILS)
- Paediatric Immediate Life Support (PILS)
- All certificated by RC(UK)
- Advanced Trauma Life Support Course (ATLS) certificated by ALSG and available from Tunbridge Wells Hospital Education Centre

5.0 Patients for attempted CPR: Procedure

5.1 Prevention of cardiopulmonary arrest

A track and trigger system (National Early Warning System (NEWS2) Score) is in place to identify patients who are at risk of becoming critically ill and therefore at risk of cardiopulmonary arrest. This runs alongside the Nervecentre system.

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 NEWS2.

Please refer to Standard Operational Procedure for the Critical Care Outreach Service at Maidstone and Tunbridge Wells Hospitals [RWF-THT-IC-GUI-1]

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 cardio-pulmonary 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 2222 and stating:

- "Cardiac arrest" and in case of children stating "paediatric arrest".
- Exact location of patient / casualty **including hospital site**. Abbreviations are not to be used.

5.3.2 Team members for each hospital site are detailed in Appendix 4a and roles of the team leader are given in Appendix 4g.

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 being 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. In certain circumstances it may be appropriate to dial 999 for external assistance from the Ambulance Service

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 4a)

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 two 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, either manually or using the AED facility on the defibrillator, 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 one 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 basic life support (RC (UK) 2015)' Appendix 4d and 'Paediatric advanced life support (RC (UK) 2015)' Appendix 4e.

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 'Newborn life support (adapted using RC (UK) guidelines 2015)', Appendix 4f.

5.7 Resuscitation at the threshold of viability (22 to 26 weeks gestation)

5.7.1 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 basis following consultation with parents or carers.

5.7.2 If circumstances preclude discussion before birth the physician (Paediatrician) has the responsibility to make an assessment of the infant's 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 infant's 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. Appendix 4k

5.7.3 Department of Paediatrics

Guidelines relating to the birth of preterm babies

If it is thought the delivery is likely between 23 weeks and 0 days (23+0 weeks) and 26+6 weeks gestation 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 six years follow up data are shown in table on the next page. Following discussion, a management plan should be formulated, documented in the healthcare record 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 foetal loss except in exceptional circumstances.

<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. The paediatrician might attend delivery on special request from the parents or obstetricians.

>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 baby's 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 situations where discussion with the parents has not taken place, the 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 is 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.

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 weeks	23 weeks	24 weeks	25 weeks
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 six years	2 (1%)	25 (10%)	98 (33%)	183 (43%)
Survived at six years 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*** ***www.bmj.com/content/345/bmj.e7976***

5.8 Maternal

5.8.1 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.

5.8.2 When the cardiac arrest call is made to switchboard the caller must state ‘Maternal Cardiac Arrest’. This call should include the Obstetrician, Paediatrician and Anaesthetic Senior Clinician to be immediately called to the arrest as well as the Resuscitation Team.

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

5.9 Resuscitation in Emergency Department (ED)

The largest group of cardiac arrests within ED are the continuation of pre-hospital cardiac arrests. The survival from pre-hospital cardiac arrest is 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 ED is required.

5.10 Relative witnessed resuscitation

5.10.1 Relatives may remain during a resuscitation attempt. This is common during paediatric resuscitation although uncommon during resuscitation of adult patients.

5.10.2 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.

5.10.3 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)
- There is sufficient space to enable 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 18 years or older.
- 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.

5.11 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.

5.11.1 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.

5.11.2 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.

5.11.3 Appropriately trained and experienced staff should accompany a patient being transferred. Relatives should be informed of the transfer.

5.12 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.

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.

5.13 Training

(See section 4.0)

5.14 Resuscitation Team (Appendix 4a)

Refer to above Appendix 4a for listings of Team members across the Trust.

5.15 Resuscitation equipment (Appendix 4h)

Refer to above Appendix 4h for listings of requirements and responsibilities for equipment checking.

5.16 Audit

5.16.1 Audit of both the process and outcome of resuscitation attempts is essential. It is the responsibility of the Resuscitation Committee **(see** Appendix 4j), supported by the Clinical Audit department, to ensure that this occurs and to keep the Trust Clinical Governance Committee informed of any issues that arise from it that cannot be resolved by the Resuscitation Committee alone

5.16.2 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 training office at either Tunbridge Wells Hospital or Maidstone Hospital.

