Policy No. 007
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Resuscitation Policy	
Originated by: Date Ratified: Ratified by:	SHH Resuscitation Group 12/2012 Clinical Governance Committee
Revised by: Dr Karen Chumbley, Clinical Director and Deputy CEO Revision No. 012 Date: 04/2020 Ratified by: Jo Tonkin, Director of Care Date ratified: 04/2020	
Date of next review: 10/2020	
Document Owner:	Clinical Director

Revision Summary

- 04/2020 (2) Section “DNACPR Decisions during COVID-19 Pandemic” added; Appendix 4 added. Revision date amended to 10/2020 from 11/2021.

Revision History

- 04/2020 (1) Updated to reflect the Resuscitation Council UK statement on COVID-19 in non-acute hospital settings.
- 03/2020 Updated to reflect current Covid-19 guidance from the Resuscitation Council.
- 09/2018 Routine review undertaken.
- 06/2018 Revised to inclusion location of AEDs.
- 08/2016 Revised to reflect new working practices. Minor revisions, definitions of CPR and BLS added and Monitoring section clarified by Quality Lead in liaison with Practice Educator.
- 11/2015 Revised to reflect new working practices.

Policy Statement

What is this policy intended to achieve?

This policy recognises that resuscitation from cardiopulmonary arrest may be required at any time by patients, staff and / or visitors. As a non-acute setting, the hospice will ensure that staff and/or volunteers will be trained and supported to provide adult BLS and use an AED.

St Helena (SH) does not have the facilities to provide advanced life support or ongoing care following successful resuscitation. This would be provided by paramedics via a call to 999 and a transfer to hospital.

This policy is also intended to prevent inappropriate, futile and/or unwanted attempts at cardiopulmonary resuscitation (CPR) for adult patients (aged over 16 years) under the care of St Helena.

It does not refer to other aspects of care; for example, analgesia, antibiotics, suction, treatment of choking, treatment of anaphylaxis or other interventions, which are sometimes loosely referred to as ‘resuscitation’.

To whom does this policy apply?

This policy applies to the care of all patients, staff and visitors over the age of 16 years

Who should read this policy?

All clinical staff.

Definitions & Terminology

Cardiopulmonary Arrest is defined as the absence of spontaneous and effective ventilation and systemic perfusion (circulation) Cardiopulmonary Resuscitation (CPR) is an attempt to restart a person’s heart function and breathing using emergency treatment, which at SHH can include:

- BLS

- AED

Basic Life Support (BLS) is ‘airway, breathing and circulation support without the use of equipment other than a protective barrier device.

Automated External Defibrillator (AED) is a device that delivers electrical energy to the heart in the form of a single shock via hand free pads placed on the person’s chest.

Do not attempt cardiopulmonary resuscitation (DNACPR) This decision is made with respect to cardiopulmonary resuscitation in the effect of cardiopulmonary arrest only. It does not refer to other aspects of care; for example, analgesia, antibiotics, suction, treatment of choking, treatment of anaphylaxis or other interventions, which are sometimes loosely referred to as ‘resuscitation’.

Advance decision to refuse treatment (ADRT) a decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding for healthcare staff.

Advance Care Plan (ACP) is a plan which allows the individual to express and record wishes about future care in the final months of life.

My Care Choices Register (MCCR) is a register to record advanced care plans for people in the north east Essex area

Resuscitation

All clinical staff will be trained annually to deliver adult BLS and use an AED. Nonclinical staff and volunteers will be offered training should they wish to undertake this.

All people are initially presumed to be for CPR unless a valid DNACPR decision or a valid Advance Decision to Refuse Treatment (ADRT), refusing CPR, has been made and documented.

Clinical sites

In the event of suspected cardiopulmonary arrest, the person who is first on the scene should call for help. If they are trained in adult BLS they should then proceed to assess

the person in accordance with the adult BLS procedure. Because of the heightened awareness of the possibility that the victim may have COVID-19 the person should look for signs of life and absence of normal breathing without listening or feeling for normal breath by placing their cheek close to the patient's mouth. If they are not trained then they should locate someone who is suitably trained.

