Cardiopulmonary Resuscitation Policy

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<tr>
<td>Version Number</td>
<td>V1</td>
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<td>Job Title of Document Author</td>
<td>Resuscitation Officer</td>
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<tr>
<td>Target audience:</td>
<td>All employees of Staffordshire and Stoke on Trent Partnership NHS Trust involved in direct contact with patients/clients.</td>
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<thead>
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<th>Version</th>
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| V1.1    | Harmonisation of predecessor organisation policies in line with NHSLA requirements | 08/08/2012 | - Standardisation of key processes.  
- Policy to focus on CPR and a separate policy to be developed to address DNACPR decisions and practice. |
| V1.2    | Consultation with Resuscitation Group Members                      | 15/11/2012 | - Standardisation of terminology relating to Partnership Trust.  
- Additional content relating to decision making and mental capacity. |
| V1.3    | Consultation with Resuscitation Group Members                      | 03/12/2012 | - Deletion of equipment check list                                                      |
| V1.4    | Consultation with NHS and Social Care Operational Leads            | 14/12/2012 | - References to clinical staff and practices amended to reflect Social Care staff needs. |
| V1.5    | Policy For the Development and Implementation of Procedural Documents | 02/01/2013 | - Policy amended to meet required style and format of procedural documents              |
| V1.6    | Consultation with Equality Lead                                   | 16/01/2013 | - Statement regarding equality impact assessment included                               |
| V1.7    | Equality Analysis Update                                          |            | - Equality analysis reviewed with Equality and Inclusion Manager                        |
| V1.8    | Clarification of term clinical area in relation to Social Care settings | 08/04/2013 | - Clinical area replaced with ‘areas where patient/service user care is delivered’     |
Key Points
This policy outlines the framework in relation to Cardiopulmonary Resuscitation only, other forms of resuscitation such as intravenous fluids, antibiotic therapy and oxygen therapy are not considered within this document and would form part of the individual’s treatment or care plan. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is NOT addressed within this policy; a separate policy exists addressing the issues associated with DNACPR.

This policy takes into account the joint statement from the British Medical Association, the Resuscitation Council, and the Royal College of Nursing (2007) and the Standards for Clinical Practice and Training document (the Royal College of Physicians, Royal College of Anaesthetists, the Intensive Care Society and the Resuscitation Council, 2004) in addition to Guidance from the General Medical Council.

Staffordshire and Stoke on Trent Partnership NHS Trust (Partnership Trust) requires all employees or staff working on behalf of the organisation in direct patient/client contact to attend Cardiopulmonary Resuscitation Training to Basic Life Support standard in line with the schedule set out by the Workforce & Development Team.

The key areas covered within this policy include:
Duties of employees
Communicating CPR and DNACPR decisions
Children and Young people
Post resuscitation care
Equipment required as part of CPR attempts and monitoring processes associated with this equipment
Training needs of all staff
Monitoring of compliance with the above

This policy must be followed in full to ensure that a high quality and robust resuscitation care is available for anyone who is in contact with services provided by the Partnership Trust at all times.

Available Support
Support in implementing this policy can be sought from the Resuscitation Officer, Professional Head of Nursing or Medical Director.
Cardiopulmonary Resuscitation Policy

1. Introduction

1.1 Employees of Staffordshire & Stoke on Trent Partnership NHS Trust (the Partnership Trust) may be involved in resuscitation procedures in the course of their work. This policy is written to support best practice as set out by the Resuscitation Council UK.

1.2 All staff that have direct patient/client contact should be able to instigate basic life support procedures for a person who collapses because of a cardiac or respiratory arrest or for other unknown reasons.

1.3 This policy has been constructed so as to promote compliance with the NHS Litigation Authority Risk Management Standards (NHSLA) and Staffordshire County Council Gateway Standards.

1.4 Effective resuscitation is crucial for those who have suffered a cardiopulmonary arrest. Cardiopulmonary resuscitation (CPR) is undertaken in an attempt to restore breathing and spontaneous circulation in a patient/client in cardiac and/or respiratory arrest. CPR is a relatively invasive medical therapy and usually includes chest compressions and other invasive techniques (BMA, RCUK, RCN 2007) and it is therefore essential to identify patient/clients for whom cardiac and/or respiratory arrest represents a terminal event in their illness. The Partnership Trust has a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy which should be read in conjunction with this policy to ensure that CPR is only initiated for patient/clients when it is appropriate and in their best interests. This policy should also be read in conjunction with the following documents:

- Do Not Attempt Cardiopulmonary Resuscitation Policy
- Consent Policy
- Medicines Policy
- An Organisation-wide Policy and Procedure for the Management of Incidents, including the Management of Serious Incidents
- Manual Handling Policy
- Infection Prevention and Control Policies
- Mental Capacity Act Policy
- Safeguarding Children and Child Protection Policy & Procedures
- Safeguarding Vulnerable Adults Interagency Policy & Procedures
1.5 The aim of this document is to set out the Partnership Trust’s policy regarding resuscitation for adults and children and identify responsibilities deriving from it.