5.16.3 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.

5.16.4 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
- National Cardiac Arrest Audit (NCAA)
- Resuscitation decisions / DNACPR (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.

5.16.5 Compliance with mandatory training in CPR will be monitored by the Learning and Development Department.

6.0 Procedure for making a Do Not Attempt Cardiopulmonary Resuscitation decision

Summary

- This policy applies to all health providers in Kent and Medway.
- The decision making framework and DNACPR form **(see** Appendix 4m) provides the basis for CPR decision making in the previous NHS Kent and Medway region and is based on the guidance given in the Joint Statement from the BMA, Resuscitation Council (UK) and the RCN (2007)
- A DNACPR order documented on the standard red bordered form is therefore valid in all healthcare settings including during transfer from one setting to another across the Kent and Medway 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 DNACPR form is valid and applicable.
- The healthcare 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? (See Appendix 6)
  - Does the patient have capacity to be involved in decision making?
- The healthcare 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 healthcare professionals to complete the DNACPR form.
- This policy should be read in conjunction with the Mental Capacity Act (2005).
- 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.

6.1 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 patients 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.

There are five different situations in which a DNACPR decision needs to be considered depending on the likelihood of success of CPR (see Appendix 6) and the capacity of the patient.

Guidance on the completion of the adult DNACPR form can be found in (Appendix 10).

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

- Patients should 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 (Trust leaflet: Cardiopulmonary Arrest, Choices about resuscitation).
- 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 making this decision.

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 (see Appendix 7).
- For patients who are un-befriended an Independent Mental Capacity Advocate (IMCA) must be involved. (Mental Capacity Act)
- 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) but they should be part of a best interest discussion.

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

- Whilst patients' 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.

- If CPR is futile, the Trust 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 decision maker must ensure that the patient is informed of the decision, or that the next of kin is informed if the patient lacks capacity.

When attempts at CPR have little or no chance of success and the patient lacks capacity for making this decision (see Appendix 6)

- 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.
- It is important to know who holds LPA on health and welfare issues.

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

- There may be occasions when due to unavoidable circumstances a healthcare 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 Trust will support any appropriate decisions made by the Healthcare professional in these circumstances. However, such decisions must be incontrovertible and very clearly documented.
- This only applies in emergency situations and healthcare 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 healthcare records.

6.2 Discussion of CPR decisions (see Appendix 7)

- 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
- The responsible healthcare 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.

6.3 The DNACPR form (Appendix 4m), the DNACPR Decision Record (Appendix 4l) and communication with other healthcare professionals.

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

The DNACPR form is in three parts and carbonised, 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 Trust has agreed that the Resuscitation Council red bordered model DNACPR form will be the preferred form for recording the decision and will be used in all adult settings.

The red edged form, which requires an ink signature, and should be located as the very front page in the patient's healthcare record and 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 healthcare record 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 appropriate 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 professional's 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 healthcare record.

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 countersigned 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.

A verbal DNACPR decision is not valid. Only decisions 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).

6.4 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 should determine the frequency of this review, and this will depend on the general health status of the patient.
- Where a patient has a long-term stable condition, it is good practice for a regular patient review by members of the healthcare team to take place. This is an opportunity to review resuscitation status decisions where appropriate.
- If uncertainty exists a member of the healthcare team should seek advice from a senior colleague (and potentially a legal representative of the care provider). The legal situation regarding CPR is set out in Appendix 5.
- 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.

Cancelling DNACPR decisions

If the 'DNACPR' decision is cancelled the form should be removed from the front cover of the healthcare record, crossed through with two lines and highlighted with the instruction 'This order has been cancelled', signed, dated and filed normally. A suitable entry must also be made in the patient's healthcare 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.