If cardiopulmonary arrest is confirmed

- someone should wear PPE (plastic apron, fluid repellent mask, gloves and goggles/visor), place a cloth/towel over the victim's mouth and attempt compression only CPR and early defibrillation once the AED arrives. Do not attempt mouth to mouth resuscitation.
- someone should call 999, informing them if COVID-19 is suspected.
- someone should retrieve the AED, this should be prioritised over chest compressions.

The AED is located at:

- Myland Hall Main Reception
- The Tendring Centre Main Reception

After performing compression only CPR, all rescuers should wash their hands thoroughly with soap and water.

Community

In the event of suspected cardiopulmonary arrest, the person who is first on the scene should call for help. This may necessitate making a call to 999 if no-one else is available to do so. Clinical staff trained in adult BLS they should then proceed to assess the person in accordance with the adult BLS procedure.

BLS will be administered in accordance with the Resuscitation Council (UK) Guidelines (2015) and with due care to the increased risk of the possibility the victim has Covid-19 as detailed in the guidance for clinical sites. All clinical staff should have PPE available when out on visits.

DNACPR Decisions

All DNACPR decisions are based on current legislation and guidance.

St Helena has adopted the NHS East of England Integrated Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy for Adults (2011 – revised November 2015).

Discussions about DNACPR should form part of a broader Advance Care Plan discussion. These can be initiated by any member of clinical staff looking after the patient. DNACPR decisions can be made and documented by any doctor or senior nurse involved in the patient's care who has the appropriate expertise.

The most senior clinician involved in the patient's care is ultimately responsible for this decision, and should be made aware of any such discussions at the earliest opportunity. The decision making process should follow the Summary Decision Making Framework (Appendix 2).

The patient should be given as much information as they wish about their situation, including information about CPR in the context of their own illness, and sensitive communication around dying and end of life issues.

Where a decision is made on medical grounds because CPR will not be successful the presumption should be in favour of the patient being informed of this unless it will cause them significant harm.

A patient cannot demand to receive CPR if the medical opinion is that it will not be successful. This should be explained sensitively and a second opinion sought if agreement is not reached.

Decisions regarding CPR will be shared with all clinical teams involved in the patient's care and recorded in one or more of the following places:

- Red Bordered East of England DNACPR Form (see Appendix 3) – this should follow the patient between care settings
- Patient notes on SystmOne
- MCCR if patient consents

DNACPR Decisions during COVID-19 Pandemic

West Suffolk and North East Essex have agreed a new temporary process for remote discussion and completion of community DNACPR forms during the COVID-19 pandemic. Please see Appendix 4 for full details.

The Hospice

The majority of inpatients at St Helena are unlikely to benefit from CPR. This should include an assessment of the potential benefit of hospital admission taking the current COVID-19 situation into account. If, on admission, a patient does not already have a DNACPR decision in place, this should be considered. The senior doctor covering the ward is responsible for this.

In the event that it is considered that the patient might still benefit from CPR it should be clearly documented, both in the clinical record and on the ward board in the team room. Any changes to resuscitation status of a patient should be clearly discussed with the shift leader so that the decision is cascaded to the team and handed over at the board round.

Should an inpatient suffer cardiopulmonary arrest they should receive early defibrillation with the AED only. All staff in attendance should be wearing PPE (gloves, aprons, fluid repellent surgical mask and goggles/visor).

Day Therapy Groups

The clinical team should be aware of patients with a DNACPR decision or ADRT covering DNACPR in place.

If no decision is in place, patients are presumed to be for CPR in event of cardiopulmonary arrest.

Any patient wishing to discuss a DNACPR decision should be directed to an appropriate clinician.

Community Patients

The clinical team should be aware of patients with a DNACPR decision or ADRT covering DNACPR in place.

If no decision is in place, patients are presumed to be for CPR in event of cardiopulmonary arrest.

A DNACPR discussion as part of a broader Advance Care Plan discussion should be considered for all patients.

