### Management of Resuscitation Policy

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| Title of originators/authors: | Head of Resuscitation and Clinical Skills  
Chair Resuscitation Committee |
| Title of Relevant Director: | Chief Medical Officer |
| Target audience: | All Trust staff |

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This Trust-wide CBR has been developed / reviewed in accordance with the Trust approved ‘Development & Management of Trust-wide Corporate Business Records Procedure (Clinical and Non-clinical strategies, policies and procedures)’

**Summary of Trust-wide CBR:**
(Brief summary of the Trust-wide Corporate Business Record)

This document outlines the details for the management of resuscitation including training, DNACPR orders, Cardiac Arrest Team Composition, Post resuscitation care etc

**Purpose of Trust-wide CBR:**
(Purpose of the Corporate Business Record)

To provide direction and guidance for the planning and implementation of a high quality robust resuscitation service.

**Trust-wide CBR to be read in conjunction with:**
(State overarching/underpinning Trust approved CBRs)

Clinical Guidelines for In-hospital resuscitation including AED, ALS, PBLS, APLS, Anaphylaxis and Advanced Cascade Training.

**Relevance:**
(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)

Governance and Operational

**Superseded Trust-wide CBRs (if applicable):**
(Should this CBR completely override a previously approved Trust-wide CBR, please state full title and eLibrary reference number and the CBR will be removed from eLibrary)

Trust-wide Resuscitation Policy, Cardiac Arrest Team Composition, and Trust Resuscitation Training Policy.

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1.0 SCOPE

1.1 This policy has been developed to ensure all staff within the Trust are familiar with all aspects related to resuscitation. This policy fully supports the recommendations for clinical practice and training in cardiopulmonary resuscitation published by the Resuscitation Council (UK) (2008) and has been constructed to promote compliance with the NHSLA Risk Management Standards.

2.0 INTRODUCTION

2.1 The purpose of this policy is to provide direction and guidance for the planning and implementation of a high quality and robust resuscitation service within the Trust. Staff will be familiar with their training requirements, resuscitation equipment, composition of the cardiac arrest team and DNACPR orders. This policy should be used in conjunction with the Clinical Guidelines for procedures such as ALS. The strategy for resuscitation incorporates the current published guidelines for resuscitation (Resuscitation Council (UK) 2010).

3.0 STATEMENT OF INTENT

3.1 The aim of this policy is to set out clear guidance and direction for the management of resuscitation issues within the Trust.

4.0 DEFINITIONS

4.1 Cardiopulmonary Resuscitation (CPR) - refers to any attempt to restore spontaneous cardio-respiratory function following a cardiopulmonary arrest.

4.2 Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order - refers to any documented decision made by the Consultant in charge of care, or a Specialist Registrar, that stipulates that the patient is not for resuscitation in the event of cardiopulmonary arrest.
4.3 Medical Emergency - refers to any patient who has an acute physiological deterioration in their condition.

4.4 Automated External Defibrillation (AED) - refers to a defibrillator which is pre-programmed with the Resuscitation Council (UK) guidelines and may use either visual or voice prompts to inform the responder of what to do. The defibrillator will analyse the heart rhythm and determine whether it requires defibrillation. They may be fully automated or semi-automated.

5.0 DUTIES / RESPONSIBILITIES

Duties within the Organisation
The Trust has a responsibility to provide an effective resuscitation service to its patients and appropriate training to its staff. A suitable infrastructure is required within the Trust to establish and support these activities.

It is the responsibility of the Patient Safety Committee/Resuscitation and Clinical Skills Department and the Resuscitation Committee to ensure all relevant documentation is distributed, implemented and compliant throughout the Trust.

5.1 Chief Executive
The Chief Executive has overall accountability for the resuscitation service within the Trust. The Chief Executive delegates responsibility for the delivery of the resuscitation service to the Chief Medical Officer, Chief Nurse and Operating Officer and Clinical Directors.

5.2 Trust Board
The Trust Board will ensure that appropriate structures are in place to implement an effective resuscitation service. The Trust Board will be responsible for committing resources necessary to adequately manage the resuscitation service.

5.3 Resuscitation Committee
The Resuscitation Committee is a formal committee accountable to the Patient Safety Committee (refer to its Terms of Reference). The Resuscitation Committee reports bi-annually to the Patient Safety Committee. The Resuscitation Committee has responsibility for the management of the resuscitation service.
• The Resuscitation Committee reports to the Patient Safety Committee which in turn is accountable to the Trust Board.
• The Resuscitation Committee has links with the Mandatory Training Committee which monitors and reviews mandatory resuscitation training.
• The Resuscitation Committee has responsibility for ensuring that relevant policies and Clinical Guidelines are reviewed and amended as necessary. This is particularly pertinent to the Clinical Guidelines because the Resuscitation Council (UK) guidelines are reviewed and amended every 4 years.
• The Resuscitation Committee has responsibility for overseeing the location and availability of resuscitation equipment throughout the Trust.
• The Resuscitation Committee has representatives from all key disciplines and both nursing and medical membership to ensure information is cascaded to all staff.
• The Resuscitation Committee has responsibility for reviewing the results of all resuscitation audits such as Cardiac Arrest Trolley Audit, Resuscitation Audit and DNACPR audit and monitoring compliance.
• The Resuscitation Committee has responsibility for determining the resuscitation training needs of the Trust and for prioritising training. It has joint responsibility with the Mandatory Training Committee for monitoring compliance with the Trust Resuscitation Training Policy.
• The Resuscitation Committee has an approved Terms of Reference and Membership.