7.0 Temporary suspension of a DNACPR order

Some operative procedures or medical interventions have a risk of triggering cardiorespiratory arrest. In these circumstances it may be acceptable to suspend the existing DNACPR order and re-instate it once the intervention and any required recovery time is complete. This is because in these situations, prompt recognition and treatment of the cause of arrest often results in no deterioration of the patient from their baseline function(1). Types of procedures include but are not limited to:

- General anaesthesia for surgery
- Regional anaesthesia
- Coronary stenting
- Pacemaker insertion
- Central line insertion (with risk of VT/VF due to guidewire insertion)

The decision to suspend a DNACPR order should form part of the consent process and involve a discussion with the patient or their representative and be clearly documented in the healthcare records. The time of reinstating the DNACPR order must also be agreed in advance.

For the majority of cases, suspension of a DNACPR order will apply only to the intra-operative and immediate phase 1 recovery period (i.e. the period spent in the operating suite and recovery room). In these circumstances it is imperative that the senior clinician responsible for the suspension communicates the suspension to all team members (ideally at the WHO checklist sign-in or 'team huddle' prior to list commencement) and to recovery staff. If a further period of suspension extending to the ward is deemed appropriate, it is advised that the DNACPR be cancelled in its entirety and rewritten when it is due to be reinstated to avoid any confusion.

In the situation that a patient wishes their DNACPR order to remain valid during the procedure, then it is at the discretion of the most senior clinician (i.e. usually the consultant) to decide on whether to proceed. The decision to proceed or not should also be clearly documented in the patient's healthcare records.

8.0 Standards

8.1 A log must be kept of all cardiac arrests from the switchboard data of emergency calls made and reconciliation with audit forms received.

8.2 Audit forms must be completed after each cardiac arrest and reports compiled by the Resuscitation Training department reported quarterly to Resuscitation committee and Directorate Governance Committee.

8.3 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.

8.4 All key members of the cardiac arrest team must have had ALS training.

8.5 Where patients have had status changed, this must be checked with the consultant.

8.6 All patients who die in hospital must have either a cardiac arrest audit form or a valid DNACPR form.

8.7 All resuscitation trolleys will be checked daily by the ward staff (see Appendix 8) and this compliance will be monitored on a monthly basis by the Resuscitation Training team.

Appendix 1

Process requirements

1.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy and procedure to the Corporate Governance Assistant (CGA) who will upload it to the policy database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & guidelines'. 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.

- This policy and procedure should be implemented with immediate effect.
- All clinical staff with patient contact are 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. (Junior Doctors are also made aware of the Junior Doctor DNACPR guidelines; see Appendix 4.)

2.0 Monitoring compliance with this document

Collection of audit forms and analysis of data is carried out by Trust Resuscitation Officers. In addition, all cardiac arrest data will be entered into the National Cardiac Arrest Audit (NCAA) database. Analysis is presented quarterly to the Resuscitation Committee.

All training provided by the Resuscitation Department is recorded by the Learning and Development Department.

The Trust Resuscitation Committee is responsible for:

- Writing and reviewing this 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 Directorates 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.

Monitoring minimum requirements

The Lead Resuscitation Officer, the Chair of the Resuscitation Committee and the 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 Trust Clinical Governance Committee.
- **Early warning systems in place for the recognition of patients at risk of cardio-respiratory arrest**
  The National Early Warning Score (NEWS2) 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 NEWS2 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 ICU, 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 is normally taken by the medical registrar (team leader) in consultation with anaesthetist and Intensivist in charge of ICU. The 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.

  The ICU/HDU monitors and audits the admission, care and transfer of all their patients.
- **Do not attempt cardiopulmonary resuscitation orders (DNACPR)**
  The Trust has adopted the DNACPR policy as described in section 6.0 – Procedure for making a Not For Resuscitation Decision (6.0 - 6.4).

  Guidance on the completion of the adult DNACPR form is available in Appendix 10

  The dissemination of information is the responsibility of the clinical tutors for medical training.
- **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 when possible.
- **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 is included in subsequent monitoring reports until the issue has been satisfactorily resolved.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every four years.

