Rotherham Doncaster and South Humber NHS Foundation Trust

Resuscitation policy manual

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1. Document summary

1.1 What is this policy about?

This policy tells colleagues what to do when a person becomes very unwell, stops breathing or their heart stops.

1.2 What must colleagues do in an emergency?

Colleagues must recognise a deteriorating person:

- check that it is safe to help
- check if the person responds and is breathing
- call for help straight away. Use the local alarm and call the emergency number for your site
- start cardiopulmonary resuscitation (CPR) if it is needed and you are trained to do so. Keep going until emergency services take over or an appropriate clinician tells you to stop.

1.3 When might CPR not be given?

- A person may have a valid decision not to attempt CPR. This is called a DNACPR decision.
- A ReSPECT plan may also record what should happen in an emergency.
- A DNACPR decision only applies to CPR. The person must still receive all other suitable care and treatment.
- If there is no valid decision and colleagues are unsure, they must start CPR and call for help.

1.4 How are decisions made?

- Decisions must be about the individual person
- Colleagues must consider the person's health, wishes, ability to make the decision and best interests
- Colleagues should explain decisions sensitively to the person and, when appropriate, to people close to them
- Decisions must be recorded, shared with the right people and reviewed when circumstances change.

1.5 What else does the policy cover?

- Spotting when a person is getting more unwell
- Using NEWS2 and other observations
- Emergency medicines and equipment
- Head injuries, choking, anaphylaxis and ligature incidents
- Training for colleagues and support after an incident
- Reporting emergencies so the Trust can learn and improve

1.6 What must colleagues remember?

- Complete the training needed for your role.
- Know where emergency equipment is kept and how to call for help in your work area.
- Report every resuscitation attempt and other life-threatening emergency.
- Ask your manager or the Resuscitation Service if you are unsure.

2. Introduction and aim

This manual brings together the Trust's arrangements for resuscitation and decisions not to attempt cardiopulmonary resuscitation (DNACPR) for adults and children. Each procedure explains why it is needed and what colleagues must do.

This manual and its linked procedures give colleagues clear guidance for adults and children. They cover:

- managing risks linked to resuscitation
- the systems needed to provide safe and effective resuscitation
- recognising and responding to a deteriorating patient
- DNACPR decisions
- the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

The manual explains the Trust's duties and colleagues responsibilities. It also explains how the Trust will check that these arrangements are followed and that the service remains safe and effective.

2.1 Definitions

- **Advance decisions to refuse treatment (ADRT)**: A decision made by any person aged 18 years or over, whilst having mental capacity, to refuse specified life sustaining treatment or intervention at a later time, should they lose capacity to make such decisions.
- **Anaphylaxis**: Anaphylaxis is a severe, life threatening, generalised, or systemic hypersensitivity reaction.
- **Best interests**: When a patient has been assessed as lacking capacity, anything done for, or decisions made on their behalf, should be done in their best interest. Best interests are assessed by healthcare professionals weighing up the treatment options in the context of the individual patient, once appropriate enquiries have been made of the patient (as far as is possible) and others. Best interest decisions include wider issues than medical issues. Mental Capacity Act (2005) Code of Practice. General Medical Council (2010).
- **Cardiopulmonary resuscitation (CPR)**: Cardiopulmonary resuscitation is a combination of external chest compressions, artificial respiration, and defibrillation. It is undertaken to restore breathing and circulation in a person where these life-giving functions have failed.
- **Child**: Within the context of this policy manual and procedures, the term child refers to patients who are under the age of 16.
- **Choking:** Choking is the occlusion of the airway by a foreign body, causing the inability to breathe, it is a medical emergency and can, if not treated cause cardiorespiratory arrest.
- **Community life support:** Community life support is resuscitation training that includes the recognition of cardiorespiratory arrest, how to provide external chest compressions and artificial respiration, how to deal with choking situation in adults and children, the manual handling of a patient in emergency situations and the introduction to defibrillation.
- **Do not attempt cardiopulmonary resuscitation (DNACPR) order:** Do not attempt cardiopulmonary resuscitation is an order stating that a decision has

been made either by the patient or medical officer in charge of their care that cardiopulmonary resuscitation (CPR) would have no clinical benefit or be wished for in this situation. It is essential that healthcare professionals, patients and those close to the patients understand that a decision not to attempt cardiopulmonary resuscitation applies only to cardiopulmonary resuscitation and not any other treatment that may be appropriate for example, antibiotics, analgesia, feeding, hydration, suction, treatment for choking and so on.

- **Futility:** When treatment is considered unable to produce the desired benefit because it cannot achieve its physiological aim, for example, there is no real prospect of restarting the heart and breathing for a sustained period of time.
- **Healthcare professional:** A registered nurse, doctor, or allied healthcare professional.
- **Immediate life support:** Immediate life support is training that includes the recognition of the deteriorating patient and cardiorespiratory arrest, how to provide external chest compressions, artificial respiration, and defibrillation, and how to deal with a choking situation in adults and children. The course also includes the use of the early warning score, neurological observations, oxygen therapy, suction, the dangers of restraint and rapid tranquillisation.
- **Independent mental capacity advocate (IMCA):** An independent advocate appointed to support vulnerable patients who lack mental capacity and have no one appropriate to act on their behalf. Independent mental capacity advocates can also become involved if colleagues conclude that relatives or other carers may not be acting in a patient's best interests.
- **Lasting power of attorney (LPA):** A legal document whereby an individual (the donor) authorises another person (the donee) to act on their behalf, in the event that the donor should lose the capacity to make their own decisions. This authority can be in respect of decisions regarding personal welfare and consent to medical treatment. In order to be valid a lasting power of attorney should be executed on the prescribed form and registered with the public guardian. If it applies to end-of-life decisions this must be clearly stated
- **Medical officer in charge of patient care:** In inpatient care this will be the patients named consultant and in the community the patient's GP, unless an agreed service provision is in place.
- **Mental capacity:** The ability of an individual to make decisions regarding specific elements of their life. This is also sometimes referred to as "competence".
- **Mental incapacity:** A person lacks sufficient capacity in relation to a matter if, at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in, the functioning of the mind or brain. This lack of capacity may be permanent or temporary.
- **Relevant other:** For the purpose of this policy, the term "relevant others" is used to describe patient's spouses, partners, relatives, carers (who are not acting in a paid, professional capacity), representatives, advocates, people with lasting power of attorney, independent mental capacity advocates and court appointed deputies and any other person deemed to have an interest in the wellbeing of the patient.

- **Young person**: Within the context of this policy manual and procedures, the term young person refers to any patient aged 16 or 17 years of age.

3. Procedures

3.1 Resuscitation and the deteriorating adult procedure

Healthcare services must provide suitable cardiopulmonary resuscitation (CPR). Patients can expect appropriate emergency support. Colleagues working for Rotherham Doncaster and South Humber NHS Foundation Trust (the Trust) may therefore need to take part in resuscitation during their work.