5.4 Nominated Executive Director
The Medical Director (Executive Director) is responsible for ensuring the resuscitation strategy for the Trust is implemented.

5.5 Head of Resuscitation and Clinical Skills Department
The Head of Resuscitation and Clinical Skills has responsibility for implementing and managing the resuscitation and clinical skills strategy which includes service delivery and performance.

5.6 Chair Resuscitation Committee
The Chair of the Committee is responsible for ensuring the Committee meets quarterly. They have responsibility for ensuring the committee is run in accordance with the terms of reference. They have responsibility for monitoring and ensuring all action points are completed and any key issues are raised with the Executive
Director for resuscitation and thereafter at the Patient Safety Committee meeting.

5.7 Groups
Groups are responsible for ensuring compliance with current legislation, the NHSLA Standards for Acute Trusts and the requirements of this policy.

5.8 Heads of Groups are responsible for ensuring:

- Ward/department Managers adhere to current legislation with regards to resuscitation training and resuscitation equipment within their groups.
- There is a reporting mechanism whereby non compliance with resuscitation training is highlighted.

5.9 Department/Ward managers
Department/Ward Managers are responsible for monitoring and ensuring their staff are compliant with resuscitation training. In addition they are responsible for ensuring the cardiac arrest trolley in their ward or department is checked once in every 24 hours and following its use and there are no missing items of equipment.

5.10 All staff

- All staff are responsible for ensuring they are up to date with their mandatory resuscitation training.
- Are familiar with the cardiac arrest equipment in their area.
- Where relevant, ensure cardiac arrest equipment is checked and ready for use and any missing items are replaced immediately.
- Report and record any patients with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders and communicate this to relevant members of staff.
- Staff who are responsible for making the decisions about DNACPR orders must comply with the standards specified in this document and complete the national DNACPR form ensuring it is valid.
6.0 DETAILS OF THE POLICY

6.1 Early Warning and Prevention of Cardiac Arrest
The Trust has an established observation and Early Warning/Patient at Risk System to help in the prevention of cardiopulmonary arrest. This Track and Trigger system is a clinical assessment tool which helps to predict and detect actual or impending deterioration in the acutely ill patient. This is in line with the NICE guidance published in July 2007. It is applied to all observations recorded on the Adult and adolescent wards across the Trust (VitalPac, Operational Policy OPER-POL-007-10).

The Critical Outreach Team has responsibility within the Trust for the effectiveness of the Early Warning Scoring System for Adults and adolescents. All ward staff are trained in the identification of critically ill patients and in the use of the Modified Early Warning Score (MEWS) (CG35 MEWS Prediction and Detection of impending critical illness in adults). This enhances decision making and care escalation.

Within the paediatric service there is a Paediatric Early Warning system (PEWS) (CG 1618 Paediatric Observation and Monitoring Guidelines for Nursing and Medical Staff) which is used by all paediatric nurses and medical staff. Other specialities such as surgery have access to PEWS. Nursing staff are responsible for undertaking observations in line with PEWS and escalating care in line with the PEWS Escalation Algorithm.

Within the Maternity service there is a Maternity Early Obstetric Warning Score (MEOWS) (CG 1025) which is used by all Midwifery and Medical Staff. All Midwifery staff are responsible for undertaking observations in line with MEOWS and escalating care according to the Clinical Guideline. Within the Maternity Unit there are always a team of Obstetricians on site and consequently any scores greater than 1 (Yellow) will prompt staff to contact the obstetrician immediately.

6.2 The Emergency Team response
In the event of an adult medical emergency call being identified and triggered, the cardiac arrest team will be alerted and informed that urgent medical assistance is required (See Cardiac Arrest Team composition 6.3.3).

All medical emergency calls will be placed using the universal number 2222. The precise location of the patient/visitor will be communicated to the switchboard operator. The switchboard operator will also be informed if the emergency is related
to an adult, paediatric or obstetric patient.

All cardiac arrest bleeps will be alerted simultaneously by the switchboard operator via a speech channel. Each member of the team must respond at their earliest opportunity. Switchboard will repeat the crash call alert through the speech channel 1 minute after the initial alert.

### 6.3 Policy for Cardiac Arrest Team Composition and responsibilities of the Cardiac Arrest Team Leader

#### 6.3.1 Introduction

The Trust is currently based across two separate sites, University Hospital (UH) and the Hospital of St Cross (Rugby). Each site has different medical team structures and consequently the composition of the Cardiac Arrest Teams is different for each site.