4.0 Archiving

The policy database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

Appendix 2

CONSULTATION ON: Resuscitation Policy / Do Not Attempt Cardiopulmonary Resuscitation Policy and Procedures

Please return comments to: Lead Resuscitation Officer

By date: 12/11/2018

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff must be included in all consultations:				
Corporate Governance Assistant	16/10/18	23/10/18	Y	Y
Counter Fraud Specialist Manager (tiaa)	10/09/18			
Energy and Sustainability Manager	10/09/18			
Chief Pharmacist and Formulary Pharmacist	10/09/18			
Formulary Pharmacist	10/09/18			
Staff-Side Chair	N/A	N/A		
Complaints & PALS Manager	N/A	N/A		
Emergency Planning Team	10/09/18			
Head of Staff Engagement and Equality	10/09/18			
Health Records Manager	10/09/18			
All individuals listed on the front page				
All members of the approving committee (Resuscitation Committee)	10/10/18	12/11/18	Y	Y
Additional consultees: continue over page for additional consultees the author believes should be consulted				

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Other individuals the author believes should be consulted	10/09/18	23/09/18	Y	Y
All Clinical Directors	10/09/18	01/10/18	N	N
The following staff have given consent for their names to be included in this policy and its appendices:				

Appendix 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of document	Resuscitation Policy / Do Not Attempt Cardiopulmonary Resuscitation Policy and Procedures
What are the aims of the policy?	To ensure safe and best practice in Resuscitation and decision making processes
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	Quality standards for cardiopulmonary resuscitation practice and training Acute Care Resuscitation Council (UK) November 2013 Advanced Life Support 7th Edition revised Jan 2016
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.**
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No

Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document

Further appendices

The following appendices are published as related links to the main policy/procedure on the policy database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Junior doctor DNACPR guidance	RWF-OWP-APP89	This policy
4a	Hospital Resuscitation Teams and call numbers	RWF-OWP-APP90	This policy
4b	Adult basic life support (RC (UK) 2015)	RWF-OWP-APP91	This policy
4c	Adult advanced life support (RC (UK) 2015)	RWF-OWP-APP92	This policy
4d	Paediatric basic life support (RC (UK) 2015)	RWF-OWP-APP93	This policy
4e	Paediatric advanced life support (RC (UK) 2015)	RWF-OWP-APP94	This policy
4f	Newborn life support (adapted using RC (UK) guidelines 2015)	RWF-OWP-APP95	This policy
4g	The Resuscitation Team Leader	RWF-OWP-APP96	This policy
4h	Resuscitation equipment	RWF-OWP-APP97	This policy
4i	The role of the Resuscitation Training Department	RWF-OWP-APP98	This policy
4j	Resuscitation Committee terms of reference	RWF-OWP-APP99	This policy
4k	Management of babies born extremely pre-term <26 weeks gestation	RWF-OWP-APP100	This policy
4l	DNACPR decision record	RWF-OWP-APP101	This policy
4m	DNACPR form	RWF-OWP-APP102	This policy

5	Legal situation	RWF-OWP-APP103	This policy
6	Evidence to help identify situations when attempts at CPR are likely to be unsuccessful	RWF-OWP-APP104	This policy
7	Examples of possible ways of introducing discussions on CPR status	RWF-OWP-APP106	This policy
8	Daily checklist for trolleys	RWF-OWP-APP107	This policy
9	Use of intraosseous vascular access	RWF-THT-THT-GUI-3	This policy
10	Guidance on the completion of the adult DNACPR form	RWF-THT-THT-GUI-4	This policy

NHS
Maidstone and Tunbridge Wells NHS Trust

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION
DECISION RECORD

Name
Address
Date of birth
NHS or hospital number

Date of DNACPR order:
/ /

DNACPR adult DRT 1(March 2009)

Adults aged 18 years and over

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

1 Does the patient have capacity to make and communicate decisions about CPR? If "YES" go to box 2 — YES / NO

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

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted. — YES / NO

All other decisions must be made in the patient's best interests and comply with current law.

