Policy:

NPCS 007 Resuscitation

Executive or Associate Director lead	Executive Director of Nursing, Professions, and Care Standards
Policy authors	Resuscitation & Physical Health Lead Nurse Deputy Physical Health Nurse
Feedback on implementation to	Resuscitation & Physical Health Lead Nurse

Document type	Policy
Document status	Version 2.1
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Ratified by	Executive Directors' Group
Date of issue	28 January 2019
Date for review	31 January 2022

Target audience	All SHSC employees, or contracted staff from other NHS Trusts or private individuals working with SHSC service users.

Keywords	Resuscitation, physical health, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR), deteriorating patient, Early Warning Signs (EWS)

This is version 2.1 of this policy.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.
Any printed copies of the previous versions should be destroyed and if a hard copy is required, it should be replaced with this version.

This version briefly covers Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR).

Contents

1. Introduction

The availability of suitable cardio-pulmonary resuscitation is expected of healthcare services, and a service user has the right to expect such support from a healthcare provider. It is recognised that employees of Sheffield Health and Social Care NHS Trust may be involved in resuscitation procedures in the course of their work.

As a provider of specialist Mental Health, Learning Disability, Primary Care and Community Services it is essential that the Trust provides resuscitation at an appropriate level. For effective life support, standardised equipment, training and protocols must be provided.

Across the Trust this provision will be determined by the location of the healthcare facility, the staff available and the type of healthcare provided and will at all times be supported by the local ambulance service.

This policy outlines the systems in place in the Trust to provide high quality resuscitation to its patients at all times. It also supports the Quality Standards for CPR – Mental Health inpatient care (updated May 2017) and Quality Standards for CPR – Primary Care (updated May 2017) published by the Resuscitation Council (UK).

This policy has been reviewed and updated in line with National Patient Safety Agency (NPSA) Rapid Response Report (RRR010/2008), Resuscitation Council UK Guidelines 2015 and also the introduction of a single Do Not Attempt CPR form across the Yorkshire and Humber region.

2. Scope

This policy applies to **all employees** (clinical and non-clinical) of Sheffield Health and Social Care NHS Foundation Trust, including Bank Agency and Locum staff.

3. Definitions

- **Cardio-respiratory arrest** is defined clinically by unconsciousness in association with no established breathing pattern and no signs of life.

- **Cardio-Pulmonary Resuscitation (CPR)** 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.

- **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.

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

- **Basic Life Support (BLS)** is resuscitation training that includes the recognition of cardio-respiratory arrest, how to provide external chest compressions and artificial respiration, Use of an Automated External defibrillator, how to deal with a choking situation in adults, anaphylaxis and Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR).

- **Immediate Life Support (ILS)** is training that includes the recognition of the deteriorating patient and cardio-respiratory 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.

- **Automated External Defibrillator (AED)** is the device used in addition to BLS in an attempt to reverse cardiac arrest. These devices are available on most inpatient units. (NICE, 2005).

- **DNACPR –** Do Not Attempt Cardio-Pulmonary Resuscitation (Appendix G).

- **Advanced Life Support (ALS)** - Advanced airway management (e.g. intubation), use of bag/mask/valve with oxygen, defibrillation and use of intra-venous drugs and fluids. Also includes cardiac monitoring.

- **Care Staff** - Doctors, Nursing Staff, Support Workers and Therapists or other staff providing direct care to a patient.

- **Registered Practitioner** – Professionally registered staff e.g. Doctor, Nurse, Allied Health Professional, Therapist.

4. Purpose

To set out the arrangements for managing the risks associated with provision of resuscitation

To ensure there is an effective system in place to support effective resuscitation provision for service users/patients.

To outline the duties and responsibilities of the Trust and its staff members to comply with relevant legislation and guidance (Resuscitation Council UK Guidelines and Quality Standards)

5. Duties

Healthcare organisations have an obligation to provide an effective resuscitation service to their patients and appropriate training to their staff. A suitable infrastructure is required to establish and continue to provide continuing support for these activities. (Quality standards for cardiopulmonary resuscitation practice and training, Mental health - inpatient care - Quality standards, updated May 2017)

5.1 Chief Executive

The Chief Executive is responsible for making arrangements to support the safe and effective implementation, monitoring and review of this policy.

5.2 Medical Director and the Chief Operating Officer

Are responsible for the implementation and monitoring of the policy across the Trust.

5.3 Executive Director of Nursing & Professions

Executive Director of Nursing, Professions and Care Standards
(Quality standards for cardiopulmonary resuscitation practice and training, Mental health - inpatient care - Quality standards, updated May 2017)

- Responsible for resuscitation service structure. This service must be part of the Trust management/governance structure
- Responsible for implementation and monitoring of the policy within the Trust.
- Ensure there is defined financial support for an effective resuscitation service and training.