#### 6.3.2 Background

The composition of the cardiac arrest teams on both sites complies with the Resuscitation Council (UK) guidelines for Cardiac Arrest Team composition. Cardiac Arrest Teams must also attend all Medical Emergency calls.

#### 6.3.3 Composition of the Adult Cardiac Arrest teams at UHCW

The Adult Cardiac Arrest Team consists of: **Daytime**

- ITU F2 Bleep 1889/2592
- Admissions F2 Bleep 2311
- Admissions F2 Bleep 2312
- Cardiology F2 Bleep 2008
- Late Admissions F2 Bleep 1826
- Medical SpR/ST Bleep 1462 (notification only)
- Hospital Bleep Holder Bleep 2302 (notification only)

The Cardiac Arrest Team Leader will be the Cardiology SHO unless they are unable to attend. In this instance the Team Leader will be the first SHO to arrive.

**Night time**

- Night Ward F2 (GEN MED) Bleep 1826
- ITU F2 Bleep 1889
• Clinical Night Sister
• Clinical Night Sister
• Medical SpR/ST Bleep 1462 (notification only)
• Hospital bleep holder Bleep 2302 (notification only)

The Cardiac Arrest Team leader will be the Night Ward F2 unless they are unable to attend. In this instance the Team leader will be the first F2 to arrive.

The Medical Registrar on call will also be notified of the cardiac arrest. They should attend if requested to do so by the Cardiac Arrest Team.

In the event of a second cardiac arrest within 20 minutes of the first call, the Medical Registrar on call will then attend the second Cardiac Arrest.

It should be possible to stand down some members of the Cardiac Arrest team but TWO Medical F2s must remain.

In the event of a second cardiac arrest, any F2s previously stood down must attend. It may also be necessary to split those F2s present at the first arrest.

All doctors must attend each arrest unless unable to do so. In the event that they are unable to attend they must telephone switchboard immediately on 2222.

The Team leader is responsible for completion of the Resuscitation record. This is a mandatory Trust requirement. This form must also be completed for all Medical Emergency calls.

6.3.4 Composition of the Adult Cardiac Arrest Team at the Hospital of St Cross

• Medical F2 Bleep 4127
• Medical F1 (daytime only) Bleep 4128
• Anaesthetic Resident Bleep 3067
• Hospital Site Co-ordinator Bleep 3034
• Orthopaedic Fellow (night-time only if one other doctor is unavailable) Bleep 3058

The Team leader is responsible for completion of the Resuscitation record. This is a mandatory Trust requirement. This form must also be completed for all Medical
Emergency calls.

During the daytime the composition of the Cardiac Arrest team remains as specified. However at night between the hours of 21.30 and 09.00 hrs the F1 will not be present – the Medical F2 and resident Anaesthetist only will attend. In the event of the Medical F2 being unable to attend, the Orthopaedic Fellow will provide cover.

In the event that the resident Anaesthetist has to leave St Cross, Rugby to transfer a patient, the second on call Anaesthetic Consultant must ensure the continuing presence of an anaesthetist holding the cardiac arrest bleep unless there is a more urgent clinical requirement within UHCW NHS Trust. This could be by undertaking the transfer themselves.

6.3.5 Paediatric Cardiac Arrests – University Hospital

- Paediatric F2 on call Bleep 2888
- Paediatric Registrar/ST on call Bleep 1407
- Third on call Anaesthetist Bleep 2813
- ITU Middle Grade/ST Bleep 1684
- Paediatric Bleep Holder Bleep 2188
- Consultant Paediatrician to be informed Own bleep
- Children’s Emergency Department Bleep holder Bleep 2908

6.3.6 Neonatal Emergency Team

- Neonatal F2/Advanced Neonatal Practitioner Bleep 2500
- Neonatal Registrar/ST on call Bleep 1408
- Neonatal Nurse Bleep Holder Bleep 2195
- Consultant Neonatologist to be informed Own bleep

6.3.7 Additional Information

Following successful resuscitation, the Cardiac arrest team leader must ensure the patient is transferred to an appropriate Critical Care area environment. This transfer must be undertaken in accordance with the Trust guideline for the Transfer of patients (Patient Transfer Policy GOV-POl-001-08). If it is inappropriate to transfer the patient to a Critical Care area the team leader must hand over responsibility of the ongoing care of the patient to the relevant team.
The Cardiac arrest team leader is responsible for completing the Resuscitation record for all Cardiac arrests and Medical Emergency calls and ensuring the top (Yellow) copy is filed in the medical notes and the pink forms are returned to the Resuscitation and Clinical Skills department where the information will be collated for audit purposes.

It is the team leader’s responsibility to make a decision about when to stop resuscitation. Where possible, the team leader should seek advice from the patient’s own team or consultant.

All Adult Cardiac Arrest team leaders must be Resuscitation Council (UK) Advanced Life Support Providers. All Medical Senior House Officers who do not hold an ALS Provider certificate should attend a Resuscitation Council (UK) Advanced Life Support course within six weeks of commencing employment with the Trust. They should all pass a Resuscitation Council (UK) Advanced Life Support course within three months of commencing employment.