2. Executive Summary

2.1 NHS Trust Chief Executives are required to ensure that an appropriate and effective resuscitation policy is in place.

2.2 The policy must be adopted uniformly across all services ensuring that gender, sexuality, religion or beliefs, disability, culture, sexual orientation or age do not influence the decision making processes or clinical practices relating to cardiopulmonary resuscitation.

2.3 The policy must be understood by all relevant staff and be accessible to those that may need to access it and that such policies are subject to audit and regular review.

2.4 The provision of effective resuscitation techniques for individuals who experience a cardiopulmonary arrest must be an operational priority.

2.5 The organisation has a duty of care to provide effective resuscitation training and ensure effective application of that training in emergency situations and to ensure that all relevant staff are trained and regularly updated to a level compatible with their expected degree of competence.

3. Purpose and Justification

3.1 The purpose of this policy is:
- to optimise survival of patient/clients who suffer cardiopulmonary arrest
- to provide clear direction and guidance for clinical staff
- to support robust and coherent operational implementation of resuscitation techniques and procedures related to cardiopulmonary resuscitation (CPR)
- also to support all staff, including bank, honorary, locum and agency staff, to provide a prompt and appropriate response when resuscitation is required.

3.2 Some Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) issues are included within the document however a separate policy; Do Not Attempt Cardiopulmonary Resuscitation is in place which details the Partnership Trust requirements in these circumstances.

3.3 The document reflects the revised Standards for Clinical Practice and Training (RCUK 2010) along with guidance on Decisions relating to Cardiopulmonary Resuscitation (BMA, RCUK, and RCN 2007).
4. **Scope**

4.1 This policy applies to all health care and social care staff employed by the Partnership Trust including bank, honorary, locum, and agency staff. It is also available to independent providers of healthcare, where applicable, who may find it useful or as a reference for good practice, or as a resource to inform their own policy development.

4.2 CPR will be performed on any person (adult or child) who has suffered either a cardiac or respiratory arrest, unless the doctor, GP or Consultant responsible for their care has agreed and documented a prior decision or the circumstances outlined in paragraph 4.3 apply. If no explicit decision has been made in advance about CPR and the express wishes of the patient/client are unknown and cannot be ascertained, there should be a presumption that health care professionals will make all reasonable efforts to attempt to revive the patient/client in the event of cardiac or respiratory arrest (BMA, RCUK, RCN 2007).

4.3 The decision to not resuscitate will be made by the most senior clinician, usually the medical consultant or General Practitioner, but in conjunction with the other members of the healthcare or social care team, the patient/client and their carer(s); that such a course of action should not be pursued or where the attempt is deemed to be futile e.g. irrefutable signs of death are present (see paragraph 6.5).

4.4 This policy does not detail the processes to be adopted where CPR is deemed inappropriate and these processes are outlined in the Do Not Attempt Cardiopulmonary Resuscitation Policy.

5. **Duties and Responsibilities**

Provider organisations have an obligation to provide an effective resuscitation service to their patient/clients and appropriate training to their staff. A suitable infrastructure is required to establish and continue support for these activities.

5.1 *The Chief Executive* is responsible for ensuring that the Partnership Trust discharges its duties under respective legislation and NHS professional guidance.

5.2 *The Resuscitation Group* has a duty to set its terms of reference, decide an appropriate membership and publish up-to-date policies and guidance for all members of staff involved in care delivery. The Resuscitation Group must be involved in the audit process and evaluation of service efficacy including review of all resuscitation attempts and subsequent clinical outcomes.

5.3 *The Resuscitation Officer(s)* will ensure that all training events follow current national resuscitation guidelines and ensure that all training registers are
submitted to the Training & Education Department for collation. They will monitor service efficacy which will include audits of resuscitation equipment; lead reviews of cardiac arrest outcomes and occasions where CPR is attempted. Reports will be reviewed by the Resuscitation Group and submitted to the Safety & Effectiveness Sub-Committee.

5.4 **Education & Training Department** will maintain accurate training records from submitted registers and will provide figures to assist with the training needs analysis process.

5.5 **Operational Managers** should ensure that:
- all relevant staff are aware of the policy and have access to it
- the policy is understood and implemented
- all staff understand their role and expectations related to CPR
- all relevant staff have access to appropriate resuscitation equipment
- all staff attend mandatory training on CPR in line with the Partnership Trust guidance.

5.6 **Service/Team Leaders** are responsible for ensuring all staff having direct patient/client contact attends CPR training. They must also ensure that resuscitation equipment is checked in accordance with policy guidance and is fully functional, decontaminated and ready for use.