The Trust provides mental health, learning disability and community services. It must provide resuscitation at a level that is suitable for each service. Safe life support depends on standard equipment, training and procedures. Local arrangements will reflect the site, the colleagues available and the care provided, with support from the ambulance service.

This procedure outlines the systems in place in the trust to provide high-quality resuscitation to its patients at all times.

3.1.1 Cardiopulmonary arrest prevention and the deteriorating patient

The resuscitation service will work alongside the medical director (physical health and wellbeing) to promote the importance of physical wellness and healthy lifestyles.

The trust will wherever possible promote the prevention of cardiopulmonary arrest occurring by monitoring and observing:

- physically unwell and deteriorating patients
- those being restrained both during and after the restraint
- those that have been given rapid tranquillisation
- those with Head injuries or possibility of head injury (unwitnessed fall)
- those who have been suspected of using a ligature

Physical observations for these patients will be taken in conjunction with the use of a track and trigger system the National early warning score 2 (NEWS2), a plan for vital signs monitoring that identifies which variables need to be monitored including the frequency of measurements, as advised by the Resuscitation Council, National Institute for Health and Care Excellence (NICE) and National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

To work alongside the NEWS2 and neuro observations the resuscitation service has developed flow charts for both head injuries and ligatures. See appendix B and C.

3.1.2 Emergency lifesaving drugs

The provision of standardised medication to treat the deteriorating patient is vital, therefore, all inpatient areas carry drugs that can be given in emergency situations by a registered nurse, these drugs will be kept in stock medication cupboards, easily accessible at all times, stored with the appropriate paraphernalia to administer, and the appropriate flow chart displayed on the outside of the cupboard. These drugs are:

- aspirin
- glyceryl trinitrate (GTN) spray
- naloxone
- glucagon or glucogel
- adrenaline
- oxygen
- salbutamol

When an emergency lifesaving drug is administered the following details must be recorded in the patient records:

- date
- time
- drug name
- strength
- dose
- route
- batch number
- expiry date
- along with the details of the patient's presentation at the time of administration

3.1.3 Equipment

The provision of suitable, standardised equipment is paramount in resuscitation so that colleagues are familiar, proficient and confident with the use of that equipment. For areas revaluating the provision of resuscitation equipment within their areas the trust emergency equipment risk assessment must be used in conjunction with discussions with the resuscitation officer.

Details are shown in appendices F to H, equipment required in healthcare areas.

3.1.4 Initiation of and criteria for resuscitation

Colleagues must start resuscitation for any patient, visitor or colleague who collapses on or near Trust premises. Colleagues caring for a person in hospital, another healthcare setting or the person's home must start CPR and call for appropriate help unless a valid DNACPR decision is in place, rigor mortis is present or there are clear signs of decomposition. Do not use skin temperature or colour alone to decide whether to start CPR.

If colleagues believe a person should have a DNACPR decision but none is available, they must start full resuscitation. Continue until the emergency service takes over or a doctor directs colleagues to stop.
When someone has collapsed, colleagues must immediately use the danger, response, airway, breathing and circulation (DRABC) approach. Shout for help and activate the local alarm. Once a medical emergency is identified at Tickhill Road Hospital or elsewhere on the Tickhill Road site, call an ambulance without delay.

Dialling: 2222 on the internal phone system, state cardiac arrest, the caller will be given instructions by switchboard colleagues to enable the call to be transferred to the ambulance service.

- Great Oaks dialling: 9-999
- The Woodlands dialling: 9-999
- Swallownest Court dialling: 9-999
- All other areas dialling: 999
- Softphone: 999 goes straight through to emergency services

3.1.5 Relatives who choose to witness resuscitation attempts

Some relatives want to be present during a resuscitation attempt. Being present may help them understand what happened and reassure them that colleagues did everything possible. However, seeing CPR can be distressing. Colleagues must consider each situation individually and, where it is safe and practical, support a relative who wishes to stay.

"Many relatives want the opportunity to be present during the attempted resuscitation of their loved one." (RCUK, 2021).

If a relative is present, a member of the care team should support them and explain what is happening. If they cannot be present, colleagues should communicate clearly, provide a private place for discussion where possible, explain bad news sensitively, support their grief, and help with viewing, faith, legal and practical arrangements. In community settings, colleagues who are working alone must deal with the clinical emergency first and offer support to the family as soon as possible afterwards.
In the community setting, where colleagues often visit patients alone, the trust support colleagues prioritising the clinical emergency first and if there is an opportunity after the event then to support the family.

3.1.6 Do not attempt cardio-pulmonary resuscitation orders

The Trust uses the Yorkshire and Humber approach to DNACPR decisions. Colleagues must follow the DNACPR procedure in this manual and know which process applies in their care group, including whether to use the ReSPECT process or the current regional DNACPR form.

3.1.7 Incident reporting, including external reporting requirements

Record every resuscitation attempt on the Trust incident reporting system. Complete the cardiac arrest report form in appendix I and email it to the resuscitation officer within 24 hours.

Also report any life-threatening medical emergency, such as choking or anaphylaxis, and any failure of emergency medical equipment. Follow the Trust's incident management policy for internal and external reporting requirements.

3.2 Do not attempt cardiopulmonary resuscitation (DNACPR) adult

Medical treatment should benefit the patient, protect or improve health where possible, and avoid unnecessary harm. Treatment should not be given when it no longer provides an overall benefit or when a patient with capacity has refused it.

Extending life will often benefit a patient, but treatment should not continue at any cost without considering the person's quality of life and the burden of treatment. CPR may not be appropriate when it is unlikely to work, when a person is dying, or when it

would only prolong suffering. In these situations, care should focus on comfort and dignity.

Under the provisions of the Mental Capacity Act (2005), patients with capacity can decide that the stage has been reached beyond which, for them, continued treatment aimed at prolonging life, although possible, would be inappropriate. Patients may have also utilised the provisions of the act to identify a point in the future after which they do not want treatment, including life sustaining, and refuse further interventions through an advanced decision. Please refer to the trust's policy for advance statements and advance decisions

Under the provisions of the Mental Capacity Act (2005) where patients have no advance decision and lack capacity, all decisions about whether to provide treatment must be taken in a way that reflects their best interests. Under the act, patients have the right to appoint an attorney to make healthcare decisions on their behalf.

An attorney can only make life-sustaining treatment decisions if this is made explicit within the lasting power of attorney order. In these circumstances the attorney must always act in the donor's best interests (Mental Capacity Act (2005) Code of Practice (2007)). Please refer to the trust's Mental Capacity Act (2005) policy.

Where the patient who lacks capacity has no relative or friend to support life-sustaining decisions, the Mental Capacity Act (2005) has made provisions for the instruction of an independent mental capacity advocate to be consulted to support the best interest decision-making process. Please refer to the trust's Mental Capacity Act (2005) policy.