All Paediatric Cardiac Arrest Team leaders must be Advanced Paediatric Life Support providers.

All members of the Neonatal Resuscitation Team will be Neonatal Life Support (NLS) providers.

6.3.8 Cardiac Arrests that occur in non-clinical areas
If a cardiac arrest or medical emergency occurs in a non-clinical area at UHCW, such as, the Clinical Sciences Building (CSB) or a car park at the front of the hospital, the Cardiac Arrest Team Leader must ensure a 999 call has been placed to secure an ambulance for transferring the patient to the Emergency Department. In addition the Team Leader must send a member of the team to collect the Medical Emergency/Cardiac Arrest equipment grab bag that is located behind the main reception desk in the hospital Main entrance. In all other areas it is the responsibility of the Team Leader to ensure that the closest cardiac arrest equipment to the scene is mobilised.

The cardiac arrest team are responsible for attending cardiac arrests and medical emergencies that may occur in the car parks at the front of the hospital, FM building and reaching to the ICT and BMI building and at the rear of the hospital which includes the Clinical Sciences Building (CSB). Beyond these points it is not feasible for the team to attend and basic resuscitation should be commenced and a 999
ambulance called.

At St Cross, Rugby the cardiac arrest team are responsible for attending cardiac arrests in the car parks immediately outside the hospital. If resuscitation equipment is required, the team leader must deploy a member of the team to collect the grab bag located in the Emergency Department. The Cardiac Arrest Team Leader must ensure a 999 call has been placed to secure an ambulance for transferring the patient to the Emergency Department or UHCW.

6.4 Post resuscitation care
Once a patient has been successfully resuscitated the Cardiac Arrest Team Leader must make provision for the safe continuity of care and, where necessary, safely transfer the patient to a high dependency or critical care environment. All staff should adhere to the Trust Transfer Policy when transporting patients from one area to another (Patient Transfer Policy GOV-POL-001-08).

When making decisions about the patient, post resuscitation, the following steps may be involved, referral to Critical Care, preparation of equipment, oxygen, drugs and monitoring systems, intra or inter-hospital transfer, liaison with the ambulance services, informing relatives, utilising staff who are experienced in patient retrieval and transfer. A full and complete handover of care must be undertaken.

6.5 Resuscitation Equipment and Cleaning
All cardiac arrest trolleys and grab bags must be maintained and stocked and ready for use at all times. Any items found to be missing must be replaced immediately. Minimum stock levels are specified in the Cardiac Arrest Trolley Checklist booklet and the Grab Bag Checklist. These are located on each cardiac arrest trolley and in each grab bag. The cardiac arrest trolleys and grab bags should be checked by a qualified member of staff at least once every 24 hours and immediately following conclusion of a resuscitation attempt. The Cardiac Arrest Trolley checklist book and Grab bag checklist must be completed (Cardiac Arrest Trolley Checklist booklet and Grab Bag Policy CG 1314). All wards/departments either carry stocks of disposable items of equipment or have access to a local storage area. Non-disposable items should be decontaminated/cleaned in accordance with both the manufacturers guidance and infection control (Infection Prevention and Control Assurance Framework OPER-POL-03-10) and re-instated on the cardiac arrest trolley as soon as is practical. In the interim, these items must be replaced in case the cardiac arrest trolley is required.
Cardiac arrest drug boxes must be replenished from the pharmacy department. Out of hours the hospital bleep holder will replace the cardiac arrest drug box.

The defibrillator must be operationally checked in accordance with the Defibrillator Check-Book issued by Medical Equipment and Bio-Engineering Services (Policy for the use and routine management of medical equipment used for diagnosis and treatment in UHCW GOV-POL-006-06).

6.6 Handling and Moving
In situations where the patient is collapsed on the floor, in a chair or a restricted/confined space the Trust Handling and Moving Guidelines for the movement of the patient must be followed (Handling and Moving Policy OPER-POL-008-10). This is to minimise the risks of manual handling and related injuries to both staff and the patient. Please also refer to the Resuscitation Council (UK) statement about manual handling (www.resus.org.uk).

6.7 Cross Infection
Whilst the risk of infection transmission from patient to rescuer during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. It is therefore advisable that direct mouth-to-mouth resuscitation should be avoided in the following circumstances:

- All patients who are known to have or suspected to have an infectious disease.
- All undiagnosed patients entering the Emergency Department, Outpatients and other admission areas
- Other patients where the medical history is unknown.

All clinical areas should have immediate access to airway management adjuncts such as the bag-valve-mask device in order to minimise the need for instituting mouth-to-mouth ventilation. However, in situations where airway management adjuncts are not immediately available, chest compressions should be started whilst awaiting the arrival of the airway equipment.

6.8 Defibrillation
Defibrillators must only be operated by personnel specifically trained in their use. The operation of defibrillators by nurses, midwives and allied healthcare professionals is
subject to their compliance with the Clinical Guidelines for Advanced Life Support (ALS) CG 804 and In-hospital resuscitation including automated external defibrillation (AED) CG 803.