Go to box 2

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

3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4 Summary of communication with patient's relatives or friends:

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

6 Healthcare professional completing this DNAR order:

Name _____ **Position** _____

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

7 Review and endorsement by most senior health professional:

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

Review date (if appropriate)

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

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

DNACPR form [Version 6.0 RWF-OWP-APP102]

NHS Maidstone and Tunbridge Wells NHS Trust

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

DNARadult.1(March 2009)

Adults aged 18 years and over

Name

Address

Date of birth

NHS or hospital number

Date of DNACPR order:

/ /

DO NOT PHOTOCOPY

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

1 Does the patient have capacity to make and communicate decisions about CPR?
If "YES" go to box 2 — YES / NO

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

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted. — YES / NO

All other decisions must be made in the patient's best interests and comply with current law.

Go to box 2

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

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4 Summary of communication with patient's relatives or friends:

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

6 Healthcare professional completing this DNAR order:

Name _____ Position _____

Signature _____ Date _____ Time _____

7 Review and endorsement by most senior health professional:

Signature _____ Name _____ Date _____

Review date (if appropriate)

Signature _____ Name _____ Date _____

Signature _____ Name _____ Date _____

Evidence to help identify situations when attempts at CPR are likely to be unsuccessful

The survival rate after cardiorespiratory arrest and CPR is relatively low. After CPR for cardiorespiratory arrest that occurs in hospital, the chances of surviving to hospital discharge are at best about 15-20%.[5]

Where cardiac arrest occurs out of hospital, the survival rate is lower, at best 5-10%.[6] The probability of success depends on factors including the cause of the arrest, how soon after the arrest CPR is started, and the equipment and staff available to deliver it. Attempting CPR carries a risk of significant adverse effects such as rib or sternal fractures, hepatic or splenic rupture, or prolonged treatment in an intensive care unit (ICU), possibly including prolonged artificial ventilation.

In the immediate post-CPR period most patients require at least a brief period of observation and treatment in an ICU or a coronary care unit (CCU) or both. Some patients will require treatments such as artificial ventilation, renal dialysis or haemofiltration, and circulatory support with inotropic drugs and/or an intra-aortic balloon pump. It is not uncommon for difficult decisions about CPR to arise in respect of patients for whom it may be possible to re-start the heart after cardiac arrest but for whom admission to an ICU for continued organ support would be clinically inappropriate because they would be unlikely to survive their admission to the ICU.

There is also a risk that the patient will be left with brain damage and resulting disability, especially if there is delay between cardiorespiratory arrest and the initiation of the CPR. Some CPR attempts may be traumatic, meaning that death occurs in a manner that the patient and people close to the patient would not have wished.

A previous study suggested that 41% of patients in hospital survive the immediate CPR attempt but only 13% survive to discharge.[7]

In cancer patients:

- 22% survival for patients suffering a sudden, unanticipated cardiac arrest
- 0-2% survival for patients with an anticipated arrest due to a pre-existing condition which is already unresponsive to treatment.
- Patients spending more than 50% of time in bed have a 2-3% chance of survival [8,9,10]

Outcome from CPR is better in the following circumstances:

- Reversible medical condition
- Sudden, witnessed heart rhythm disturbance
- Being in hospital

Outcome from CPR is poorer in the following circumstances:

- Non-witnessed cardiac arrest
- Being outside a hospital environment
- Co-morbid disease: pneumonia, renal and heart failure, sepsis, hypoxia
- Prolonged attempt at resuscitation

Neither the presence of metastatic disease nor age per se is predictive of response to CPR.

Long term health outcomes following CPR:

- Quality of life considered satisfactory, although impaired, by patients studied
- Only about ⅔ of survivors could be studied because the rest were too ill or died shortly after discharge from hospital
- Quality of life was related to duration of arrest and patients' condition pre-arrest.[11,12]

Examples of possible ways of introducing discussions on CPR status

1. **Assessing current understanding of condition**
   "Tell me what you understand about how your illness is progressing."

2. **Exploration of perceptions of the future**
   "How do you see the future going?"

3. **Clarification of the current situation by suggesting a poor outlook so providing a warning shot**
   "We are concerned about your condition; you don't appear to be getting any better. What do you think?"

4. **Permission to continue to discuss future**
   "We would like to talk about your future care and management, would that be OK?"

5. **Explanation about probability of dying and the changing focus on managing symptoms explaining that whilst attempting to maintain the situation there are some things that would not be of benefit**
   "We are concerned you may be dying now and that we need to focus on maintaining your comfort"

Or:

"Whilst we will try to get you as well as we can there are some procedures that will not help and will probably cause you more suffering; such as CPR / ventilation / artificial nutrition, etc."