A best interests assessment must consider the patient's clinical condition, current wishes and any wishes or preferences they expressed before losing capacity. Colleagues must discuss resuscitation sensitively with patients who have capacity and, where appropriate, with people close to a patient who lacks capacity. These discussions should explain why treatment may be offered and why some treatment may not provide benefit.

Each case involves an individual patient with their circumstance, and it is important that these circumstances are central to each decision rather than applying the same decision to whole categories of patients. Unless a patient who lacks capacity has an appointed Attorney with explicit powers to make decisions regarding life-sustaining treatment, any decision not to attempt resuscitation is ultimately the responsibility of the medical officer in charge of the patient's care (see definition section). Good practice however dictates that consultation should, whenever possible, take place with the other members of the team involved in the care of the patient. Provisions are made under the Mental Capacity Act (2005) and its Code of Practice (2007) for referring decisions to the Court of Protection should professionals' judge that an Attorney is not acting in a donor's best interest. Please refer to the trust's Mental Capacity Act (2005) policy.

This procedure is based on the guidelines produced in 2016 by the British Medical Association (BMA), Royal College of Nursing (RCN) and Resuscitation Council (UK)

and should be read in conjunction with this document. It is written with due regard for the requirements of the Mental Capacity Act (2005).

This procedure should be read in conjunction with the relevant professional standards and guidelines including the Nursing and Midwifery Council (NMC) publication Professional standards of practice and behaviour for nurses and midwives 2015 and the General Medical Council (GMC) publication, treatment and care towards the end of life; good practice in decision-making (July 2010).

This procedure should be read in conjunction with the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) South Yorkshire Integrated Care Board regional policy and the trust wide standard operating procedure.

3.2.1 Do not attempt cardiopulmonary resuscitation in inpatient areas

On admission to an inpatient area, it is only necessary to discuss the cardiopulmonary resuscitation status of a patient and consider making a do not attempt cardiopulmonary resuscitation decision in the following circumstances:

- where the patient's condition indicates that cardiopulmonary resuscitation is unlikely to be successful
- where successful cardiopulmonary resuscitation is likely to be followed by a length and quality of life which would not be in the best interests of the patient to sustain
- where cardiopulmonary resuscitation is not in accord with the recorded sustained wishes of a patient who has capacity
- where cardiopulmonary resuscitation is not in accord with a valid applicable written advance decision which demonstrates a patient's informed, voluntary and competently made refusal, which relates to the circumstances which have arisen, is legally binding upon medical colleagues

In cases where a patient is admitted to a ward with an existing do not attempt cardiopulmonary resuscitation (DNACPR) order, this order will remain but must be reviewed on the day of admission and an entry made in the patients notes on the DNACPR template (see appendix K).

All patients admitted to an inpatient area should have their resuscitation status documented within the admission documentation, if they have a recommended summary plan for emergency care and treatment (ReSPECT) plan:

- RDaSH ReSPECT and DNACPR template. The template must be completed for all patients that have a ReSPECT plan and their Resuscitation status identified.
- a discussion with the patient (and, or those close to them, where appropriate) is only required if the medical decision is for DNACPR
- clinicians completing or reviewing a ReSPECT document must follow the ReSPECT procedure

Clinicians involved in these discussions must understand the framework for making decisions about resuscitation. It is essential to recognise whose decision it is, and to distinguish between the legal requirements and the clinical responsibilities.

Conversations should focus on ensuring that the patient, or those closest to them are fully aware of the decision, rather than simply completing a DNACPR form. The only exception is when there is an advance decision to refuse treatment (ADRT) that specifically declines cardiopulmonary resuscitation (CPR).

See decision-making framework flowchart.

3.3 Child 18 years and under recommended summary plan for emergency care and treatment procedure

Within Rotherham Doncaster and South Humber NHS Foundation Trust (the trust) physically ill children under 18 years of age will be under the care of a consultant from a neighbouring acute trust. However, these children may be cared for within the community by trust services.

The document used to document the resuscitation status of a child under the age of 18 years is the recommended summary plan for emergency care and treatment (ReSPECT) document. Please see the ReSPECT procedure for emergency care planning and do not attempt cardiopulmonary resuscitation (DNACPR) decisions that have used this process.

The clinical circumstances that surround cardiorespiratory arrest in children differ from those of adults; the legal and ethical aspects also differ.

It is vital that when these agreements have been made that the child is offered the same treatment by all clinicians involved in their care.

The aim of this procedure is to ensure that trust colleagues are aware of their responsibilities surrounding the children and young peoples advanced care planning (CYACP) which is the children's ReSPECT form.

The procedure aims to ensure a consistent approach for sharing the planned decisions for children across the trust and to ensure that decisions that have been made about children in other specialist services can transfer between the different services and localities of the trust and that the trust does not compromise patient care.

The procedure outlines the duties and responsibilities of the trust to comply with relevant legislation and guidance.

If a child within the care of the trust children's services has an existing recommended summary plan for emergency care and treatment (ReSPECT) from within another organisation, the lead trust clinician should liaise with the child's consultant from the other organisation, the child and their family to discuss this and to ensure that circumstances have not changed and that is still current.

3.3.1 Communication of the order

The lead trust clinician must ensure that all clinicians involved in the child's care are aware of the order.

The order must remain with the child. Discussions should be held with the child if possible, and their parents as to the importance of ensuring the document goes with them when they are attending services, school etc.

Any child that has a child and young person's advance care plan (CYPACP) in place should have an alert added to SystmOne by the practitioner completing the recommended summary plan for emergency care and treatment (ReSPECT) trust template to alert multidisciplinary teams that the child or young person has a ReSPECT in place.

Also, the clinician should add a reminder (high-priority category) stating that ReSPECT in place and where the electronic version is saved in the patient record. The key clinician should also notify South Yorkshire Ambulance Service (YAS) for an alert to be flagged on their systems.

If the decision within the ReSPECT is that in the case of cardiopulmonary arrest that resuscitation will not take place, this needs to be clearly documented and shared with relevant parties. In the event of this decision being made the lead trust clinician will inform the trust medical director and share the ReSPECT document with them.

3.3.2 Presumption to resuscitate

"All patients being attended by a clinician, whether in hospital, healthcare unit or their own home, are to be actively and vigorously resuscitated and suitable assistance called, unless they have a recommended summary plan for emergency care and treatment (ReSPECT) that details otherwise. Where no decision has been made about cardiopulmonary resuscitation (CPR) before any subsequent cardiopulmonary arrest, and the express wishes of the person are unknown it is expected that colleagues will attempt resuscitation."

However, the Resuscitation Council state the below, which does allow for some senior clinical decision-making.

"Where no explicit decision about cardiopulmonary resuscitation has been considered and recorded in advance there should be an initial presumption in favour of cardiopulmonary resuscitation. However, in some circumstances where there is no recorded explicit decision (for example a person in the advanced stages of a terminal illness where death is imminent and unavoidable, and cardiopulmonary resuscitation would not be successful) a carefully considered decision not to start inappropriate cardiopulmonary resuscitation should be supported." (Resuscitation Council 2021)

Is it important to note that healthcare or nursing assistants must commence cardiopulmonary resuscitation if a ReSPECT form is not in place that details that resuscitation is not to be undertaken.