6.9 Procurement
All resuscitation equipment is subject to the Trust’s standardisation strategy. Consequently prior to ordering, all resuscitation equipment that is purchased must be sanctioned by the Resuscitation and Clinical Skills Department.

6.10 Do Not Attempt Cardiopulmonary Resuscitation Orders (DNACPR’s)
6.10.1 Introductions
Cardiopulmonary Resuscitation (CPR) can be attempted on any individual in whom cardiac or respiratory function ceases. Such events are an inevitable part of dying and thus CPR can theoretically be used on any individual prior to death.

In the event of a patient suffering a cardiac arrest, the cardiac arrest team will be called and resuscitation will be commenced. Resuscitation will be conducted in accordance with Resuscitation Council (UK) current guidelines. It is the Cardiac Arrest Team Leaders responsibility to make a decision about when to stop resuscitation. In certain situations resuscitation will not be commenced. These involve cases where a patient may have a valid DNACPR order.

Non-medical staff must always call the cardiac arrest team for any patient who is found in cardiac arrest unless a valid DNACPR order is present.

In any medical emergency situation the cardiac arrest team will be called and advised “urgent medical assistance required”. The cardiac arrest team will attend and the patient will be assessed, treated and transferred appropriately.

However, for some patients cardiac arrest represents a terminal event in their illness and thus CPR is inappropriate. This must be documented appropriately by completing a DNACPR order.

6.10.2 DNACPR orders
When making a DNACPR order it is vital to encourage the involvement of patients and the health care team in decision making, and to ensure the communication of decisions to all relevant healthcare professionals. This policy aims to provide clear standards of care and principles for best practice for clinicians involved in these
difficult decisions (Please see Appendix 1 DNACPR Standards and Appendix 2 DNACPR form).

It is appropriate to consider a DNACPR decision in the following circumstances;

A. Where the patients’ condition indicates that CPR is unlikely to be successful.
B. Where CPR is not in accord with the recorded, sustained wishes of the patient who is mentally competent.
C. Where CPR is not in accord with a valid applicable advance directive (anticipatory refusal or living will).
D. Where CPR is likely to be followed by a length and quality of life which would be unacceptable to the patient.

6.10.3 Key Principles

- The documented views of competent patients are of paramount legal and ethical importance in informing any advance decision regarding resuscitation.
- Adherence to the Mental Capacity Act 2005 (which came into force 1st April 2007) is a legal requirement and should always be referred to when considering a DNACPR.
- There is a requirement for a minimum set of documented information for any DNACPR order to be considered valid – Reason for making the DNACPR order, Date, Time, Consultant name and signature – See Appendix 1.
- Use of the DNACPR order document and DNACPR form will ensure that the required minimum set of information is documented.

Where a DNACPR order has not been made resuscitation should be initiated if cardiac or respiratory arrest occurs. Anyone initiating CPR in such circumstances will be supported by their senior medical or nursing colleagues.

6.10.4 Discussing DNACPR orders

- Where sensitive discussion of issues relating to cardiopulmonary resuscitation occurs, it is especially important to stress that should a DNACPR order be made, it relates only to cardiopulmonary resuscitation and no other aspect of care.

Whilst it is appropriate to consult people close to the patient if there is a legitimate
reason that discussion with the patient cannot take place (impaired consciousness etc), such discussion should be for the purpose of trying to ascertain the patient’s views in order that decisions reflect the patient’s preferences. It is the doctor who has the authority to act in the patient’s best interests where consent is unavailable, and the perception that where a patient is incapacitated, people close to the patient have the final say in whether to attempt CPR has no legal basis.

6.10.5 Review of DNACPRs
The DNACPR decision must be reviewed if the patient’s circumstances change or if the patient is transferred to a different Clinical team or department. This must be done at the earliest convenience. Regular review of the DNACPR decision is no longer required.

6.10.6 Cancellation of DNACPRs
If the DNACPR decision is cancelled, this must be clearly documented on the form in Section 7 (Review and endorsement by Consultant) and the form clearly struck through with two diagonal lines and marked ‘CANCELLED’ with date, time and signature within the lines. The DNACPR form must then be removed from the front of the patients’ medical records and secured at the back of the medical records.

6.10.7 Monitoring of DNACPRs
The standards of care form specific and measurable indicators that apply for all DNACPR orders. Use of the DNACPR order document including the DNACPR form (see Appendix 1) will ensure that these standards are met in each instance. Trust-wide Clinical Audit against all the standards will be undertaken on an annual basis.

7.0 DISSEMINATION AND IMPLEMENTATION

7.1 The policy will be saved on the Trust’s eLibrary system, where it is available to all Trust staff. The production of each new version will be advertised via the corporate Team Brief and managers must ensure that relevant updates are cascaded to their staff.
8.0 TRAINING

8.1 Introduction
Staff have differing requirements for training depending on the likelihood that they will be called upon to manage either a potential or actual cardiac arrest.