5.4 Non-Executive Trust Director - To be confirmed

Designated responsibility on behalf of the Trust Board to ensure that a Resuscitation Policy is agreed, implemented and regularly reviewed within the clinical governance framework (Quality standards for cardiopulmonary resuscitation practice and training, Mental health - inpatient care - Quality standards, updated May 2017)

5.5 Resuscitation Officer (Resuscitation & Physical Health Lead Nurse)

- Liaise with Senior Operational Managers and Ward Managers to assist with and develop a training package and updates in life support to a level equal to the Immediate Life Support course of the Resuscitation Council (UK) for registered nurses and doctors working in areas where restraint or rapid tranquilisation may be used.
- Work with Education, Training & Development to develop other levels of resuscitation and medical emergency training. This should including trainer training where required.
- Review and analysis of training data held centrally by the training department to monitor staff and department training compliance.
- Develop action plans for staff members who do not meet the requirements set out in national life support and choking guidelines.
- Collate data about incidents involving life support and/or resuscitation events.
- Act as a specialist advisor to the Trust on resuscitation and related matters such as mortality reviews.
- Produce an annual audit of resuscitation events, resuscitation equipment, choking incidents and DNACPR orders.
- 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 staff at all levels in improving practice and promoting organisational learning.
- Be available as a source of specialist advice and support to the Trust, managers and staff, including incident debriefing.
- Lead the review and updating of this policy.

5.6 Resuscitation Committee

The Deputy Chief Nurse is finalising the Terms of Reference for this group. In the absence of a committee, all incidents relating to resuscitation / physical health are monitored by the risk department, Resuscitation & Physical Lead Nurse, overseen by the Deputy Chief Nurse. These issues are linked to the Service User Safety Group which meets monthly. Responsibilities include:

- Determining the level of resuscitation training required.
- Facilitating adequate provision of training in resuscitation.
- Determining requirements for and choice of resuscitation equipment.
- Promoting adherence to national resuscitation guidelines and standards.
- Making available resuscitation/emergency equipment for clinical use.
- Producing policies relating to resuscitation and anaphylaxis, including a policy on resuscitation decisions, e.g. Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR).
- Implementing operational policies governing resuscitation practice and training.
- Commissioning audits of resuscitation practice.
- Ensuring the reporting and review of critical incidents in relation to resuscitation.
- Driving and implementing change outlined in this policy and related policies.

5.7 Ward/Team Managers

Are responsible for ensuring that;

- Staff attend training as identified by the assessment and organisational training needs analysis.
- There is appropriate emergency equipment for all their staff which is regularly checked and recorded.
- There are procedures for summoning the emergency services and Trust emergency equipment, if not available in their ward/area.
- An incident report and Resuscitation Record Form (Appendix I) is completed for every resuscitation attempt.

Manage and maintain the resuscitation/emergency equipment within the area of responsibility via:

- An up to date Medical Devices Inventory.
- Signed and dated weekly equipment check records and in line with the manufacturer's recommendations. A record of these checks will be kept for 3 years.
- Manage any equipment issues immediately or seek assistance from Resuscitation Officer.
- Adequate stocks of disposable/single use parts of the resuscitation/emergency equipment required in that area, to maintain continued functioning of the equipment by immediate replacement.

5.8 Consultants and GP's

- Overall responsibility for decisions relating to resuscitation rest with the Consultant or GP in charge of the patient's care.

5.9 All Staff with direct patient contact and all designated First Aiders

- Attend training and updates (yearly) in Life Support as outlined by this policy and the Trust training requirements, and maintain professional standards. All life support training to include training on choking as directed by National Patient Safety Agency (NPSA) report (2008).
- Report concerns to their line manager.
- Initiate CPR in line with policy guidance and training.
- Complete an incident report for every resuscitation attempt in line with the incident reporting policy.
- Contribute to the review of incidents in an open and positive manner in order to improve practice and promote organisational learning.

5.10 Senior Operational Managers (SOM's)

- Disseminate, implement and evaluate the use of this policy within areas of responsibility.
- Facilitate and support Ward/Team Managers in their responsibilities with regard to policy implementation and monitoring.
- Identify and allocate resources in order to comply with this policy.
- Make available appropriate and suitably maintained resuscitation equipment, keeping an up to date Medical Device Inventory 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 staff at all levels in improving practice and promoting organisational learning.
- Proactively seek advice and support from the Resuscitation Officer and training department.

6. Resuscitation Procedure

Where no explicit decision has been made about the appropriateness or otherwise of attempting resuscitation prior to a patient having a cardiac arrest then there should be a presumption that care staff will make all reasonable efforts to revive the patient.

In the event of staff or a visitor suffering a cardio-respiratory arrest then attempts should also be made to revive them.

Prevention and recognition of arrest/deterioration - All teams should:

- Use track & trigger tools (Early Warning Score) to aid recognition and management of deterioration in physical health.
- Be able to recognise deterioration of physical health using an (ABCDE) approach: Airway, Breathing, Circulation, Disability, Exposure. (Appendix F).
- Use effective models of communication e.g. SBARD (Situation-Background-Assessment-Recommendation-Decision).
- Offer a physical examination on admission.
- Encourage Service Users to lower the risk of physical deterioration by offering support with Health and Well Being including Lifestyle factors.

Cardiac arrest is rarely a sudden event. The use of a track and trigger system will aid to identify deterioration in a patient's condition and the escalation procedure on the Modified Early Warning Score (MEWS) should be followed at all times.

6.1 Response to a Sudden Cardiac Arrest

In all instances where a person is suspected of collapsing due to a cardio-pulmonary arrest the ambulance service will be called. This does not apply to teams which have a resuscitation service (crash team) provided by an acute trust with whom they share the site.
Basic Life Support (BLS) should be commenced and continue until the emergency service arrive. Where available an Automatic External Defibrillation (AED) should be used.