In circumstances where cardiopulmonary resuscitation has been initiated without the knowledge of an existing documented decision to not resuscitate, and this form is presented the continuation of cardiopulmonary resuscitation would be inappropriate however the decision to stop must come from a senior healthcare professional (doctor or registered nurse). If there is any doubt, cardiopulmonary resuscitation should continue until reviewed by the attending paramedic or doctor.

3.3.3 Review of the recommended summary plan for emergency care and treatment form

The recommended summary plan for emergency care and treatment (ReSPECT) form will be reviewed when the health needs or circumstances changes, although it Is good practice to review at least annually, and should be reviewed in each person's individual situation.

3.4 Recommended summary plan for emergency care and treatment (ReSPECT)

This is a South Yorkshire Integrated Care Board policy, please refer to South Yorkshire Integrated Care Board ReSPECT policy.

4. Responsibilities

4.1 Clinical and non-clinical colleagues

- Follow this manual within the limits of their role. All colleagues must be able to recognise cardiac arrest, start CPR and call for help.
- Tell their manager about anything that may prevent the manual being followed, including problems with training or equipment.
- Report incidents under the incident reporting policy and complete the correct cardiac arrest report form.
- Keep a personal record of completed training.
- Take part openly and constructively in incident reviews so that practice can improve and the Trust can learn.

4.2 Ward or team managers

- Facilitate effective local induction processes for all new starters
- Manage the process of releasing colleagues for training and updating at least annually in the skills relevant for their area, in line with the mandatory risk management training policy.
- Maintain colleagues training records for the area, including temporary, bank and agency colleagues.
- Proactively identify risks due to lack of training or resources to the manager or modern matron.
- Manage and maintain the resuscitation equipment within the area of responsibility via:
    - an up-to-date medical devices Inventory
    - signed and dated daily and weekly equipment check records (as per requirements set out in appendix D continual availability of equipment, see appendix D, emergency equipment required in healthcare areas), in line with the manufacturer's recommendations; a record of these checks will be kept for 3 years
    - report any equipment issues immediately to the manager or modern matron
    - adequate stocks of disposable or single use parts of the resuscitation equipment required in that area, such as pocket masks, oxygen masks, airway tubes, defibrillator pads etc. to maintain continued functioning of the equipment by immediate replacement

- Maintain the equipment ready and available for use for another event as soon as practicable after a resuscitation attempt where the equipment is used.
- Make timely arrangements for colleagues involved in a resuscitation event to be supported, debriefed, and offered counselling as required in conjunction with the resuscitation officer.
- Facilitate an environment where incidents are reviewed in an open and positive manner, involving colleagues at all levels in developing policy and practice and promoting organisational learning.
- Proactively seek advice and support from resuscitation service.

4.3 Managers or modern matrons

- Disseminate, implement and monitor implementation of this policy manual within areas of responsibility.
- Facilitate, support and monitor ward or team managers in their responsibilities with regard to policy implementation and monitoring.
- Identify and allocate resources in order to comply with this policy manual.
- Make available appropriate and suitably maintained resuscitation equipment, maintaining up-to-date medical devices inventories in all areas of responsibility.
- Promote incident reporting and audit requirements as specified within the policy through local induction processes in all areas of responsibility.
- Facilitate an environment where incidents are reviewed in an open and positive manner, involving colleagues at all levels in improving practice and promoting organisational learning.
- Proactively seek advice and support from the resuscitation service.

4.4 Resuscitation service

- Liaise with managers or modern matrons to formulate suitable colleagues training programmes to support effective implementation of this policy manual.
- Deliver training using the current national guidelines.
- Maintain a central record of training delivered and produce reports on training compliance.
- Discuss with the managers or modern matrons the approach to be taken with colleagues who do not successfully complete the training assessments.
- Act as specialist advisors to the trust on resuscitation and related matters.
- Produce an annual audit of resuscitation events, resuscitation equipment, choking incidents and do not attempt cardio-pulmonary resuscitation (DNACPR) or recommended summary plan for emergency care and treatment (ReSPECT) orders.
- Produce a quarterly audit report on the continual availability of equipment, see appendix D, emergency equipment required in healthcare areas.
- Facilitate policy and practice development and organisational learning as a result of audit.
- Support Managers in facilitating an environment where incidents are reviewed in an open and positive manner, involving colleagues at all levels in improving practice and promoting organisational learning
- Be available as a source of specialist advice and support to managers and colleagues, including incident debriefing.

- Represent the trust on the regional DNACPR working party and the Doncaster locality End of Life group as the DNACPR lead for the trust.
- Lead the review and updating of this policy.

4.5 Resuscitation Committee

The Resuscitation Committee reviews the assurance arrangements in this manual. It also oversees the annual audit programme against Resuscitation Council UK quality standards.

4.6 Consultants and medical officers

The consultant or medical officer responsible for the patient's care has overall responsibility for clinical decisions made under this manual.

5. Training

In adherence with the expectations of the Resuscitation Council UK, all colleagues should have basic knowledge and skills in resuscitation. All colleagues should be equipped to recognise cardiac arrest, to commence cardiopulmonary resuscitation (CPR) and call for help. All colleagues should attend, as a minimum, community life support (CLS) every 12 months.

All employees working in areas where physical restraint, rapid tranquilisation or seclusion may be required, will be trained to a level equal to the immediate life support (ILS) course of the Resuscitation council UK. This will be repeated every 12 months.
All employees working within areas with immediate access to a defibrillator will be trained to the equal level of the immediate life support course of the Resuscitation Council UK. This will be repeated every 12 months.

5.1 Enhancing clinical colleagues support in resuscitation training

Objective: our organisation is committed to empowering clinical colleagues through resuscitation training, ensuring everyone has equitable access to learning, support, and workplace inclusion. Our aim is to support clinical colleagues not only in training, but also in identifying and managing any clinical limitations appropriately.

Equality, Diversity and inclusion commitment: in alignment with the Resuscitation Council UK's Diversity and Inclusion policy:

"Resuscitation council UK recognises the value of having a diverse group of people with a diversity of thinking and perspectives involved in the organisation" and "is committed to working with partners that represent all of society... ensures that all its officers, trustees, colleagues, instructors and other volunteers and consultants have equal opportunity to achieve their full potential."

Resus council UK equal opportunities policy: this policy underpins our approach, affirming that training and support must be inclusive, fair, and reflective of diverse needs and perspectives.
Identification and risk assessment:

- clinical limitations identified during training (for example, physical, cognitive, sensory, or other) will be escalated to the colleague's line manager

- the line manager is responsible for conducting a tailored risk assessment to determine appropriate adjustments or accommodations in the workplace

Learning and development support:

- our Learning and Development team is dedicated to providing reasonable adjustments during resuscitation training. These may include assistive aids, alternative formats, extra time, or modified practical setups
- where adjustments are implemented, the Learning and Development team will communicate feedback to the line manager to facilitate consistent support beyond training

Escalation to senior resuscitation officer: if additional support or guidance is required, the trust's senior resuscitation officer must be promptly contacted to offer further assistance and oversight.