5.7 **All clinical staff and social care practitioners** are required to undertake annual CPR training commensurate with their role and maintain their competencies in resuscitation. All staff having direct contact with patient/clients must adhere to the policy and notify their manager if there are issues that may prevent their full compliance with it.

6. **Definition of Terms**

6.1 **Advance Decision Refusing Treatment (ADRT).** This is a decision made by a competent person to refuse a specific medical treatment (MCA 2005). Health care and social care staff are legally bound to comply with a valid and applicable refusal of treatment which specifically addresses the situation that has arisen.

6.2 **Anaphylaxis** is a severe life-threatening generalised or systemic hypersensitivity reaction.

6.3 **Cardiopulmonary arrest (cardiac arrest)** is a sudden and complete loss of mechanical cardiac function, confirmed by the absence of detectable signs of life, resulting in loss of effective circulation and respiratory function.

6.4 **Cardiopulmonary Resuscitation (CPR):** Intervention delivered with the intention of re-establishing respiration and effective cardiac output in someone who is suffering a cardiopulmonary (cardiac and/or respiratory arrest) arrest using basic life support techniques which will include chest compressions and
ventilations. Additional measures include such interventions as defibrillation and the administration of drugs.

6.5 **Conditions Unequivocally Associated With Death: Rigor Mortis** and **Hypostasis** are two of the seven conditions listed by Joint Colleges Ambulance Liaison Committee as being unequivocally associated with death where resuscitation should not be attempted. **Rigor Mortis** is stiffness that occurs after death from the post mortem breakdown of enzymes in the muscle fibre. **Hypostasis** is the pooling of blood in congested vessels in dependent parts of the body in the position in which it lies after death.

6.6 **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) formally known as DNAR**: describes a situation where basic life support techniques (CPR) are not instituted. These instances include where a do not attempt resuscitation order is in place or a valid and applicable Advanced Decision to Refuse Treatment is in place.

6.7 **Mental Capacity Act (MCA 2005)**. The Mental Capacity Act 2005 provides a legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards. The Act was fully implemented in 2007 and is supported by a Code of Practice (2007).

6.8 **Modified Early Warning Score (MEWS)**: a patient/client assessment tool used to identify changes in vital signs and changes in clinical status.

6.9 **Natural Death**: A natural death can be described as ‘a death occurring naturally as a result of disease process running its course’.

6.10 **Presumption in favour of attempting resuscitation**: where no advanced decision has been made about appropriateness, or otherwise, of attempting resuscitation prior to a patient/client suffering cardiopulmonary arrest and there are no irrefutable signs of death present, there should be a presumption that the health professional will make a reasonable effort to revive the patient/client.

6.11 **Respiratory arrest** can be described as a sudden and complete cessation of breathing.

6.12 **Reversible Events**: An event which occurs for which there is a known remedy, for example choking or anaphylaxis.

7. **Clinical Decisions Not to Attempt Cardiopulmonary Resuscitation**

7.1 If the clinical team believe that CPR will not re-start the heart and maintain breathing, it should not be offered or attempted. Before this decision is made the individual patient/client circumstances and the most up to date guidance must be considered carefully (BMA, RCUK, RCN 2007).
7.2 All decisions not to attempt resuscitation should be supported by appropriate documentation i.e. DNACPR Form.

7.3 In circumstances where there are irrefutable signs of death such as rigor mortis or hypostasis CPR should not be attempted.

7.4 This policy does not detail the processes to be adopted where CPR is deemed inappropriate and these processes are outlined in the Do Not Attempt Cardiopulmonary Resuscitation Policy.

8. Communicating CPR and DNACPR Decisions

8.1 It is essential that a discussion with the patient/client, and/or those close to the patient/client, is offered and where this is congruent with the patient/client’s wishes, a sensitive discussion facilitated. Where communication may be hampered due to language differences or cognitive impairment all reasonable measures such as use of interpreters or advocates should be adopted to facilitate effective dialogue. All aspects of the patient/client’s condition will be considered and a record of the discussion having taken place will be made. Patient/clients should not however feel compelled to participate in discussion related to CPR, and their wish not to enter into such discussions must be respected. A record should be made in the patient/client held record/care plan of this preference.

8.2 If no explicit decision has been made in advance about CPR and the express wishes of the patient/client are unknown and cannot be ascertained, there should be a presumption that health and social care professionals will make all reasonable efforts to attempt to revive the patient/client in the event of cardiac or respiratory arrest (BMA, RCUK, RCN 2007).

8.3 The patient/clients known wishes regarding CPR must always be communicated when referred or discharged to another service.

8.4 The decision regarding CPR status must be communicated effectively to the patient/client / carers (consistent with patient/client wishes / consent) or other significant person. Feedback and discussion should be on-going.