NOTE - Cardio-Pulmonary Resuscitation will be initiated unless a DNACPR decision has been made.

All health and social care staff (managers, doctors, nurses, social workers, psychologists/therapists, occupational therapists and support staff) that work directly with people using Trust services are expected to recognise cardiac arrest, call for help and/or initiate BLS. Staff who are trained to use the Trusts AED's should initiate this procedure upon arrival.

All support staff (e.g. Admin and Clerical) who work indirectly with people using Trust services are expected to be able to recognise people in distress, call for help and assist staff in such an emergency as required. All patients, visitors, and staff who collapse within the vicinity of Trust premises are to be resuscitated in line with this policy. All patients being attended by a clinician, whether in hospital, healthcare unit or their own home, are to be actively resuscitated and suitable assistance called, unless they have a 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) order in place, rigour mortis is present, or there are signs of decomposition. The temperature and pallor of the person's skin should not be used as an indicator of the initiation of CPR.

In circumstances where staff think the casualty should have a DNACPR order, but doesn't, full resuscitation is to be attempted until an ambulance arrives and takes over, or a recognised doctor issues orders to stop resuscitation efforts.

On finding someone collapsed, staff should immediately assess the casualty, and summon further assistance by initially shouting for help and activating any alarm systems in place. As soon as a medical emergency has been identified, then an ambulance will be summoned. In certain circumstances people may wish to exercise their right not to be resuscitated either in person or through an advance decision, see the Trust policy on Consent to Treatment. The

persons' wishes should always be respected. Where someone suffers a cardio-pulmonary arrest, a Trust incident form must be completed and forwarded to the appropriate manager who will decide if an investigation is needed (See Trust Incident Reporting and Investigation Policy).

6.2 CPR in the Community

All people receiving community services will be presumed to be for resuscitation unless a decision not to resuscitate has been agreed with the person's General Practitioner (GP) prior to a sudden collapse. All decisions with regard to a Do Not Attempt CPR decision by the GP should be documented. Failure to document such a decision places a legal responsibility on the attending community staff to obtain emergency assistance.

6.3 Risk to the Rescuer

Whilst the risk of infection transmission from patient to rescuer during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. A suitable barrier device will be used to deliver rescue breaths.

- All clinical areas should have immediate access to barrier devices (e.g. a pocket mask) that conforms to current recommendation to minimise the need for mouth-to-mouth ventilation.
- Should the rescuer be unable or unwilling to undertake rescue breathing without a barrier device and one is not immediately available chest compressions alone should be commenced and continued without interruption while awaiting the arrival of a barrier device
- The minimal level of personal protection for all community based staff is a Face shield. If staff do not have a barrier device readily available chest compressions should be started immediately rather than searching around for equipment.

6.4 Emergency Equipment

All in-patient settings have emergency equipment readily available in the practice area. This equipment is checked weekly to ensure standard contents. A record is maintained of the checks carried out by ward staff and are archived within the practice area. In-patient settings are assessed by Ward/Team managers to ascertain the level of risk and the necessary equipment is stored in accordance with the perceived risk level (see Appendix H).

The provision of suitable, standardised equipment is paramount in resuscitation so that staff 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.

6.5 Incidents Reporting, Including External Reporting Requirements

ALL resuscitation attempts **MUST** be reported on the Trust Incident Reporting System (Safeguard Risk Management System) and by the completion of the Resuscitation Record Form (Appendix I) which must be received by the Resuscitation Officer within 48 hours of the incident via internal mail. Alternatively a scanned copy of the form can be sent to **resus@shsc.nhs.uk**.

ALL serious (life threatening) sudden medical emergencies, e.g. choking and anaphylaxis, and any emergency medical equipment failures should be reported using the Trust Safeguard incident reporting system and flagged up to the Resuscitation Officer via email: **resus@shsc.nhs.uk.**

All patient safety incidents will be reported to the National Patient Safety Agency (NPSA) and all deaths to the Coroner's Office and certain deaths to The Care Quality Commission as per the Trust Incident Reporting Policy.

7. Dissemination, storage and archiving (Control)

The policy is available on the SHSC intranet and available to all staff within 10 days of ratification. An “All SHSC” e mail alert will be sent to all staff.

The policy will be sent to Clinical and Associate Directors for dissemination throughout the Trust.

The integrated Risk/Governance Team will keep a paper & electronic version of the previous policy. Managers will be responsible for removing and replacing paper copies of the policy.

8. Training and other Resource Implications

Mandatory Training Requirements

All staff should receive a full face to face BLS session to include Adult BLS (with paediatric modifications) including AED, Anaphylaxis, Choking, and DNACPR at induction.