5.1.1 Summary of training responsibilities

- Clinical colleagues: participate in training; disclose any limitations identified.
- Line manager: review limitations; conduct a risk assessment; implement workplace adjustments.
- Learning and development: provide reasonable adjustments during training; feedback outcomes to line management.
- Senior resuscitation officer: offer further assistance and oversight if required.

See colleague clinical limitations and reasonable adjustment risk assessment form (colleagues' access only).

Basic training on do not attempt cardiopulmonary resuscitation (DNACPR) and recommended summary plan for emergency care and treatment (ReSPECT) will be within the community life support and immediate life support sessions. For clinicians who have such discussions within their job roles (includes some specialist nurses identified in the Resuscitation Committee), additional training is required (see DNACPR and ReSPECT sections)

The Yorkshire and Humber e-learning is an excellent source of information and can be used as a training resource in team meetings. It can also be used as an individual training resource and can be found on the trust eLearning platform.

5.2 All non-clinical and community clinical colleagues community life support training (includes do not attempt cardio-pulmonary resuscitation or recommended summary plan for emergency care and treatment)

- How often should this be undertaken: 12 months.
- Length of training: 3 hours.
- Delivery method: face to face.
- Training delivered by whom: resuscitation service.
- Where are the records of attendance held: electronic colleagues record (ESR).

5.3 All in-patient clinical colleagues immediate life support (ILS) training

- How often should this be undertaken: 12 months.
- Length of training: 3 hours.
- Delivery method: face to face.
- Training delivered by whom: resuscitation service.
- Where are the records of attendance held: electronic colleagues record (ESR).

5.4 Clinicians that have escalation plan discussions in care groups that have recommended summary plan for emergency care and treatment: e-learning

- How often should this be undertaken: one-off.
- Length of training: 40 minutes.
- Delivery method: e-learning, ReSPECT.
- Training delivered by whom: Resuscitation Council UK.
- Where are the records of attendance held: electronic colleagues record (ESR).

5.5 Clinicians that have escalation plan discussions in care groups that have recommended summary plan for emergency care and treatment

- How often should this be undertaken: one off and more if required.
- Length of training: 1 hour.
- Delivery method: face to face clinical supervision for additional sessions.
- Training delivered by whom: nurse consultant in palliative care, consultants in older peoples mental health.
- Where are the records of attendance held: electronic colleagues record (ESR).

6. Monitoring Arrangements

6.1 Policy implementation

- Policy implementation including:
    - requirement for a documented plan for vital signs monitoring that identifies which variables need to be measured, including the frequency of measurement
    - use of an early warning system within the trust to recognise patients at risk of deterioration
    - actions to be taken to minimise or prevent further deterioration in patients
    - how the trust documents that resuscitation equipment is checked, stocked and fit for use
    - incident reports of resuscitation events
    - incident reports of choking situation events
    - colleagues training, as identified in the training needs analysis

- How: resuscitation audit.
- Who by: resuscitation officer.
- Reported to: quarterly and annually.
- Frequency: Resuscitation Committee.

7. Related documents and associated references

- Consent to care and treatment policy
- Clinical risk assessment and management policy
- Clinical skills policy
- Incident management policy
- Infection prevention and control
- Mandatory and statutory training policy
- Mental Capacity Act (2005) policy
- Medical devices management policy
- Slips, trips and falls for staff and visitors, prevention and management policy
- Rapid tranquillisation policy and guidelines (pharmacological management of violence)
- Resuscitation Council (UK) (2021) resuscitation guidelines
- Guidance, do not attempt cardiopulmonary resuscitation (DNACPR) and cardiopulmonary resuscitation (CPR) decisions
- Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), Resuscitation Council UK
- Mental Capacity Act (2005)
- Advance decisions to refuse treatment guide
- Advance care planning, end of life care, Royal College of Nursing

8. Appendices

8.1 Appendix A the deteriorating patient

Refer to appendix A: the deteriorating patient (colleague access only).

8.2 Appendix B new head injury flow chart

Refer to appendix B: new head injury flow chart (colleague access only).

8.3 Appendix C ligature flow chart

Refer to appendix C: ligature flow chart (colleague access only).

8.4 Appendix D normal parameter exception care plan

Refer to appendix D: normal parameter exception care plan (colleague access only).

8.5 Appendix E emergency drugs

Refer to appendix E emergency drugs (colleague access only.

8.6 Appendix F emergency equipment

Refer to appendix F: emergency equipment (colleague access only).

8.7 Appendix G grab bag checklist

Refer to appendix G: grab bag checklist (colleague access only).

8.8 Appendix H equipment checklist

Refer to appendix H: equipment checklist (colleague access only).

8.9 Appendix I cardiac arrest report form

Refer to appendix I: cardiac arrest report form (colleague access only).

8.10 Appendix J young people aged 16 and 17 years special considerations

The following points apply when a patient is aged 16 or 17.

8.10.1 Current practice relating to young persons

The Association for Children's Palliative Care (2004) recommends that every young person with a life limiting condition should be helped, with their family, to decide on an end of life or palliative care plan.
Within the trust, the large majority of children (16 to 18 years) needing palliative care are under specialists in Sheffield.

8.10.2 Who should or could initiate discussion, and when?

Professionals caring for a young person with a life-limiting or life-threatening condition may start discussions about end-of-life planning before the person is terminally ill. A discussion may also be needed after an acute or repeated illness, when the risk of deterioration or sudden death has increased. The named paediatrician or palliative care practitioner will usually be the right person to begin the discussion.

Choose the timing sensitively and offer support to the young person and family. Do not put pressure on them to make a decision. If they do not want to continue a

discussion about DNACPR, respect their wishes and record this in the medical record. The young person or family may ask to discuss the issue at any time. Discussion may also be initiated by the young person or family at any time.

8.10.3 Who can make decisions?

The Department of Health (2009) state that:

> "By virtue of section 8 of the Family Law Reform Act (1969), young people aged 16 and 17 are presumed to be capable of consenting to their own medical treatment. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16 to 17 may in certain circumstances be overridden by either a person with parental responsibility or a court."

In exceptional circumstances it may be impossible for all concerned to reach a united decision regarding the best interest of the young person. If this cannot be resolved by the patient's consultant, the consultant should request further advice from regional experts, trust medical director and trust legal services department.

To establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria should be used as for adults. If a young person lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, the mind or brain then the Mental Capacity Act (2005) will apply in the same way as it does to those who are 18 and over (Department of Health (2009)).

Where a young person lacks capacity to decide, a person with parental responsibility for the young person may make a DNACPR decision where they consider that to be in the young person's best interests.