8.5 An Independent Mental Capacity Advocate (IMCA) must be instructed if the patient/client lacks capacity and has no consultable friends and family (MCA 2005). The entry in the clinical record should be made by the appropriate senior clinician and effectively communicated to other relevant health professionals.

9. Children and Young People

9.1 This policy applies to children and young people as well as adults.
9.2 Where cardiopulmonary/respiratory arrest occurs in those aged below 18 years of age cardiopulmonary resuscitation must be initiated unless there is a valid DNACPR order or Emergency Management Plan in place. Emergency Management Plans are typically drawn up between the consultant, child and family and are compliant with relevant legislation detailing all aspects of emergency care including DNACPR status.

9.3 In circumstances where there are irrefutable signs of death such as rigor mortis or hypostasis, CPR should not be attempted.

10. Non Discrimination

10.1 Resuscitation decisions are amongst the most sensitive decisions that clinicians, patient/clients and parents may have to make. Patient/clients (and where appropriate their relatives and carers) have as much right to be involved in those decisions as they do other decisions about their care and treatment. As with all decision-making, professionals including doctors have a duty to act in accordance with an appropriate and responsible body of professional opinion and the legislative framework including instructing an IMCA if applicable.

10.2 All decisions relating to resuscitation matters must be made on an individual basis and reflect best practice evidence whilst respecting an individual's rights, personal beliefs and decisions and be in accordance with the Equality Act 2010.

10.3 The Equality Act (2010) identifies 'protected characteristics' and these are currently:
   - race
   - sex
   - gender reassignment status
   - disability
   - religion or belief
   - sexual orientation
   - marriage and civil partnership status
   - pregnancy and maternity

   In addition the law also protects people who are at risk by association or perception. This could include, for example, a carer who cares for a disabled individual.

10.4 An equality impact assessment will have been conducted on this policy to ensure its consideration to the impact on local vulnerable people and those from the protected equality groups.
11. **Post Resuscitation Care**

11.1 The Partnership Trust must make provisions for safe continuity of care and where necessary, safe transfer following resuscitation of the patient/client. This may involve the following steps:
- Liaison with the Ambulance Service
- Transfer to an acute unit or emergency department
- Full and complete handover of care to a qualified paramedic or other healthcare professional.
- Preparation of equipment, oxygen, drugs and monitoring systems
- Informing relatives or carers of transfer

11.2 Where a resuscitation attempt has been unsuccessful the appropriate care of the deceased and their family will be carried out by Partnership Trust staff in accordance with religious practices as directed by the relatives or religious leaders.

11.3 Following a resuscitation attempt, whether successful or otherwise, it is necessary for staff to complete both a CPR Audit form (appendix 2) and an adverse incident form (electronic).

11.4 All resuscitation attempts will be scrutinised within the Partnership Trust Resuscitation Group where outcomes and learning from these events will be identified and disseminated.

11.5 Staff involved in situations requiring cardiopulmonary resuscitation are likely to find these events to be extremely stressful and may need additional support. Managers need to be aware of this and consider the use of debriefing sessions as well as checking how individual staff are coping. A post resuscitation debrief meeting can be requested from the Partnership Trust Resuscitation Officer to support staff learning following a resuscitation attempt. Additional support can be sought through the Staff Counselling Service.

12. **Equipment**

12.1 Basic equipment for CPR should be available in all health care settings, particularly where staff carry out clinical procedures. It is the responsibility of the individual carrying out a clinical procedure to ensure that resuscitation equipment is available and fit for use.

12.2 Where higher risk procedures such as immunisations are conducted, staff must only carry out the procedure where additional appropriate equipment is available, i.e. anaphylactic shock pack, pocket mask

12.3 Staff carrying out clinical procedures away from the health care setting such as; in a patient/client’s home, do not normally need to carry resuscitation
equipment, although they should carry a pocket mask to avoid the risk of infection and also an anaphylactic shock pack if administering medications.

12.4 Following Death in Custody Recommendations, all prison Nursing/Health Care staff are expected to wear an emergency pouch on their prison belt to include a pocket-mask, gloves and an airway.

12.5 Whilst the risk of infection transmission from patient/client 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 be avoided in the following circumstances:
- All patient/clients who are known to have or suspected of having an infectious disease;
- Other persons where the medical history is unknown

12.6 All areas where patient/service user care is delivered should have immediate access to ventilation devices e.g. a pocket mask to minimise the need for mouth to mouth ventilation. However in situations where airway protective devices are not immediately available, it is advised that the rescuer commences chest compressions whilst awaiting a ventilation device. If there are no contraindications consider giving mouth-to-mouth ventilations, if staff are unwilling or mouth to mouth ventilations are not appropriate continuing with chest compressions until a ventilatory device is available is appropriate.