Staff Group**	Specific staff members	Minimum training standard	Frequency of training
Nurses – all Psychosocial Intervention Workers Drug and Alcohol Workers Support Workers Physiotherapists Occupational Therapists Occupational Therapists Assistants Clinical Pharmacists Clinical Psychologists Corporate Management with Clinical Contact		Adult BLS (with paediatric modifications) including AED Anaphylaxis Choking DNACPR	On induction, then annually.
Nurses (bed-based) Physiotherapists (If delivering chest physiotherapy and deep suctioning)	Recommended for staff members who take charge of ward areas and essential for staff involved in rapid tranquilisation, restraint or seclusion.	Minimum of ILS training is essential	Annually
Doctors – all		Adult and Paediatric BLS including AED Anaphylaxis Choking DNACPR	On induction, then annually

	Doctors prescribing rapid tranquilisation and/or involved in restraint or seclusion	Minimum of ILS training is essential	
Corporate Management with no clinical contact. Administrative staff, non-clinical staff (including Housekeepers, Estates and Facilities)		Use e-learning* adult BLS training, and www.life-saver.org.uk	Face to face session on induction then e-learning annually.

*e-learning package to be decided upon and purchased
** Community Staff fall within designated staff group.

Staff Members who do not successfully complete the training assessments will need to attend further training within one month. Failure to complete this assessment will be discussed with the line manager and an action plan will be agreed upon.

All training is recorded using the Oracle Learning Management (OLM) system which is maintained by the Education, Training and Development Team. Records of all training should also be maintained on the individual's personal file held by line managers. For all staff, training is provided internally.

- In areas delivering services to patients, residents or clients there should be a minimum of a face-shield readily available, possibly pinned to notice boards for ease of access, for community staff a key fob with face shield may be the most practicable equipment.
- For in-patient areas the minimum should be a single-use pocket mask with an Emergency (Resuscitation) Bag (see Appendix H) including Oxygen.

- In administration/non-clinical areas a face-shield should be available within the First Aid container.
- Items can be ordered through Procurement Department and drugs through pharmacy. For restocking and ordering of partially/empty oxygen cylinders contact Procurement Department (or NGH Oxygen Porters for Longley Centre)..
- Manual handling is an essential part of daily care and in order to minimise injury to staff or patient it is advised that standard manual handling procedures are followed during resuscitations. Patients should not be moved until their condition has been stabilised sufficiently to allow for their transfer. It is rare that a patient will not need to be moved, and a few minutes delay will not pose a problem. Therefore time will be available to make an assessment of the most appropriate and least hazardous method by which to move the patient. It is recommended that the patient is lifted with the aid of a hoist where available and a manual lift should only be considered as a last resort if a minimum of 7 people are available with a suitable lifting device (i.e. a lifting sheet or a scoop).
- Please refer to the Trust Manual Handling Advisor or the Resuscitation Council website for further guidance. (www.resus.org.uk/pages/safehand.pdf)

- All staff members are to receive training in the use of automated external defibrillators. Defibrillation at 90 seconds after collapse has been shown to increase the chances of survival up to 60%; defibrillation at 7 minutes has been shown to have a survival rate of 30%.
- Staff members involved in situations that require resuscitation are likely to find it extremely stressful and therefore will need additional support. Managers need to be aware of this and consider the use of post-incident review as well as checking out how individual staff are doing (refer to Incident Reporting and Investigation Policy). Staff can also be supported through the use of existing mechanisms such as clinical supervision and Workplace Wellbeing.

9. Audit, Monitoring and Review

NHSLA Risk Management Standards - Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/Group/ Committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/Group/Committee for action plan development	Responsible Individual/Group/Committee for action plan monitoring and Implementation
A) Review of Modified Early Warning Score (MEWS) recorded for all service users to ensure that vital signs are being recorded and escalated appropriately.	MEWS charts and Insight Records review of 10 service users selected at random.	Ward Managers	Monthly	Ward Managers to send results to Resuscitation Officer on a monthly basis to be collated by administration support.	Ward Managers, Resuscitation Officer and Resuscitation Committee	Ward Managers, and Resuscitation Officer
B) Trust wide audit of MEWS that identifies which variables need to be measured including the frequency of measurement and escalation protocol	Trust wide audit of all current inpatients MEWS charts and documented escalation within insight records	Resuscitation Officer/team to lead audit	Every 2 years	Report to be presented and discussed at Resuscitation Committee meeting	Resuscitation Committee	Ward Managers, and Resuscitation Officer
C) Do not attempt resuscitation orders (DNAR)	Audit of DNACPR forms and documented reasons for DNACPR order in insight notes as per region wide policy.	Ward/Team Managers/Risk Department	Annual	Resuscitation Committee	Resuscitation Committee	Ward Managers and Medical Teams
D) Resuscitation equipment check	Monitoring of equipment checking procedures	Ward/Team Managers	Weekly	Team Governance Groups	Team Governance Groups	Directorate Governance Groups

E) Review of every CPR attempt which is to be reported through the Trusts Safeguarding Incident reporting System as recommended by National Confidential Enquiry into Patient Outcome and Death (**NCEPOD**)	All incidents to be forwarded to the Resuscitation Officer for review and collated with a weekly review and follow-up of 2222 call log from switch board. All information to form a database of all CPR attempts within the trust.	Resuscitation Officer	Weekly	Mortality Review Group to review these weekly.	Mortality Review Group and Resuscitation Committee.	Review by Resuscitation Committee and reported on which will be presented to the Board annually
F) Audit of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) and Resuscitation Policies	Annual review of audit data and most recent national guidance to ensure that the policies are fit for purpose.	Resuscitation Committee	Annually	Resuscitation Committee	Resuscitation Committee	Resuscitation Committee