Staff can therefore be grouped into one of four categories:

Category 1: Likely to manage a potential or actual cardiac arrest.
Category 2: Those who may be involved in a cardiac arrest but would not be responsible for managing a cardiac arrest.
Category 3: Those staff who may be first responders at a potential cardiac arrest and will use the defibrillator.
Category 4: Those Support Workers who may be first responders at a potential cardiac arrest.

Separate categories have been formulated for those staff who manage ADULT, PAEDIATRIC & NEONATAL patients.

Medical and Nursing staff may be reassigned to different categories in light of any regulatory or NHSLA requirements which may be subsequently directed.

Resuscitation Training will be delivered through a variety of methods such as Advanced Cascade Trainers, mandatory days, departmental based training and centralised delivery.

8.2 Non-Clinical Staff
All hospital staff with regular contact with patients will be familiar with when and how to place either a medical emergency or cardiac arrest call.

8.3 Staff caring for Adult patients
CATEGORY 1 – ADULT
Members of the cardiac arrest team or staff who work in critical care areas.

Training: These staff will have attended a Resuscitation Council (UK) Advanced Life Support (ALS) course.

In addition all medical staff will receive a 6 monthly ALS update and all nursing staff will receive an annual ALS update and assessment.

• All Medical F2s & ST1-3s
• All F1s in the Trust
• All Band 6 and Band 7 Cardiology (CCU, ward 10 & 11) and Emergency Department Nurses.
• All Band 6 & 7 Cardiothoracic Critical Care Nurses
• Nurses that have been nominated as Advanced Cascade Trainers
• All Consultants, ST4s and above in Emergency Department
• All clinical medical ST4s and above
• Clinical Night Sisters

CATEGORY 2 – ADULT
These are staff that would be involved in a potential cardiac arrest, but are not responsible for managing the arrest.

Training: These staff will receive an annual 2 hour advanced life support training session. (Including manual or automated defibrillation.)

• All Band 6 and Band 7 Critical Care Nurses, Critical Care ST4’s & above and Consultants.
• Clinical Consultants not already specified.

CATEGORY 3 - ADULT
This category includes any midwives and registered adult and paediatric practitioners who may be first responders at a potential cardiac arrest.

Training: On induction to the Trust, these staff will receive a 2 hour In Hospital resuscitation (including Automated External Defibrillation AED) training session from the Resuscitation and Clinical Skills department. All other staff will receive an annual assessment of in hospital resuscitation (including AED) from the Resuscitation and Clinical Skills department or from the Advanced Cascade Trainers. (See Clinical Guideline CG803, In-hospital resuscitation including AED). Any Paediatric nurses who have successfully completed an APLS or PLS course will receive an annual assessment of In-hospital resuscitation including manual defibrillation.

• All Trained Nursing and Midwifery staff not already specified.
• Allied Health Professionals (AHP’s).
• Non clinical Consultants inc. histology, pathology

CATEGORY 3.1 – ADULT
The following staff will attend a Resuscitation Council (UK) Immediate Life Support
(ILS) course.

- All AHP Advanced Cascade Trainers
- All qualified Cardiac Rehabilitation staff
- All Cardiac Physiologists involved in Exercise testing

CATEGORY 4 – ADULT
This category includes support workers who may be first responders at a potential cardiac arrest.
Training: These staff will receive an annual In-hospital resuscitation for adults update (Clinical Guideline CG 804) from Cascade Trainers.

- All support workers

8.4 Staff caring for children
CATEGORY 1 - CHILD
This includes staff responsible for caring for seriously ill children.
Training: These staff should have successfully completed an APLS (Advanced Life Support ALSG approved) course and will receive annual Paediatric Advanced Life support update and assessment (1-2 hours).

- All Paediatric Consultants and ST4s and above and any ST3s on the middle grade rota.
- All ED Consultants and middle grades.
- Paediatric Band 6 and 7 bleep holders & all Band 6 and 7 nurses in CED & within paediatric wards.
- Paediatric HDU Band 6 nurses.
- All ENP’s and Band 7’s within ED at St Cross

All Anaesthetists who anaesthetise children on their own will receive an annual 2-3 hour APLS update.

CATEGORY 2 - CHILD
This includes staff involved in caring for seriously ill children on a regular basis.
Training: These staff should be trained in the (ALSG) PLS course. In addition staff will attend annual Paediatric Life Support update and assessment (1-2 hours).

- All Paediatric FY2 & ST1-3 doctors
• All ED FY2 & ST1-3 doctors.
• Band 6 Nurses within Paediatrics & CED
• Band 6 & 7 Nurses within the Day Surgery Unit
• All nursery nurses within Paediatrics
• All qualified paediatric staff within the paediatric unit not specified above

CATEGORY 3 – CHILD
This includes staff infrequently involved in caring for seriously ill children and/or who work in areas where it is anticipated that immediate help from better trained staff is available.