If a 16 or 17 year-old is capable of making an informed decision then it is not legally necessary to obtain additional consent from a person with parental responsibility. It is, however, good practice to involve the young person's family in the decision-making process, unless the young person specifically wishes to exclude them, if the young person consents to their information being shared.

If a young person decides that he or she does not wish to be resuscitated and that the family should not be involved with or informed about the decision this must be urgently referred to the trust medical director and legal services department.

8.10.4 What is, and who has, parental responsibility?

Parental responsibility is defined by section 3 of the Children Act (1989) as:

"All rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to a child and his property."

Parental responsibility is therefore concerned with bringing the child up, caring for him and making decisions about him, including the right to consent or withhold consent for medical treatment. Parental responsibility is relinquished on a young person's eighteenth birthday.

The Children Act (1989) sets out persons who may have parental responsibility. These include:

- the child's mother
- the child's father, if he was married to the mother at the time of birth
- unmarried fathers, who can acquire parental responsibility in several different ways:
    - for children born before 1 December 2003, unmarried fathers will have parental responsibility if they:
        - marry the mother of their child or obtain a parental responsibility order from the court
        - register a parental responsibility agreement with the court or by an application to court
    - for children born after 1 December 2003, unmarried fathers will have parental responsibility if they:
        - register the child's birth jointly with the mother at the time of birth
        - re-register the birth if they are the natural father
        - marry the mother of their child or obtain a parental responsibility order from the court
        - register with the court for parental responsibility
        - the child's legally appointed guardian
        - a person in whose favour the court has made a residence order concerning the child
        - a local authority designated in a care order in respect of the child
        - a local authority or other authorised person who holds an emergency protection order in respect of the child.
    - it should be noted that:
        - if a child is in local authority care parents can share parent responsibility with the local authority, this is lost if the child is adopted
        - parental responsibility can also be restricted by a court order
        - foster parents do not automatically have parental responsibility

8.10.5 Children in local authority care

Where a child is in the care of the local authority the child's social worker must be involved in all of the discussions as well as parents, as the local authority shares parental responsibility with the parents. However, when a child is in voluntary care (section 20, Children Act (1989)) the parents retain full parental responsibility.

8.10.5.1 What happens when a young person and a person with parental responsibility disagree about a do not attempt cardiopulmonary resuscitation decision?

Decision-making with young people may be a matter of negotiation between the child, those with parental responsibility and clinicians. Inevitably there will be times when young people and those with parental responsibility for them do not agree about whether a do not attempt cardiopulmonary resuscitation (DNACPR) decision should be made.

If a young person is deemed to have the capacity to make a DNACPR decision (or believes he or she has capacity to make a decision?) and there is disagreement between the patient and those with parental responsibility despite attempts to reach agreement, legal advice should be sought.

What happens when medical colleagues and a young person or persons with parental responsibility disagree about a DNACPR decision?

Where medical colleagues are strongly of the opinion that cardiopulmonary resuscitation should not be attempted but the young person or people with parental responsibility disagree, or vice versa, a legal opinion should be sought.

8.10.6 Safeguarding issues

Where there is doubt about whether a person with parental responsibility is acting in the interest of the young person, then local safeguarding children board procedures must be instigated.

8.10.7 Education establishments

Potentially a young person may wish to continue at school with an agreed do not attempt cardiopulmonary resuscitation (DNACPR) decision in place. This can potentially cause anxieties for both the family and colleagues supporting that young person. Advice can be sought from a palliative care practitioner in dealing with those anxieties and what measures can be put in place to support the child and family during this period.

8.10.8 Interface with the child death overview process

Each safeguarding board has a designated paediatrician for all unexpected child deaths who are supported by a Rapid Response team. All deaths of a person under 18 years of age must be reported to the rapid response professional in the local area, who will notify the child death overview panel of the local safeguarding children board in accordance with the statutory guidance in chapter 7, Working Together to Safeguard Children 2010. Do not attempt cardiopulmonary resuscitation (DNACPR) status must be reported at this time. The rapid response team contact details can be found on the local safeguarding children's board website.

8.11 Appendix K cardio-pulmonary resuscitation decision-making framework

1. Is cardiac or respiratory arrest a clear possibility?
    - No, it is not necessary to discuss cardiopulmonary resuscitation with the patient unless they express a wish to discuss it.
2. Yes, is there a realistic change that cardiopulmonary resuscitation could be successful?
    - No, if a do not attempt cardiopulmonary resuscitation (DNACPR) decision is made on clear clinical grounds that cardiopulmonary resuscitation would not be successful there should be a presumption in favour of informing the patient of the decision and explaining the reason for it (see section 5). Subject to appropriate respect for confidentiality those close to the patient should also be informed and offered an explanation. Where the patient lacks capacity and has a welfare attorney or court-appointed deputy or

guardian, this representative should be informed of the decision not to attempt cardiopulmonary resuscitation and the reasons for it as part of the ongoing discussion about the patient's re (see section 5). If the decision is not accepted by the patient, their representative or those close to them, a second opinion should be offered.

3. Yes, does the patient lack capacity and have an advance decision specifically refusing cardiopulmonary resuscitation or have an appointed attorney, deputy or guardian?
    - Yes, if a patient has made an advance decision refusing cardiopulmonary resuscitation, and the criteria for applicability and validity are met, this must be respected. If an attorney, deputy or guardian has been appointed they should be consulted (see sections 9.1 and 10).
4. No, does the patient lack capacity?
    - Yes, discussion with those close to the patient must be used to guide a decision in the patient's best interests (see section 10). When the patient is a child or young person, those with parental responsibility should be involved in the decision where appropriate, unless the child objects (see section 11).
5. No, is the patient willing to discuss his or her wishes regarding cardiopulmonary resuscitation?
    - No, respect and document their wishes (see section 6.3). Discussion with those close to the patient may be used to guide a decision in the patient's best interests, unless confidentiality restrictions prevent this.
6. Yes, the patient must be involved in deciding whether cardiopulmonary resuscitation will be attempted in event of cardiorespiratory arrest.
    - If cardiorespiratory arrest occurs in the absence of a recorded decision there should be an initial presumption in favour of attempting cardiopulmonary resuscitation.
    - Anticipatory decisions about cardiopulmonary resuscitation are an important part of high-quality health care for people at risk of death or cardiorespiratory arrest.
    - Decisions about cardiopulmonary resuscitation are sensitive and complex and should be undertaken by experienced members of the healthcare team with appropriate competence.
    - Decision about cardiopulmonary resuscitation require sensitive and effective communication with patients and those close to patient.
    - Decision about cardiopulmonary resuscitation must be documented fully and carefully.
    - Decisions should be review with appropriate frequency and when circumstances change.
    - Advice should be sought if there is uncertainty.

Taken from Resuscitation Council UK, British Medical Association and Royal College of Nursing (2016) Decisions relating to cardiopulmonary resuscitation. 3rd.

8.12 Appendix L do not attempt cardiopulmonary resuscitation form (WZT652)

Refer to appendix L: do not attempt cardiopulmonary resuscitation form (WZT652) (colleague access only).