This policy will be available to the general public via the hospice external website, in accordance with Department of Health (2000) guidelines.

Associated Policies and Procedures

- Normal text

Compliance with Statutory Requirements

Under the Mental Capacity Act (2005), clinicians are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision is made.

The following sections of the Human Rights Act (1998) are relevant to this policy;

- the individual's right to life (Article 2)
- freedom from inhuman or degrading treatment (Article 3)
- respect for privacy and family life (Article 8)
- freedom of expression, which includes the right to hold opinions and receive information (Article 10)
- freedom from discriminatory practices in respect to these rights (Article

Responsibilities/Accountabilities

Title	Accountability
Chief Executive Officer	To ensure governance and compliance for this policy and accompanying procedure, and to procure and/or provide legal support.
Directors and Managers	To ensure that staff are aware of the policy and how to access it, and to ensure that it is implemented. To ensure that staff understand the importance of issues regarding DNACPR and that staff are trained and updated in managing DNACPR decisions. To ensure that the policy is audited and that the audit details are fed back to the Quality Assurance and Audit Group (QAAG) To ensure that DNACPR forms, patient leaflets, and this policy are available as required
Doctors and appropriately trained senior nurses responsible for making DNACPR decisions	To ensure they are competent to have discussions pertaining to resuscitation with the patient and to make the decision. To ensure that they verify any decisions made by junior staff/other accredited healthcare professionals, at the earliest opportunity To ensure that DNACPR decisions are correctly documented, and reviewed if necessary. To ensure that every effort is made to provide the patient with information, to involve the individual in the decision, and if appropriate to involve relevant others in making the decision.

Title	Accountability
	To ensure that DNACPR decisions are communicated to other healthcare providers.
Clinical staff	To ensure that they adhere to the policy and accompanying procedure and that they notify their line manager of any training needs. To ensure that they sensitively enquire as to the existence of a DNACPR or ADRT and check the validity of the documentation. To ensure that other services are notified of a DNACPR or ADRT document on the transfer of a patient To ensure that they participate in the audit process.

Staff Training Requirements

- Annual adult BLS training is mandatory for all clinical staff.
- Adult BLS training is optional for non-clinical staff and volunteers.
- DNACPR and ACP workshops are available for clinical staff.

Monitoring (Including Audit) and Frequency of Review

There will be a case review of all significant events requiring reference to this policy.

Investigation of all significant events relating to resuscitation will be reported via the Sentinel system to the Risk and Incident (Significant Event Audit) Group and, if necessary, from there to the Clinical Governance and Compliance Group (CGCG). The CGCG will, in turn, report incidents and outcomes to the Senior Management Team (SMT) and the Patient and Family Services (PFS) Committee of the Board of Trustees. Incidents reported to CGCG, SMT, and PFS Committee will be anonymised as required.

This policy will be reviewed every three years or more frequently if legislation or guidance requires.

Data Protection

Does this Policy require sign off from the Data Protection Officer?	Yes/No* (delete as applicable)	
DPO approved: Name		Date: DD/MM/YYYY
DPO comments		

References:

Resuscitation Council (UK) (2015) “Recommended standards for recording decisions about cardiopulmonary resuscitation”, Resuscitation Council (UK), London, available from: https://www.resus.org.uk/resuscitation-guidelines/ [accessed 04/09/2018]

British Medical Association, Resuscitation Council (UK), Royal College of Nursing (2016) “Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing”, London, available from: https://www.resus.org.uk/EasySiteWeb/GatewayLink.aspx?alId=16643 [accessed 04/09/2018]

NHS Executive (2000) “Resuscitation Policy”, NHS Executive HSC 2000/028, London, available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012184.pdf [accessed 04/09/2018]

NHS East of England (2011 revised Nov 2015) “NHS East of England Integrated Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy for Adults”, NHS East of England, Fulbourn, available from: https://heeoe.hee.nhs.uk/sites/default/files/dnacpr_policy_-_east_of_england_1.pdf [accessed 04/09/2018]