12.7 All resuscitation equipment, trolleys and emergency bags must be maintained in a state of readiness at all times. Within Partnership Trust sites a registered member of staff must check the equipment in trolleys and emergency bags once a day and immediately following the conclusion of a resuscitation/emergency event.

12.8 The equipment must be checked for fitness for purpose, that it is within expiry date and the check must be recorded to include date, time and the name and signature of the person checking it.

12.9 The resuscitation trolleys/bags should be stocked in accordance with the standardised list of equipment which is located on each trolley and in each bag. Disposable equipment must be replenished at the earliest opportunity from the central storage areas i.e. NHS Supplies. Non disposable items should be decontaminated/cleaned in accordance with both the manufacturer’s recommendations and the Partnership Trust’s infection prevention and control policies and reinstated to the trolley/bag as soon as is practical.

13. Defibrillators

13.1 The Resuscitation Council UK advises that electrical defibrillation is well established as the only effective therapy for cardiac arrest due to ventricular fibrillation, or pulseless ventricular tachycardia. The scientific evidence to support early defibrillation is overwhelming, the single most important
determinant of survival being the delay from collapse to the delivery of the first shock. The chances of successful defibrillation decline 7-10% with every minute, CPR will help to oxygenate and perfuse a fibrillating heart until a defibrillator is available.

13.2 Automated External Defibrillators (AED) indicates when a patient/client requires defibrillation. Before an AED can be used in a clinical environment staff must be appropriately trained.

13.3 Although a rare occurrence, an AED may be used in a child over the age of 1 with no signs of circulation

13.4 The Resuscitation Council (UK) Guidelines (2010) recommends that any registered or unregistered person should be able to access and operate a defibrillator in the event of an attempted resuscitation.

13.5 Due to the diverse range of make and model of defibrillators available within the organisation, operation of such devices will only be carried out by staff trained in their specific use. The operation of defibrillators by health and social care staff is subject to the successful completion of an Automated External Defibrillator training session.

14. Procurement

14.1 The procurement of resuscitation equipment is subject to the organisations purchase requisition procedure.

14.2 All equipment must be approved by the Partnership Trust Resuscitation Group.

15. Training and Competency

15.1 The Statutory and Mandatory Training department is responsible for ensuring that the necessary training required by staff is commissioned, accessible, sufficient, and appropriate, also that it is compliant with RCUK guidance (2010).

15.2 The group of staff requiring resuscitation training is set out in the Partnership Trust training strategy (appendix 1).

15.3 Appropriately identified groups of staff employed by the Partnership Trust must attend regular mandatory resuscitation training. They will be trained and equipped to the level appropriate of their expected role, to resuscitate patient/clients who experience a cardiopulmonary arrest in the community, community hospital, or whilst in custody in one of the prisons within the Partnership Trust's responsibilities. The minimum standard of proficiency for all clinical staff will be Basic Life Support (BLS).
15.4 Advanced life support techniques require the development and maintenance of skills that are not a regular feature of everyday practice within or across the settings identified above. The Partnership Trust does not expect its staff to be trained to the advanced level as they would be unable to maintain competence in Advanced Life Support.

15.5 The strategy for resuscitation training embodies the statement and guidelines published by the (RCUK 2010) and the European Resuscitation Council (ERC 2005), incorporating the most recent updates to these guidelines. The Partnership Trust will provide sufficient and appropriate resuscitation training for each member of staff.

15.6 The approach to teaching is one of positive encouragement and proven educational efficacy which follows recommendations for resuscitation teaching advocated by the RCUK (2010).

15.7 All staff are expected to update their skills and knowledge in relation to resuscitation practice, including aspects impacting on Mental Capacity Act (2005) and Consent, in line with the Partnership Trust training strategy, failure to do so may result in the individual being subject to performance management.

15.8 Where an individual has not attended CPR training within the expected timescale, as set out in the training matrix, the individual will not be permitted to work in a direct patient/client contact capacity until this requirement is fulfilled.

16. Monitoring Compliance

16.1 All events about which a 999 cardiac arrest call is made will be audited (DoH HSC 2000/028) via a completed cardiac arrest audit forms.

16.2 Staff across all areas will record all resuscitation attempts and their outcomes on the resuscitation audit form (appendix 2).

16.3 The Resuscitation Officer will provide regular reports regarding CPR attempts and outcomes to the Resuscitation Group.

16.4 An annual audit of clinical records will be undertaken by the Resuscitation Officer into compliance with DNACPR good practice adherence.

16.5 The Resuscitation Group will provide regular reports to the Safety and Effectiveness Sub-Committee and will report upon the findings of the resuscitation audits as appropriate.