8.13 Appendix M do not attempt cardiopulmonary resuscitation communication sticker

Refer to appendix M: do not attempt cardiopulmonary resuscitation communication sticker (colleague access only).

8.14 Appendix N What if my heart stops leaflet

This leaflet has been produced to help you understand what happens when your heart stops beating, how cardio-pulmonary resuscitation (CPR) can be used, and when it may not be helpful.

It may be upsetting to talk about resuscitation. This booklet tries to explain the issues as clearly and sensitively as possible.

You do not have to discuss resuscitation if you do not want to. However, your health care team is available if you change your mind.

8.14.1 Why do people die?

It's sad, but everybody dies.

Thinking about dying usually makes us sad, and perhaps a bit frightened.

It's not something we like to think about, but talking with your family or with your doctor, and making plans for that time, can make things as easy as possible for you and those close to you.

Death might be due to an accident, or a sudden event, but most people die from serious illnesses which they have had for many months or even years.

8.14.2 What happens when my heart stops beating?

When you die your heart stops beating.

No blood gets pumped round your body, so very quickly the rest of your body stops working.

Your kidneys, your liver, your lungs all stop working.

Your brain will stop working about three minutes after your heart stops beating.

8.14.3 What is cardiopulmonary resuscitation?

If your heart stops beating it may be possible to start it beating again.

Attempts to restart your heart will include pressing down firmly on your chest again and again and breathing for you.

This is called cardiopulmonary resuscitation (CPR).

Ambulance or hospital colleagues might use a machine to give your heart an electric shock to make it start working again.

They may put a tube down your windpipe to help you breathe, or give you drugs to help your heart start.

8.14.4 Do patients fully recover after cardiopulmonary resuscitation?

Each person has a different chance of cardiopulmonary resuscitation (CPR) working. Only about 2 out of 10 patients who have cardiopulmonary resuscitation survive and go home from hospital; survival is less likely in people with lots of health problems.

Even if cardiopulmonary resuscitation starts the heart again, patients usually need more treatment, often in an intensive care unit. Some patients never get fully better and suffer from mental or physical disabilities.

The decision to attempt cardiopulmonary resuscitation has nothing to do with how old you are or your abilities. It is about whether the treatment will help you.
Your doctor is the best person to decide if cardiopulmonary resuscitation is likely to help.

Cardiopulmonary resuscitation will not be attempted if it will only start your heart and breathing for a short time, or if it would prolong your suffering.

8.14.5 Will someone discuss cardiopulmonary resuscitation with me?

You might want to talk about what happens when you die, or you might have questions about cardiopulmonary resuscitation. It might be that because you have lots of health problems, cardiopulmonary resuscitation cannot help, and the health care team will decide not to attempt it when your heart stops. This is a do not attempt cardiopulmonary resuscitation (DNACPR) decision.

You have a right to be told if a DNACPR decision has been made, unless telling you would be harmful.

8.14.6 What if I don’t want to or am unable to talk about this myself?

You can appoint someone to have power of attorney for your health. This person is then allowed to speak on your behalf when you can’t do this yourself. If you cannot talk for yourself or don’t wish to, then the health care professionals in charge of your care will decide what treatment is best for you (this is a best interests decision). Wherever possible they will discuss this with those close to you.

8.14.7 What if I want cardiopulmonary resuscitation to be attempted?

Health care professionals will not refuse your wish for cardiopulmonary resuscitation (CPR) if it will be of benefit to you.

However, you cannot insist on having a treatment that will not work. Health care professionals will not offer treatment that will be degrading or cause harm.

If there is any doubt that cardiopulmonary resuscitation would work, the health care team can arrange a second opinion if you would like one.

If cardiopulmonary resuscitation might work, but it is likely to leave you severely ill or disabled, your opinion about whether the chances are worth taking is very important.

The health care team must and will listen to you.

8.14.8 What if I know I don't want to be resuscitated?

If you don't want cardiopulmonary resuscitation, you can refuse it, and your health care team must respect your wishes. You can talk to your doctor or nurse about this.

Your doctor or nurse can give you advice on making a legally binding advance decision to refuse treatment.

8.14.9 If it is decided cardiopulmonary resuscitation will not be attempted, what will happen next?

If you do not want cardiopulmonary resuscitation (CPR), or if your doctor decides that it will not work for you, a do not attempt cardiopulmonary resuscitation (DNACPR) form will be completed and discussed with you.

It tells everyone who looks after you that this decision has been made.

There is only one copy of the form which will be needed if you are admitted to hospice or hospital, or if you travel by ambulance. At home, it needs to be kept safe so that healthcare professionals can see it if needed.

8.14.10 What happens if my situation changes?

Your do not attempt cardiopulmonary resuscitation (DNACPR) form will state when the decision should be reviewed. If your health condition changes, the decision can be reviewed.

Your health care team will be happy to discuss any changes with you.

8.14.11 Can I see what is written about me?

You have a legal right to see what is written about you and can ask to do so.

If you do not understand what is written, your health care team will explain it to you.

8.14.12 What about other treatments?

If doctors decide not to attempt cardiopulmonary resuscitation, this will not affect any of your other treatment.

You will still receive the best care and medicines for your condition.

8.14.13 Who else can I talk to about this?

If you or your family do not think that you have had a chance to talk about this properly, please talk to a nurse or doctor looking after you.

If you don't want to talk about it at all, that's fine too.

There are people to listen if and when you do:

- your family, friends and carers
- a hospital chaplain, or someone from your own faith community
- an advocacy service
- community nursing teams
- palliative care teams
- your GP
- your district nurse

This leaflet has been adapted from an original collaboration between The Bradford and Airedale Palliative Care Managed Clinical Network for People with Learning Disabilities and Bradford Taking Media's Access to Information for Minorities (AIM) Project.

The Yorkshire and Humber DNACPR Regional Working Group gratefully acknowledges the work of these groups.

8.14.14 References and further reading

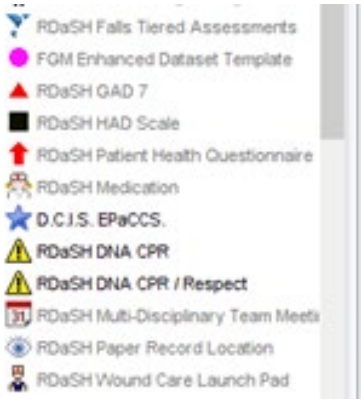
- The Bradford and Airedale palliative care managed clinical network for people with learning disabilities
  01274 323 511
- Bradford Talking media
  11 to 12 Eldon Place
  Bradford
  BD1 3AZ
  01274 848 150
  Bradford Talking Media