Training: These staff would be offered annual training in Paediatric Basic Life Support, (1 hour)

• Surgeons who operate on children
• All other staff not already specified, Band 5 Paediatric and CED Nurses
• Nursing staff in departments where children may occasionally attend as outpatients e.g. ophthalmology and dermatology.
• All other theatre staff where children’s lists occur.
• All Physiotherapists involved in the paediatric physiotherapy rota.

8.5 Staff caring for Neonates
CATEGORY 1 – NEONATES
This includes staff responsible for caring for seriously ill neonates.
Training: These staff should have completed a Resuscitation Council NLS course. Staff will attend an annual Neonatal Life Support update (CG 1127 Neonatal Life Support).

• All Neonatal Consultants and Paediatric Consultants with neonatal input.
• All Advanced Neonatal Nurse Practitioners (ANNP).
• All Neonatal specialist trainees.
• All Neonatal Nurse Specialities.
• All Band 6 and 7 midwives

CATEGORY 2 – NEONATES
This includes staff involved in caring for neonates.
Training: These staff will attend an annual update in Neonatal Life Support (1-2 hours).
• All other Neonatal nurses and Band 5 midwives

Attendance and non attendance will be managed and monitored in accordance with the Trust Mandatory training policy.

9.0 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Use of and compliance with this policy will be monitored by the Resuscitation and Clinical Skills Department with the support of the Resuscitation Committee and Patient Safety Committee. Actions will be monitored by these committees. The Trust reserves the right to change the monitoring arrangements to meet the needs of the organisation.

The monitoring arrangements are outlined in the following table:-

9.1 Monitoring Table

<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Monitoring method</th>
<th>Individual department responsible for the monitoring</th>
<th>Frequency of the monitoring activity</th>
<th>Group / committee which will receive the findings / monitoring report</th>
<th>Group / committee / individual responsible for ensuring that the actions are completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with the process for ensuring that equipment is available at all times via the stocking and daily checking of Cardiac arrest trolleys and other resuscitation equipment.</td>
<td>Audit of resuscitation equipment</td>
<td>Resuscitation and Clinical Skills Department</td>
<td>Annual</td>
<td>Resuscitation Committee</td>
<td>Resuscitation Committee Patient Safety Committee</td>
</tr>
<tr>
<td>Compliance with completion of DNACPR orders to ensure they are valid.</td>
<td>Audit of all DNACPR orders</td>
<td>Resuscitation and Clinical Skills Department</td>
<td>Annual</td>
<td>Resuscitation Committee</td>
<td>Resuscitation Committee Patient Safety Committee</td>
</tr>
<tr>
<td>Attendance and non attendance at resuscitation training</td>
<td>Attendance and non-attendance at training will be monitored in accordance with the Trust Mandatory Training Policy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Version number: 3.0
Trust-wide CBR title: Management of Resuscitation Policy
10.0 STAFF COMPLIANCE STATEMENT

All staff must comply with this Trust-wide Corporate Business Record and failure to do so may be considered a disciplinary matter leading to action being taken under the Trust’s Disciplinary Procedure. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual/s concerned.

A copy of the Trust’s Disciplinary Procedure is available from eLibrary.

11.0 EQUALITY & DIVERSITY STATEMENT

Throughout its activities, the Trust will seek to treat all people equally and fairly. This includes those seeking and using the services, employees and potential employees. No-one will receive less favourable treatment on the grounds of sex/gender (including Trans People), disability, marital status, race/colour/ethnicity/nationally, sexual orientation, age, social status, their trade union activities, religion/beliefs or caring responsibilities nor will they be disadvantaged by conditions or requirements which cannot be shown to be justifiable. All staff, whether part time, full-time, temporary, job share or volunteer; service users and partners will be treated fairly and with dignity and respect.

12.0 REFERENCES AND BIBLIOGRAPHY

12.1 Resuscitation Council (UK) 2010 Basic and Advanced Resuscitation Council Guidelines.
12.2 Resuscitation Council (UK) 2008 Cardiopulmonary Resuscitation Standards for Clinical Practice and Training.
12.4 Resuscitation Council (UK) 2009 Safer handling during resuscitation in healthcare settings.
12.5 National Institute for Heath and Clinical Excellence (NICE) 2007 Recognition of and response to acute illness in adults in hospital
13.0 UHCW ASSOCIATED RECORDS

13.1 Patient Transfer Policy GOV-POL-001-08
13.2 CG35 V2 MEWS Prediction and Detection of impending critical illness in adults
13.3 VitalPac, Operational Policy OPER-POL-007-10
13.4 CG 1618 V1 Paediatric Observation and Monitoring Guidelines for Nursing and Medical Staff
13.5 Maternity Early Obstetric Warning Score (MEOWS) (CG 1025)
13.6 Cardiac Arrest Trolley Checklist booklet and Grab Bag Policy CG 1314).
13.7 Infection Prevention and Control Assurance Framework OPER-POL-03-10
13.8 Clinical Guidelines for Advanced Life Support (ALS) CG 804
13.9 In-hospital resuscitation including automated external defibrillation (AED) CG 803
13.10 Policy for the use and routine management of medical equipment used for diagnosis and treatment in UHCW GOV-POL-006-06
13.11 Handling and Moving Policy OPER-POL-008-10
Appendix 1