16.6 Compliance with mandatory training with the designated training programmes are made to the senior management team on and to the Resuscitation Group on a monthly basis.
17. **Breach of Policy**

17.1 Failure to comply with the principles as set out within the policy may be subject to disciplinary action.

18. **Review**

18.1 This policy should be reviewed at 2 yearly intervals to ensure that it is up to date with current best practice however where changes occur in national guidance the policy will be amended accordingly.

19. **Consultation**

19.1 This policy has been developed in collaboration with members of the Resuscitation Group. The draft policy has been circulated to operational service managers, clinical specialists, professional leads, clinical teams and to Resuscitation Group members for comments and amendments made where necessary. The final copy of the policy was has been agreed by the Resuscitation Group and ratified by the Safety & Effectiveness Sub Committee.

19.2 An equality impact assessment will have been conducted on this policy to ensure its consideration to the impact on local vulnerable people and those from the protected equality groups (see 10.3).

**References**

- British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing (2007) *Decisions relating to cardio-pulmonary resuscitation*. (The revised joint statement)  
  http://www.resus.org.uk/pages/dnar.htm
  www.resus.org.uk
APPENDICES
## Appendix 1

### Staff Training Matrix (CPR)

<table>
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<th>Groups of Staff to attend</th>
<th>Course name and course content for the following training</th>
<th>Frequency</th>
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| **Basic Life Support ~ Adult and Children**  
  Community Nursing and Hospital Staff either Registered or HCA (who do not have access to a Defibrillator)  
  All Allied Health Professionals (AHP)  
  AHP Assistants  
  Health Visitors, School nurses  
  Prison unqualified staff  
  Social Care staff registered or unregistered Social Care staff having direct client contact | **Basic Life Support**  
  Cause of adult cardiac arrest  
  Cause, prevention and treatment of **anaphylaxis**  
  Chain of survival  
  Choking  
  Practical assessment of the technique on a mannequin.  
  Risks to the rescuer  
  Role of defibrillation  
  Treatment of adult & paediatric cardiopulmonary arrest | Yearly |

| **Defibrillation and Basic Life Support Adults and Children**  
  Qualified Community Hospital Nursing staff based in a Department /Ward that has a Defibrillator available.  
  Specialist Nurses who have access to a Defibrillator e.g. heart failure CNS  
  Minor Injury and Walk in Centres Qualified Staff | **Defibrillator and Life Support**  
  AED (Automated External Defibrillation)  
  Arrest prevention  
  Cause of adult cardiac arrest  
  Cause, prevention and treatment of **anaphylaxis**  
  Chain of survival  
  Choking  
  Oxygen administration  
  Practical assessment of the technique on a mannequin.  
  Risks to the rescuer  
  Role of defibrillation  
  Treatment of adult & paediatric cardiopulmonary arrest | Yearly |

| **Prison Specific Life Support**  
  All qualified staff in the Prison health Service | **Prison Specific Life Support**  
  AED (Automated External Defibrillation)  
  Arrest prevention  
  Cause of adult cardiac arrest  
  Cause, prevention and treatment of **anaphylaxis**  
  Chain of survival  
  Choking  
  First responder skills | Yearly |
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<th>Details</th>
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<tr>
<td>Risks to the rescuer</td>
<td>Role of defibrillation</td>
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<tr>
<td>Treatment of adult &amp; paediatric cardiopulmonary arrest</td>
<td>Naloxone ~ administration</td>
<td></td>
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<tr>
<td>Dental Specific Life Support</td>
<td><strong>Dental Specific Life Support</strong>&lt;br&gt;AED (Automated External Defibrillation)&lt;br&gt;Arrest prevention&lt;br&gt;Cause of adult cardiac arrest&lt;br&gt;Cause, prevention and treatment of <strong>anaphylaxis</strong>&lt;br&gt;Chain of survival&lt;br&gt;Choking&lt;br&gt;First responder skills&lt;br&gt;Oxygen administration&lt;br&gt;Practical assessment of the technique on a mannequin.&lt;br&gt;Risks to the rescuer&lt;br&gt;Role of defibrillation&lt;br&gt;Treatment of adult &amp; paediatric cardiopulmonary arrest&lt;br&gt;Buccal Midazolam ~ administration</td>
<td>Yearly</td>
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<td>Special School Nurses</td>
<td><strong>Special School Specific Life Support</strong>&lt;br&gt;AED (Automated External Defibrillation)&lt;br&gt;Arrest prevention&lt;br&gt;Cause of adult cardiac arrest&lt;br&gt;Cause, prevention and treatment of <strong>anaphylaxis</strong>&lt;br&gt;Chain of survival&lt;br&gt;Choking&lt;br&gt;Drugs administration&lt;br&gt;Oxygen administration&lt;br&gt;Practical assessment of the technique on a mannequin.&lt;br&gt;Risks to the rescuer&lt;br&gt;Role of defibrillation&lt;br&gt;Treatment of adult &amp; paediatric cardiopulmonary arrest&lt;br&gt;Tracheostomy Emergencies</td>
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<tr>
<td>Role of defibrillation</td>
<td>Treatment of adult &amp; paediatric cardiopulmonary arrest</td>
<td></td>
</tr>
<tr>
<td>Dental Specific Life Support</td>
<td>AED (Automated External Defibrillation)</td>
<td></td>
</tr>
<tr>
<td>Cause of adult cardiac arrest</td>
<td>Cause, prevention and treatment of <strong>anaphylaxis</strong></td>
<td></td>
</tr>
<tr>
<td>Chain of survival</td>
<td>Choking</td>
<td></td>
</tr>
<tr>
<td>First responder skills</td>
<td>Oxygen administration</td>
<td></td>
</tr>
<tr>
<td>Practical assessment of the technique on a mannequin.</td>
<td>Risks to the rescuer</td>
<td></td>
</tr>
<tr>
<td>Role of defibrillation</td>
<td>Treatment of adult &amp; paediatric cardiopulmonary arrest</td>
<td></td>
</tr>
</tbody>
</table>
# Cardiopulmonary Resuscitation Audit Form