10. Implementation plan

The implementation plan should be presented as an action plan and include clear actions, lead roles, resources needed and timescales. The Director of Corporate Governance team can provide advice on formats for action plans however; an example layout for the plan is shown below:

Action / Task	**Responsible Person**	**Deadline**	**Progress update**
Consultation period for new resuscitation policy	*Chief Nurse*	*01/02/2018*	
Ratification of Policy	*Chief Nurse*	*01/03/2018*	
Make teams aware of new policy	*Team managers*	*01/03/2018*	-Communications Lead to send out trust wide email. -New policy to be advertised on intranet page banner -Announcement in Connect, Chief Nurse's and Chief Executives letters to all staff members
Review of policy following recommendations from CQC	*Resuscitation and Physical Health Lead Nurse*	*01/11/18*	Sent to Policy Governance 24/10/18

11. Links to other policies, standards and legislation (associated documents)

This policy meets the requirements of the NHSLA Risk Management Standards (NHSLA, 2007), and should be used in conjunction with:

- SHSC: Incident Reporting Policy
- Physical Health Policy
- Consent Policy
- Regional guidance on the completion of DNACPR - The Yorkshire and Humber Regional Form for Adults and Young people aged 16 and over (v13)

12. Contact details

Title	***Phone***	***Email***
Resuscitation and Physical Health Lead Nurse	0114 2716375 07580033235	Resus@shsc.nhs.uk
Deputy Physical Health Nurse	0114 2263115	Resus@shsc.nhs.uk

13. References

MacKay - Jones, K. and Walker, M. (1998) Pocket Guide to Teaching for Medical Instructors. BMJ Books. London

Mental Capacity Act 2005 Department of Health

National Health Service Litigation Authority (2007) NHSLA Risk Management Standards for Mental Health and Learning Disabilities Trusts

Resuscitation Policy. Health Services Circular (HSC) 2000/028. London. Department of Health NPSA Rapid Response Report (RRR010/2008),

Resuscitation Council (UK) Decisions relating to Cardiopulmonary Resuscitation (3rd edition - 1st revision) (2016) A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. https://www.resus.org.uk/archive/archived-dnacpr-information/decisions-relating-to-cpr-statement/ [online]

Resuscitation Council (UK) Resuscitation Guidelines 2015. https://www.resus.org.uk/resuscitation-guidelines/ [online]

Resuscitation Council (UK) - Quality standards for cardiopulmonary resuscitation practice and training

- Mental health - inpatient care - Quality standards (updated May 2017)
- Primary care - Quality standards (updated May 2017)
- Community hospitals care - Quality standards for CPR (Jan 2016)

NICE guideline – Violence and aggression: short-term management in mental health, health and community settings (May 2015) nice.org.uk/guidance/ng10 [online]

NICE Quality standard – Violent and aggressive behaviours in people with mental health problems - (June 2017) nice.org.uk/guidance/qs154 [online]

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
0.1	New draft policy created	14/12/17	New policy commissioned by EDG on approval of a Case for Need.
1.0	Ratification and issue	TBC	Amendments made during consultation, prior to ratification.
2.0	Review / ratification / issue	Sept 2018	Early review undertaken to update the policy to in order to comply with new regulatory requirements.
2.1	Review following CQC report	Dec 2019	Committee structure updated Appendix changes Training revised

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
2.1	28 January 2019		

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. Will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	**NO**	**n/a**	**n/a**
DISABILITY	**NO**	**n/a**	**n/a**
GENDER REASSIGNMENT	**NO**	**n/a**	**n/a**
PREGNANCY AND MATERNITY	**NO**	**n/a**	**n/a**
RACE	**NO**	**n/a**	**n/a**
RELIGION OR BELIEF	**NO**	**n/a**	**n/a**
SEX	**NO**	**n/a**	**n/a**
SEXUAL ORIENTATION	**NO**	**n/a**	**n/a**

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: no changes made.

Impact Assessment Completed by (insert name and date) Kate Virgo 14/12/2017

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(Relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. **Is your policy based on and in line with the current law (including case law) or policy?**

☒ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. **On completion of flow diagram – is further action needed?**