NHS East of England (2011) “Cardiopulmonary Resuscitation (CPR) Patient Information Leaflet”, NHS East of England, Fulbourn, available from: https://heeoe.hee.nhs.uk/sites/default/files/dnacpr_patient_information_leaflet_generic_-_can_be_used_nationally_produced_by_east_of_england.pdf [accessed 04/09/2018]

Equality Impact Assessment Initial Screening Tool

Document Reviewer(s):	Name, Title	Date Assessment Completed:	DD/MM/YYYY

Assessment of possible adverse impact against any minority group			
Could the document have a significant negative impact on equality in relation to each area below?	Response		If yes, please state why, and the evidence used in your assessment
	Yes	No	
1. Age			
2. Sex			
3. Disability			
4. Race or Ethnicity?			
5. Religion and Belief?			
6. Sexual Orientation?			
7. Pregnancy and Maternity?			
8. Gender Reassignment?			
9. Marriage and Civil Partnership?			

- You need to ask yourself:
- Will the document create any problems or barriers to any community or group?
- Will any group be excluded because of this document?
- If the answer to either of these questions is yes, you must complete a full Equality Impact Assessment.

Assessment of positive impact			
Could the document have a significant positive impact by reducing inequalities that already exist?	Response		If yes, please state why, and the evidence used in your assessment
	Yes	No	
1. Promote equal opportunities			

2. Eliminate discrimination			
3. Eliminate harassment			
4. Promote positive attitudes towards disabled people			
5. Encourage participation by disabled people			
6. Consider more favourable treatment of disabled people			
7. Promote and protect human rights			

On the basis of the information/evidence/consideration so far, do you believe that the document will have a positive or negative adverse impact on equality?

Positive	Please rate (delete as applicable) the level of impact					Negative
HIGH	**MEDIUM**	**LOW**	**NIL**	**LOW**	**MEDIUM**	**HIGH**

Is a full equality impact assessment required? Yes/No* delete as applicable (full assessment available on SharePoint)

Appendix 1 –Resuscitation Council Guidelines

https://www.resus.org.uk/resuscitation-guidelines/adult-basic-life-support-and-automated-external-defibrillation/

[accessed 04/09/2018]