<table>
<thead>
<tr>
<th>Patient/client Name:</th>
<th>D.O.B:</th>
<th>NHS Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Time of Cardiac/Respiratory Arrest……………………… Time Ambulance Arrived……………………

Was the patient/client shocked? Yes/No Number of times shock delivered………………

Outcome: Survived / Died Time:…………… Date……………………

Initial Diagnosis on Admission

Drugs Administered: Yes/No If so by Whom?

Name of Drugs and Dose used:

Persons Present During Resuscitation event:

Person Completing Form:

DNACPR order in situ prior to event? Yes/No DNACPR order in situ post event? Yes/No

Relatives informed: Yes/No Name of Relatives: ………………………

Relationship to Patient/client…………………………………………………………

Referred to Coroner? Yes/No

Name of Person Certifying/Verifying Death:

**Print and sign your name**
Please return completed form to the Clinical Audit Department, Edric House, Wheelhouse Road, Rugeley, WS15 1VW
Appendix 3

EQUALITY ANALYSIS
CARDIOPULMONARY RESUSCITATION POLICY

STEP 1: What is the background and starting point for this policy?

This policy has been developed based on best practice guidelines as set out by the Resuscitation Council. The policy details the standards of care expected in relation to resuscitation and although there is mention of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) a separate policy has been developed to

STEP 2: What do we want to achieve?

A standardised and robust approach to the management of cardiopulmonary resuscitation across all Partnership Trust services.

This policy applies to all health care and social care staff employed by the Partnership Trust including bank, honorary, locum, and agency staff. It is also available to independent providers of healthcare, where applicable, who may find it useful or as a reference for good practice, or as a resource to inform their own policy development.

Cardiopulmonary resuscitation (CPR) will be performed on any person (adult or child) who has suffered either a cardiac or respiratory arrest, unless the doctor, GP or Consultant responsible for their care has agreed and documented a prior decision or the circumstances outlined in paragraph 4.3 apply. If no explicit decision has been made in advance about CPR and the express wishes of the patient/client are unknown and cannot be ascertained, there should be a presumption that health care professionals will make all reasonable efforts to attempt to revive the patient/client in the event of cardiac or respiratory arrest (BMA, RCUK, RCN 2007).

This policy promotes inclusion of all equality and hard to reach groups and services.

STEP 3: What do we know?

Timely and effective intervention in the event of a cardiopulmonary arrest is essential to increase the chance of survival. The number of events requiring CPR interventions is small within the organisation with only 10 events having taken place since April 2012 and there is no evidence to suggest that any one group is treated differently in relation to CPR interventions.

STEP 4: What consultation has been taken: engagement and involvement?

Consultation has been undertaken with health and social care staff who will be affected by the policy content; the policy has been reviewed by the Resuscitation Group. The Resuscitation Group is comprised of representatives from across Partnership Trust services. External review has been carried out through the Staffordshire & Stoke on Trent Adult Safeguarding Partnership Policies and procedures sub-committee.
The policy is based on best practice guidance from Resuscitation Council and forms the basis of national policy in relation to CPR.

The consultation process has been limited to professional groups both internal to and outside of the organisation as this policy focuses upon process and therefore public consultation is not justified. The version control section clearly identifies the iterations of this policy and the changes arising from the consultation process.

STEP 5:
   a) Assess the impact on the equality groups by considering the evidence and engagement activities you have listed in steps 3 and 4.

   b) Consider and detail how this policy will:
      ● Eliminate discrimination, harassment and victimisation. Record the evidence against each protected group.
      ● Promote good relationships between groups. Record the evidence against each protected group.