☒ **No, no further action needed.**

☐ **Yes, go to question 3**

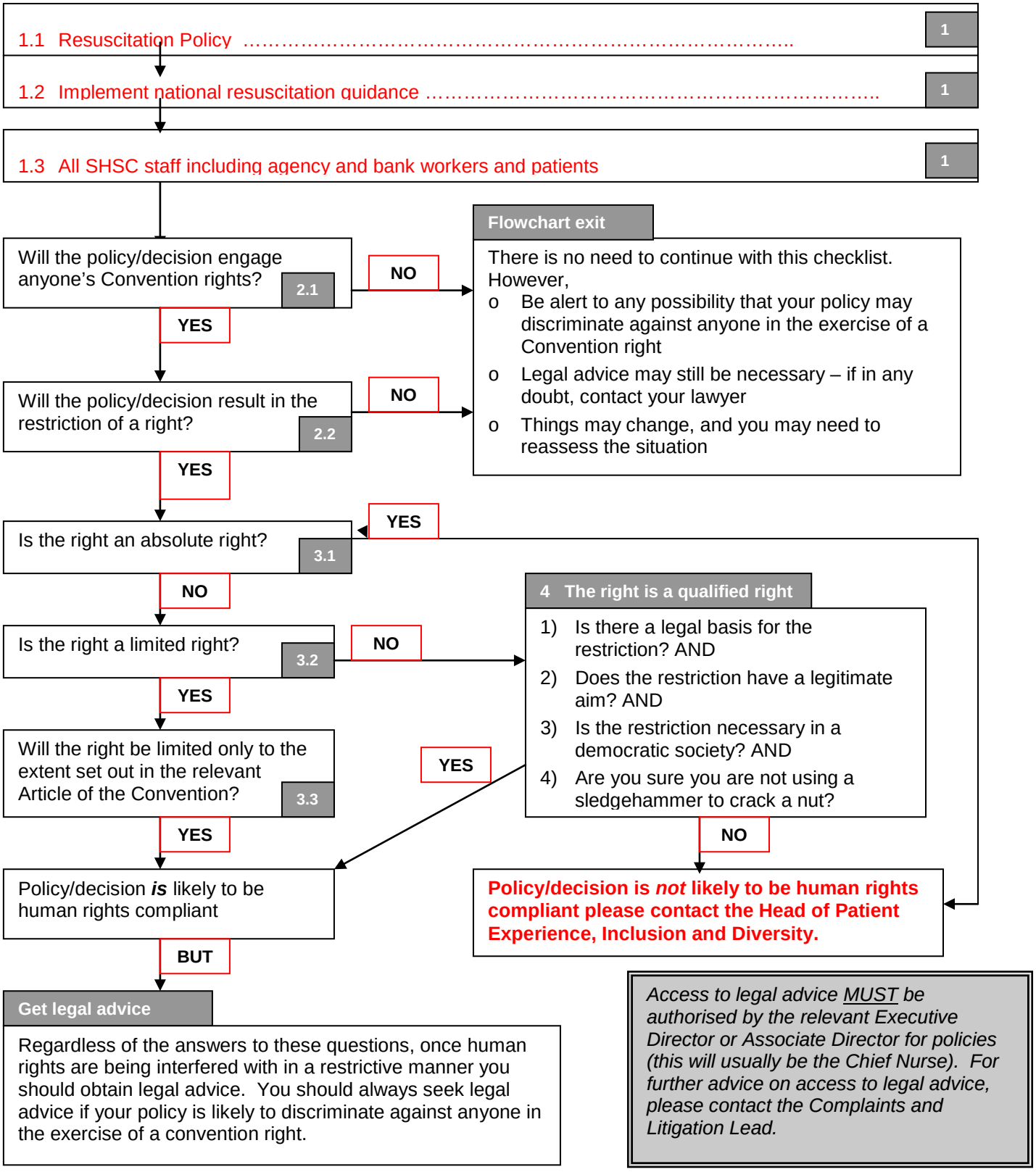
3. **Complete the table below to provide details of the actions required**

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



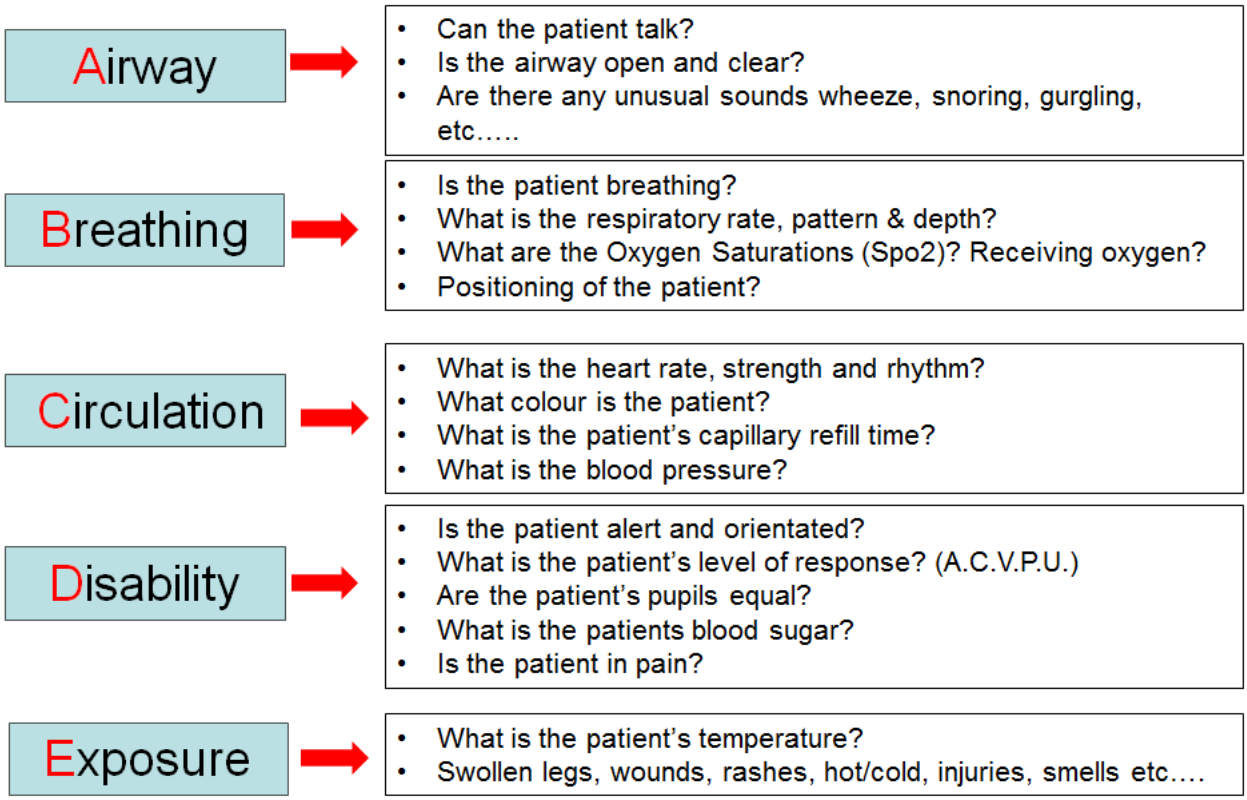
Appendix E – Development, Consultation and Verification