Trust Wide Standards of Care and Documentation for ‘Do Not Attempt Cardiopulmonary Resuscitation’ Orders

Resuscitation Policy – 2.0
Trust Policy No. TW/PL/10
[Authors: C. Baldock (Head of Resuscitation and Clinical Skills) A. Brookes (Chair Resuscitation Committee)

Making the Order

<table>
<thead>
<tr>
<th>No</th>
<th>Aspect of care</th>
<th>Responsibility</th>
<th>Standard</th>
<th>Exceptions</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical documentation of the order</td>
<td>Medical team</td>
<td>Order documented on the Trust DNACPR order document (Resuscitation Policy – 1.3)</td>
<td>None</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>Completeness of Medical documentation of the order</td>
<td>Medical team</td>
<td>Essential order information to be documented legibly on DNACPR order document (Resuscitation Policy 1.3)</td>
<td>A DNACPR order will be considered valid if the Explicit reason for making the order, Date, Time, Consultant name and signature are documented on the DNACPR form.</td>
<td>100%</td>
</tr>
<tr>
<td>No</td>
<td>Aspect of care</td>
<td>Responsibility</td>
<td>Standard</td>
<td>Exceptions</td>
<td>Target</td>
</tr>
<tr>
<td>----</td>
<td>----------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>3</td>
<td>Person making the order</td>
<td>Consultant</td>
<td>Documented evidence that the person making the order was a Consultant</td>
<td>In an emergency where the consultant cannot be contacted the order may be made by an ST3 grade or higher (excluding locum staff employed less than 1 week). The order must be discussed with the Consultant within 24 hours and countersigned within 72 hours.</td>
<td>100%</td>
</tr>
<tr>
<td>4</td>
<td>Overall responsibility for the order</td>
<td>Consultant</td>
<td>Documented evidence that the person making the order was a Consultant or the Consultant discussed and endorsed the order with the person making it.</td>
<td>None</td>
<td>100%</td>
</tr>
<tr>
<td>5</td>
<td>Patient involvement in DNACPR order decision</td>
<td>Medical team</td>
<td>Documented evidence that the patient/Welfare Attorney was involved in the decision making process</td>
<td>Explicit documented evidence that the patient/Welfare Attorney was not competent (impaired consciousness etc) to be involved in decision making process</td>
<td>100%</td>
</tr>
<tr>
<td>6</td>
<td>Relative / carer involvement in DNACPR order decision if patient</td>
<td>Medical team</td>
<td>Documented evidence that if the patient was not competent to be involved in decision making process</td>
<td>Explicit documented evidence that consultation with relatives / carers was</td>
<td>100%</td>
</tr>
<tr>
<td>No</td>
<td>Aspect of care</td>
<td>Responsibility</td>
<td>Standard</td>
<td>Exceptions</td>
<td>Target</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>--------</td>
</tr>
<tr>
<td>7</td>
<td>Retention of medical documentation of the order</td>
<td>Medical team</td>
<td>DNACPR order document (Resuscitation Policy – 1.3) secured on inside cover of the current folder in which the patients medical records are kept</td>
<td>None</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Reviewing the Order

<table>
<thead>
<tr>
<th>No</th>
<th>Aspect of care</th>
<th>Responsibility</th>
<th>Standard</th>
<th>Exceptions</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Reviews of DNACPR orders</td>
<td>Consultant</td>
<td>Documented evidence that the order has been reviewed at the earliest convenience if Patient circumstances change, Patient is transferred to a different Clinical team or department</td>
<td>None</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>♦ Dates</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>♦ Signature of reviewer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Rescinding ( Cancelling) the Order

<table>
<thead>
<tr>
<th>No</th>
<th>Aspect of care</th>
<th>Responsibility</th>
<th>Standard</th>
<th>Exceptions</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Medical Documentation of the rescinded (cancelled) order</td>
<td>Medical Team</td>
<td>Rescinding of the order documented on the Trust DNACPR order document (Resuscitation Policy – 1.3)</td>
<td>None</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Item Description</td>
<td>Responsible Party</td>
<td>Action Required</td>
<td>Compliance %</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td></td>
</tr>
</tbody>
</table>
| 10| Completeness of Medical documentation on rescinding of the order | Medical Team      | Essential order cancellation information to be documented legibly on Trust DNACPR order document (Resuscitation Policy – 1.3)  
The front of the DNACPR order document clearly struck through with two diagonal lines and marked ‘CANCELLED’ with date, time and signature within the lines. | None         | 100%          |
| 11| Person Rescinding the order                           | Consultant        | Documented evidence that the person rescinding the order was a Consultant                                 | None         | 100%          |
| 12| Retention of medical documentation of the rescinded order | Medical team      | DNACPR order document (Resuscitation Policy – 1.3) removed from the front of the patients’ medical records and secured at the back of the medical records | None         | 100%          |
Appendix 2

Do Not Attempt Cardiopulmonary Resuscitation form