6. **Discussion of likely future events and how they can be managed with a palliative approach**
   "I would like to talk through some of the things that may happen to you and how we would we manage them? How do you feel about that?"

7. **Exploration of feelings and provision of opportunity to ask any questions**
   "How does this leave you feeling? What questions would you like to ask?"

8. **Provision of opportunity for follow up**

This is meant only as a guide for leading a discussion. The exact phrases used should be determined by the patient and their responses to previous questions/statements.

Legal situation [2,4]

A decision not to attempt to resuscitate a patient lacking capacity has been found to be lawful when:

1) The patient's condition indicates that CPR is likely to be futile (i.e. team is as certain as it can be that CPR will not be successful or where imminent death is inevitable from the underlying condition). The team needs to obtain factual information about the patient's condition, diagnosis and prognosis and be clear as to the stability of the patient's condition over time, the underlying pathology, likelihood of recovery and degree of unavoidable uncertainty. A careful note of this evidence and any discussions amongst the team must be made in the healthcare records.

2) Successful CPR is likely to be followed by a future life that might be regarded as intolerable by the patient. When making this decision the views of relatives and carers should be obtained, taking into account such factors as the pain, suffering and distress to the patient if CPR were administered. If there is evidence to suggest that the patient (rather than the family, doctor or healthcare professional) would regard their future life as intolerable then CPR should not be administered. If there is any doubt over this the Trust's Legal Department must be contacted for advice.

3) The patient has made a valid and applicable advance decision refusing CPR.

The Human Rights Act incorporates the bulk of the rights set out in the European Convention on Human Rights into UK law. Decisions on DNACPR must be viewed in the light of this act.

Article 2 of Human Rights Act provides that everybody's right to life will be protected by law. The extent of obligation is limited to that which is reasonable. A doctor would not be ordered to carry out a course of medical treatment which in their clinical judgement was inappropriate because it was not in the best interest of the patient. If a patient or their carer / relatives insisted on resuscitation at all costs, where the treating doctor considered that this was not in the patient's best interest, it would be possible to rely on Article 3 which states that no-one shall be subjected to inhuman or degrading treatment. This includes the right to die with dignity.

Article 8 provides that everyone has the right to respect for his private and family life. Discussing a treatment that cannot be offered (because it would fail) causes unnecessary distress and burden on the patient, partner or relative. However, there is a need to be as open about the facts as the patient, partner and family feel able to cope with at the time.

Article 14 is also a relevant consideration in that it provides for the enjoyment of rights and freedoms that shall be secured without discrimination. Therefore a refusal to provide treatment based solely on age, physical or mental handicap is likely to be a violation of Article 14.

The spirit of the act, which aims to promote human dignity and transparent decision making, is reflected in this policy. Currently there is limited case law regarding the Human Rights Act in the area of CPR, as such this policy may be subject to change.
The Mental Capacity Act 2005 and the principles relating to advance decisions and Lasting Power of Attorney are legally binding.

If CPR is carried out when a patient is known to have stated in a valid and applicable advanced decision that they do not wish to be resuscitated, then this may constitute common assault. If a patient has an advance decision to refuse life sustaining treatment or if CPR was deemed to be futile an IMCA would not need to be consulted.

Independent Mental Capacity Advocate[2]

The Mental Capacity Act 2005 requires an Independent Mental Capacity Advocate (IMCA) to be consulted about all decisions concerning serious medical treatment where the patient lacks capacity, has not made any advance care plans and is un-befriended and in circumstances where "what is proposed is likely to involve serious consequences to the patient". Where there is a genuine doubt about whether or not CPR will be successful or where the relative risks and benefits of attempting CPR are unclear an IMCA must be involved. If under these circumstances a resuscitation status decision has to be made where an IMCA is unavailable then this should be discussed with the IMCA at the first available opportunity. It is important to note that the IMCA does not have the power to make a decision about CPR but must be consulted as part of the doctor/health professionals' consideration of what is in the patient's best interest.