The policy clearly states that the principles relating to resuscitation issues must be in accordance with the Equality Act, 2010 (section 10.0). All resuscitation decisions including DNACPR must be made in response to clinical evidence, personal wishes and in the best interests of the individual (in accordance with MCA 2005), these decisions must never be adversely influenced by an individuals, age, gender, race, sexuality, religion or belief, marital or civil partnership status or pregnancy or maternity status. This will be monitored as part of the CPR adverse incident review by the Resuscitation Group and DNACPR orders will be reviewed as part of the annual audit process detailed in the policy.

This policy has a positive impact upon equality groups. There is however a small risk that through the implementation of this policy for discrimination; this will be mitigated by providing staff with training on CPR and hence this policy provides good relationships between people for example staff and patients. Where discrimination is identified in relation to this policy the issue will be addressed through a HR framework.

An action relating to staff training (social care) has been identified and is included in the Equality Action Plan.

STEP 6: Have you identified any actions:
   a) To improve the policy
   b) To address specific equality issues and data gaps; have you identified any actions that need to be taken as a result of the data, evidence and consultation activities?
   c) To address any financial implications; resource requirements to meet the above actions etc.

The inclusion of Social Care staff into the organisation in April 2012 has resulted in the need for all staff involved in direct patient/client contact to undertake training in CPR procedures. Due to the number of staff this will be achieved in a phased
approach. Additional equipment (face masks) will need to be purchased for this staff group but this will be on a risk assessed basis and will not impact upon the delivery of this policy.

**STEP 7: How will you know that the policy has been successful?**

- What reporting, governance and monitoring mechanisms are in place re action plan and review of the policy?
- How will we know that the policy has been successful? What is the timeline for this? Describe what ‘success’ looks like.

The Resuscitation Group reports actions, outcomes and exceptions, to the Safety & Effectiveness Sub-Committee as part of the corporate governance structure. The group meets on a monthly basis and is chaired by the Medical Director.

Deviations from the policy will be reported to the Resuscitation Group and if amendments to the policy are required they will be directed by this group. All resuscitation attempts are reviewed by this group and where required lessons learnt disseminated and changes to practice/policy made.

The Safety and Effectiveness Sub-Committee will monitor any equality actions arising from this analysis.

**STEP 8: Executive Summary**

This section should be completed at the end of the analysis process. It is intended to inform how you have formulated the document with ‘due regard’ to the Public Sector equality duty of the Equality Act 2010. This should be written into the document as a clear statement.

This policy has been developed with due regard to relevant legislation, MCA (2005), Equality Act (2010) and best practice guidance. The policy clearly sets out the framework in which all staff employed or working on behalf of the organisation must work in relation to cardiopulmonary resuscitation. The policy promotes a positive approach towards and includes all equality groups as identified by the legislation (Equality Act 2010).

An equality analysis of this policy has been undertaken to ensure it is fair and accessible, compliant with legal and best practice guidelines. One key action, relating to the training has been identified and is recorded in the Equality Analysis Action Plan.
# EQUALITY ANALYSIS ACTION PLAN

**POLICY NAME:** Cardiopulmonary Resuscitation Policy  
**POLICY LEAD:** Resuscitation Officer  
**DATE:** 04/02/2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Action</th>
<th>Target Date</th>
<th>Person responsible and their Directorate</th>
</tr>
</thead>
</table>
| Training | All Social Care staff involved in direct patient/client contact are required to be trained in Basic Life Support in line with existing Healthcare staff. | August 2015 | **Directors**  
Dr Doug Wulff – Medical Directorate  
Julie Tanner – HR  
**Teams**  
Training and Development Team – Statutory Training |
## MONITORING COMPLIANCE

<table>
<thead>
<tr>
<th>Name of Procedural Document</th>
<th>Cardiopulmonary Resuscitation Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring Officer</td>
<td>Resuscitation Officer</td>
</tr>
<tr>
<td>Reporting Arrangements</td>
<td>The Cardiopulmonary Resuscitation Policy sets out auditing and monitoring processes in relation to the standards detailed below</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element to be Monitored</th>
<th>Standard Criteria</th>
<th>Actions on Recommendations</th>
<th>Changes in Practice and Lessons to be Shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Resuscitation equipment (trolleys and bags) – adherence with checking of equipment standards</td>
<td>Annual audit of adherence to checking of equipment processes</td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Staff training compliance</td>
<td>Monthly reporting to the Resuscitation Group by Training Team member</td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>Review of resuscitation attempts in relation to outcomes and learning</td>
<td>All resuscitation attempts are reported as an adverse incident and these incidents are reviewed through the Risk Team and reported on a monthly basis to the Resuscitation Group</td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>DNACPR record keeping</td>
<td>Annual records audit to be undertaken to ensure good practice relating to DNACPR is being adhered to.</td>
<td></td>
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</tbody>
</table>