https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/covid-community/

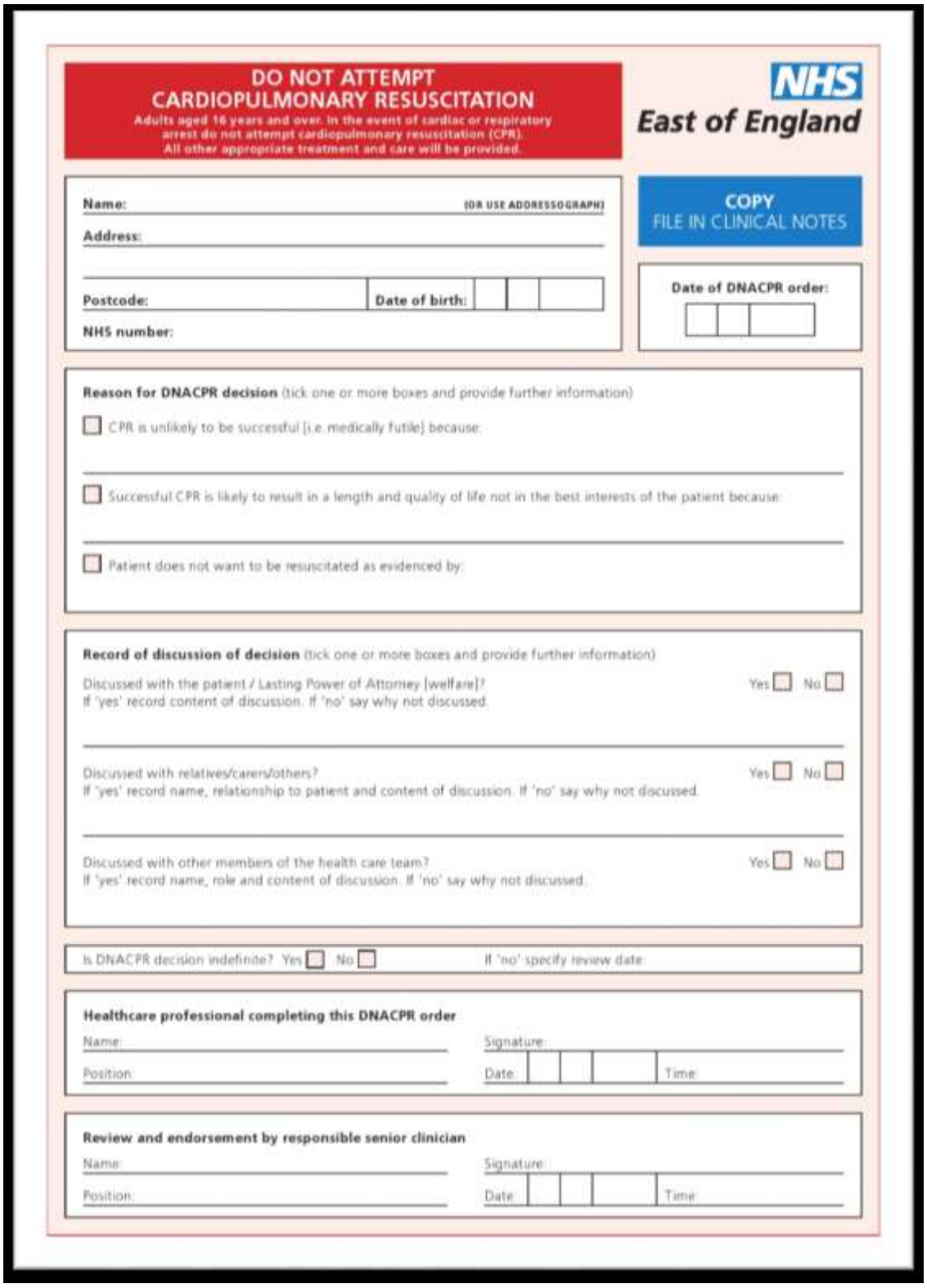
[accessed 24/03/2020]

Appendix 2 –NHS East of England Integrated Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy for Adults

https://heeoe.hee.nhs.uk/sites/default/files/dnacpr_policy_-_east_of_england_1.pdf

[accessed 04/09/2018]

Appendix 3 –DNACPR Form



DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over. In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR). All other appropriate treatment and care will be provided.

NHS East of England

Name: (OR USE ADDRESSOGRAPH)

Address:

Postcode: Date of birth:

NHS number:

COPY
FILE IN CLINICAL NOTES

Date of DNACPR order:

Reason for DNACPR decision (tick one or more boxes and provide further information)

☐ CPR is unlikely to be successful (i.e. medically futile) because:

☐ Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:

☐ Patient does not want to be resuscitated as evidenced by:

Record of discussion of decision (tick one or more boxes and provide further information)

Discussed with the patient / Lasting Power of Attorney (welfare)? Yes ☐ No ☐
If 'yes' record content of discussion. If 'no' say why not discussed.

Discussed with relatives/carers/others? Yes ☐ No ☐
If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.

Discussed with other members of the health care team? Yes ☐ No ☐
If 'yes' record name, role and content of discussion. If 'no' say why not discussed.

Is DNACPR decision indefinite? Yes ☐ No ☐ If 'no' specify review date:

Healthcare professional completing this DNACPR order

Name: Signature:

Position: Date: Time:

Review and endorsement by responsible senior clinician

Name: Signature:

Position: Date: Time:

Appendix 4 - Suffolk and NE Essex: Remote discussion and completion of community DNACPR forms during COVID-19 crisis, April 2020

Background – current process

Community DNACPR decisions are documented on an East of England DNACPR form.

The form has space for two clinicians to sign:
1. Healthcare professional completing this DNACPR (top box)
2. Review and endorsement by responsible senior clinician (bottom box)

The discussions may be initiated, and the top box signed, by any competent clinician. If the initiating clinician is not senior (e.g. community and hospice nurses, hospital junior doctors), they complete just the top box.