Do to the very short time period that was available to write this policy and make it fit for purpose this work has not yet been carried out. As this process is followed the policy will be updated.

To be completed:

- *Who was involved in developing the policy and any guidance followed?*
- *Groups and individuals consulted (including staff side groups and service user / carer involvement).*
- *Any changes made as a result of the consultation process.*
- *Which governance group verified the document*
- *Dates for consultation and verification.*

Appendix F – ABCDE Approach



DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Yorkshire & Humber Regional Form for Adults and Young People aged 16 and over (v13)

In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) will be made. All other treatment should be given where appropriate.

NHS No	Hospital No	Next of Kin / Emergency Contact
Name		
Address		Relationship
Postcode	Date of Birth	Tel Number

Section 1 Reason for DNACPR decision: Select as appropriate from A - D

Details of all discussions, mental capacity assessments and MDT decisions must be recorded in the patient's notes.

(Guidance overleaf)

A. ☐ **CPR has been discussed with this patient. It is against their wishes and they have the mental capacity to make this decision.**

(Guidance overleaf)

B. ☐ **CPR is against the wishes of the patient as recorded in a valid advance decision**
The right to refuse CPR in an Advance Decision only applies from the age of 18.

(Guidance overleaf)

C. ☐ **The outcome of CPR would *not* be of *overall benefit* to the patient and:**

i) They lack the capacity to make the decision ☐ **or**

ii) They have declined to discuss the decision ☐

This represents a best interests decision and must be discussed with relevant others

This has been discussed with ……(name) on ……(date/time) Relationship to patient:……

(Guidance overleaf)

D. ☐ **CPR would be of *no clinical benefit* because of the following medical conditions:**

……

In these situations when CPR is not expected to be successful, it is good practice to explain to the patient and/or relevant others why CPR will not be attempted.

This has been discussed with the patient ☐ Date:…../…../…… Time: ……

This has not been discussed with the patient ☐ *Specify Reason:* ……

This has been discussed with ……(name) on ……(date/time) Relationship to patient:……

Section 2 Review of DNACPR decision: Select as appropriate from i OR ii

i) DNACPR decision is to be reviewed by: …… *(specify date)*

Review Date	Full Name and Designation	Signature	DNACPR still applies	Next Review Date
			☐ (tick)	
			☐ (tick)	
			☐ (tick)	

ii) DNACPR decision is to remain valid until end of life ☐ (tick)

Section 3 Healthcare professionals completing DNACPR form *(Guidance overleaf)*

Date:…… Time: ……

Signature: ……

Print name:……

Designation & Organisation:……

GMC / NMC No:……

(Countersignature if required)

Date:…… Time: ……

Signature: ……

Print name:……

Designation & Organisation:……

GMC / NMC No: ……

These guidelines are based on an agreement within the Yorkshire and Humber region.
This form can be red or black-bordered.
For more details refer to your local policy relating to DNACPR.
This is not a legally binding document; the decision may change according to clinical circumstances

Section 1 Guidance (*Please write legibly and with black ink)*

Option A

Record details in the patient's notes, including the assessment of the patient's mental capacity to make this decision.

Option B

The Mental Capacity Act (2005) confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:

1. The decision is in writing, signed, witnessed and the patient is aged 18 or over;
2. It includes a statement that the advance decision is to apply even if the patient's life is at risk;
3. The advance decision has not been withdrawn;
4. The patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
5. The patient has not done anything clearly inconsistent with its terms; and
6. The circumstances that have arisen match those envisaged in the advance decision.

16 and 17-year-olds: *Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility*

Option C

1. The term "*overall benefit*" is used in the context defined by GMC Guidance 2010 (Treatment & Care towards the End of Life; pg. 40-46; paragraphs 6, 13) and takes into account "*best interests*" as defined by the Mental Capacity Act, 2005.
2. Whenever possible, this situation **must** be discussed with relevant others before completing the form. Record details of your discussion in the patient's notes.
3. The term "*relevant others*" is used to describe a patient's relatives, carers, representatives, people with lasting power of attorney, independent mental capacity advocates (IMCAs), advocates, and court appointed deputies (refer to Mental Capacity Act) http://www.dh.gov.uk

Option D

Record underlying condition/s (e.g. poor Left Ventricular Function, End stage obstructive airway disease, disseminated malignancy) and complete necessary discussions with patient and/or relevant others as soon as possible

Section 2 Review – In accordance with your Local Policy

It is considered good practice to review DNACPR status in the following circumstances:

- At the consultant ward round, MDT or Gold Standards Framework meeting;
- On transfer of medical responsibility (e.g. hospital to community or vice versa); or
- Whenever there are significant changes in a patient's condition.