8.14.15 Document control

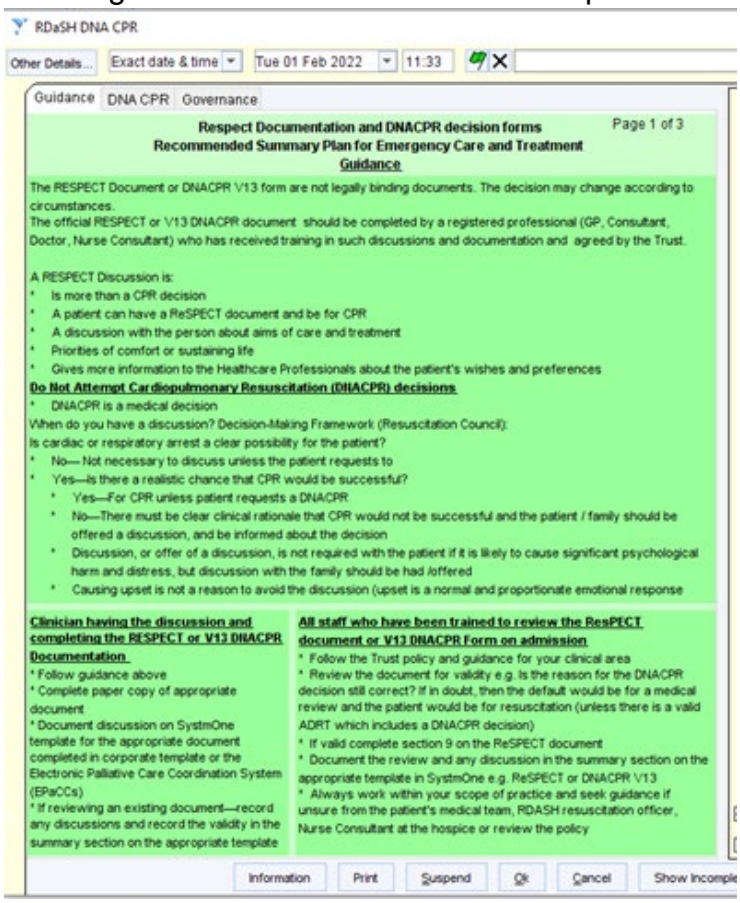
Decisions relating to cardiopulmonary resuscitation, Royal College of Nursing, Resuscitation Council (UK), British Medical Association 3rd edition 2014 Deciding right, your life your choice. NHS England Northern Clinical Networks and Senate, April 2014.

8.15 Appendix O where to document the do not attempt cardio-pulmonary resuscitation decision in the electronic records

1. **Search for DNACPR in templates** or **locate RDaSH DNACPR in the left-hand clinical tree** under corporate templates.
2. **Right click on RDaSH DNACPR**.
3. **Click again on RDaSH DNACPR**.

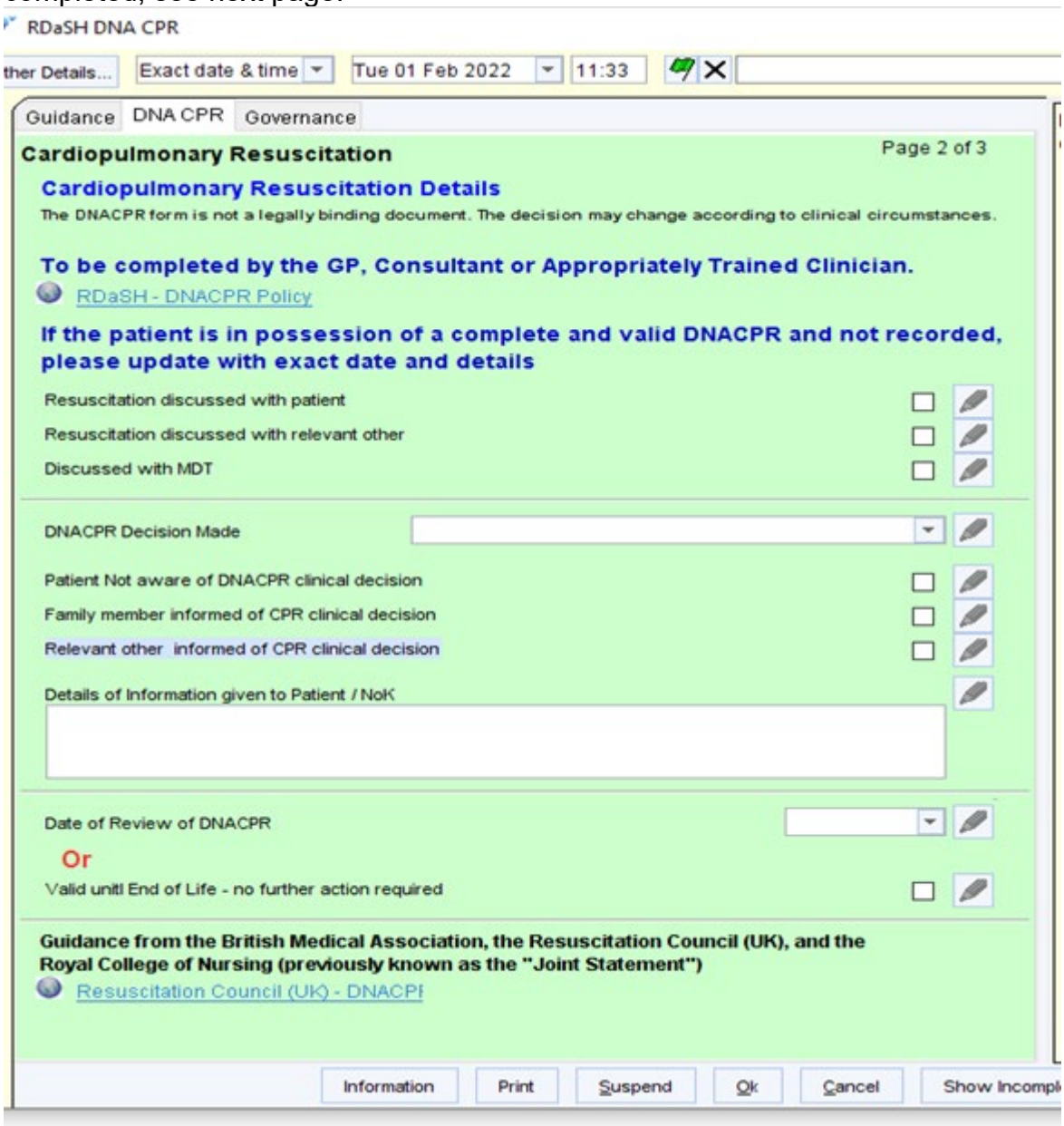


4. The green information box will come up.



5. **Click the grey DNACPR tab at the top**.

6. This page gives a guide to DNACPR. The grey tab goes to the page to be completed, see next page.



7. **Tick the relevant boxes**.
8. Select the correct action from the drop-down menu, for example, not for attempted cardiopulmonary resuscitation.
9. Write the details of the conversation with the patient or those closest to them, or the review on an existing document in the "detail of information" box.
10. If having a review date, tick the box.
11. If valid until the end of life, tick the box.
12. **Press OK and Save** as normal.