The bottom box (review and endorsement by responsible senior clinician) must be completed, as a minimum. This is only done by senior doctors (GPs, registrars, consultants, senior hospice doctors) or sometimes very senior nurses, e.g. hospice nurse consultants. (If the *initiating* clinician is senior, they just complete the bottom box.)

There will be many occasions when the initiating clinician knows, with very little doubt, that a DNACPR form would be an extremely useful addition to the patient's situation. Examples include:

- a patient with capacity (as defined by the Mental Capacity Act), regardless of how fit or frail they are, states they would not wish to have CPR
- a patient clearly near the end of their life from an advanced, incurable illness (such as widespread cancer, severe heart or respiratory failure, advanced dementia or other degenerative neurological conditions, general frailty/multiple comorbidities and a severe infective exacerbation, including a COVID-19 infection), where it is clear to the clinician that CPR would not be effective or appropriate, and either:
    - the patient has capacity and is in agreement with DNACPR, or
    - the patient does not have capacity (e.g. may have reduced conscious level, or cognitive impairment) but their family agree readily/request a DNACPR decision

Currently, a competent clinician in such a position as those described above would be able to discuss the DNACPR decision with the patient and/or family, and sign the top box on the EoE DNACPR form. They would then discuss the decision with the responsible senior clinician (quite possibly over the phone or in writing, e.g. SystmOne task), and the senior clinician would sign the bottom box, either immediately or at some later date.

Currently, the senior clinician does not always review the patient face-to-face prior to signing the bottom box.

Proposed modification to process

The new process simply allows a competent clinician, in situations such as those described above:

- to have the discussion with the responsible senior clinician over the phone (as already happens)
- and then to write the name of the senior clinician in the bottom box, rather than the clinician needing to physically sign the form itself

This is intended to remove an administrative barrier, for competent clinicians to whom the appropriate course of action is clear. It is *not* intended to put any additional responsibility on the initiating clinician, nor to pressure them to have discussions about DNACPR decisions and treatment escalation plans in situations where they would not already be having these discussions.

New process

Discussion about risks/benefits of CPR attempts may be had by any competent clinician. They can then **sign the top box** on the EoE DNACPR form. Competent clinicians include:

- Any doctor
- Community nurses
- Hospice nurses
- Allied health professionals
- Senior hospital nurses, e.g. CNS, matrons, ward managers, advanced nurse practitioners

Once a DNACPR decision has been reached between the patient/family and clinician, the review and endorsement by a senior clinician may be completed:

- As a telephone consultation between the completing clinician and the senior clinician
- The completing clinician may then complete the bottom box on the DNACPR form with the name of the clinician to whom they have spoken
- It is best practice for both the completing and senior clinicians to document this discussion/decision in the patient's healthcare records
- The completion of the DNACPR should be communicated to the GP, if completed by another organisation

Policy agreed by:

Name	Job role	Organisation
Sarah Mollart	Consultant in Palliative Medicine	St Nicholas Hospice Care
Mary McGregor	Consultant in Palliative Medicine	SNHC and WSFT
Amanda Keighley	Senior Matron for Community Services	WSFT
Debra Garside	Clinical Services Director	St Nicholas Hospice Care
Sharon Basson	Head of Nursing, Community and Integrated Services	WSFT
Dawn Godbold	Associate Director of Integration, West Suffolk Alliance	WSFT
Rowan Procter	Chief Nurse	WSFT
Lisa Nobes	Director of Nursing and Quality	WSCCG IESCCG NEECCG
Christopher Browning	GP, Chair WSCCG	WSCCG
James Heathcote	Deputy Medical Director for Primary Care	WSFT
Kelvin Bengtson	Consultant in Palliative Medicine	St Elizabeth Hospice
Karen Chumbley	Clinical Director and Deputy CEO	St Helena Hospice
Rebecca Pulman	Associate Director of Nursing	IESCCG
Policy finally ratified at teleconference call "ICS EOL Workstream", 16.4.20		