Cancellation of DNACPR: When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form, writing **CANCELLED** in large capitals and adding your signature and date. It should then be filed in the patient's notes.

Section 3 Authorisation

Responsibility for making the DNACPR decision lies with a senior doctor (e.g. Consultant, GP) who has responsibility for the patient. In some localities, other healthcare professionals who have undertaken the necessary training may make the DNACPR decision.

Countersignature: If junior medical staff or other authorised professionals have been instructed to sign the form by a senior clinician, the form should be countersigned by the senior doctor, as soon as possible or as per local policy.

Any supplementary information (e.g. family informed by nursing staff at later stage) should be signed and dated by the entry.

COMMUNICATING DNACPR DECISIONS

It is the responsibility of the healthcare team completing the form to ensure that the DNACPR status is communicated to all who need to know.

For patients being transferred between different care settings, it is essential that:

1. Where patients are being transferred to community (e.g. home or care home): the DNACPR status and an explanation of the role of the form in an emergency should be communicated to patient (if appropriate) and *'relevant others'*.
2. Send the original form with the patient. A photocopy or carbon copy version should be retained in the patient's notes for audit, marked with the words 'COPY' in large capitals, signed and dated.
3. For discharges to community settings: communicate to the GP, Out of Hours service and any other relevant services as appropriate.

v12 January 2014
Regional Review Date: January 2017
Calderdale & Huddersfield NHS Foundation Trust, West Yorkshire

Appendix H

Emergency Bag – Weekly/After Use Checklist

Ward: …… Location: …… Year ……

Please verify that the emergency bag contains the following items, in date & full working order.

	Date:																								
2 x Adult Non-rebreathing 100% Oxygen masks  Single use																									
2 x Individual oxygen tubing  Single use																									
	2 x Oropharyngeal airway Size 4																								
	2 x Oropharyngeal airway Size 3																								
	2 x Oropharyngeal airway Size 2																								
1 x Vitalograph Emergency Aspirator 																									
1 x Single use bag, valve and mask (with Oxygen reservoir)  Single use																									
1 x Single use pocket mask  Single use																									
1 x Tough-cut Scissors 																									
2 x Naso-pharyngeal Airway (Size 6mm) 																									
2 x Lubricating Jelly (sachet)																									
1 x Lightweight Portable Oxygen Cylinder 																									
1 x Ligature Cutter  Sharpen after use																									
4 (pairs) x Gloves																									

1 x Pulse oximeter																								
Doctors Box																								
2 x Cannula Size 16g – 45mm GREY																								
2 x Cannula Size 18g – 45mm GREEN																								
2 x Cannula Size 20g – 32mm PINK																								
2 x Cannula Size 22g – 25mm BLUE																								
2 x Niko-Fix (fixation device for IV cannula)																								
1 x Micropore tape (2.5cm) - roll																								
3 x Pre-filled syringes - Adrenaline 1:10,000 10mls = 1mg																								
Emergency Drug Tray (may be kept separate to bag but should be readily available near the bag) Syringes - 1ml, 3ml, 5ml, 10ml (2 of each) Needles – blue and green (2 of each)																								
Initials of person inspecting																								
Team Manager 4 weekly Check **Date:**																								
Findings:																								
Team Manager Signature:																								

Please √ if equipment is present, clean and useable
Please insert: 1= soiled – if able to please replace/clean if appropriate
2= unavailable/on order

Please report any issues to Resuscitation Officer by email: resus@shsc.nhs.uk

Appendix I

NHS	**Resuscitation Record Form**	

Please complete a form following every resuscitation incident

Section 1 - Patient details

Q1 Patients name	Q2 Date of Birth (D D M M Y Y Y Y) sex (Male Female)
Q3 Where incident occurred	Q4 Profession & grade of first staff member to incident Profession Grade

Section 2 - Incident details *(Actions by anyone other than paramedic/ambulance staff)*

Q5 Date & time the patient found collapsed (use 24 hour clock) D D M M Y Y H H M M	Q6 Time ambulance called? (use 24 hour clock) H H M M Time ambulance arrived (use 24 hour clock) H H M M
Q7 What time was Basic Life Support (BLS) started? (use 24 hour clock) H H M M ☐☐☐☐ not started ☐ Patient had a DNACPR form	Q8 Profession and grade of individuals administering resuscitation Profession Grade Trained in BLS in last year? Yes No
Q9a Was an automated external defibrillator (AED) used? If Yes, what time (use 24 hour clock) H H M M Yes No **if No, go to Q9c**	Q9b Name of person using AED…… Job Title…….. Had the person using the AED had training within the last year? Yes No

Q9c If AED was not used what were the reasons (only applicable where Resuscitation equipment assessment indicates AED should be available)

not required not available no-one to use not working other

Q10 Were any of the following principles of ALS used by anyone other than paramedic/ambulance staff? If used, had the individual received training in the last year?

Venous access	Yes	No
Administering epinephrine/adrenaline	Yes	No
	Yes	No

Q11 What was the outcome of resuscitation? Died Survived	Q12 Was an incident form completed? Yes No

Office use only: AED data Card checked ……