CHILD & FAMILY WISHES:

Discussion Record

Advance care planning with families of children with life-limiting conditions is possible months or years before the end of life. Advance decisions evolve over time through the development of a trusting relationship and an ethos of shared decision making.*

This discussion record can be used by **any member of the Healthcare Team** in co-ordination with colleagues, to record a family's preferences and requests at all stages over the life course.

These are difficult but necessary conversations and guidance is offered in the accompanying 'Information for Health Professionals' and 'Information for Families' leaflet.

Name of child:

Date of birth:

NHS/patient ID number:

Date plan first discussed:

Date plan reviewed:

After discussion with the family, please ensure that a copy of the plan is included in all medical notes and give a copy to the family, the child's GP & all other relevant services.
To have completed records uploaded to the Bristol Children's Hospital database, email to ubh-tr.WishesDocument@nhs.net

*Ref: Fraser J, Harris N, Beringer AJ, Prescott H & Finlay F (2010) Advanced care planning in children with life-limiting conditions – the Wishes document. *Archives of Disease in Childhood 95:79-82.*

COORDINATION INFORMATION

Name of child:	Date of birth:

Name of parent/carer(s):*

Address: **Telephone No:**

***Name/address of adult(s) with parental responsibility:**

(if different from above)

Diagnosis & background summary:

Framework for decision-making:

☐ Wishes of young person with capacity
☐ Wishes of parent(s) for child on 'best interests' basis
☐ Best interests basis (according to Mental Capacity Act 2005)
☐ Other (please specify)

Lead Consultant:

Name:	
Post:	
Organisation:	
Tel no:	E-mail

Care Coordinator: (the person who works closely with the family to plan, coordinate and communicate between different members of the team)

Name:	
Post:	
Organisation:	
Tel no:	E-mail

Key people involved in the care of the child & family: (NB check page 7 where there is space for more people to be included)

Name:	
Post:	
Organisation:	
Tel no:	E-mail

WISHES DURING LIFE

Name of child:	**Date of birth:**

Child's wishes:
(consider in relation to 'everyday' quality of life as well as special treats)

Family wishes:
(consider how the family want to be supported to achieve 'everyday' quality of life)

Other's wishes: (e.g. school friends)

PLANS FOR WHEN CHILD BECOMES MORE UNWELL

Name of child:	**Date of birth:**

What may happen?
(e.g. deteriorating mobility, feeding, cognitive function, worsening seizures)

Preferred place of care: (may include hospice, home, local or regional hospital ward, HDU, PICU)

Preferred treatment options: (Indicate if not applicable or inappropriate)

- **Antibiotics -** e.g. Oral / IV / 'Portacath'
- **Feeding -** e.g. NG tube / gastrostomy
- **Respiratory Support -** e.g. Oxygen / non-invasive ventilation
- **Seizure Management Plan** (please provide summary and/or location of detailed plan)
- **Advanced Life Support Requiring PICU Admission** (might include inotropic drugs, invasive ventilation and advanced renal replacement therapy)

PLANS FOR CARE DURING AN ACUTE LIFE-THREATENING EVENT

Name of child:	**Date of birth:**

	YES	**NO**
Oxygen via face mask/nasal cannulae	☐	☐
Airway management using oral/ nasopharyngeal airway	☐	☐
Bag & mask ventilation	☐	☐
Endotracheal tube & ventilation	☐	☐
External cardiac compressions	☐	☐
Defibrillation & adrenaline to restart the heart following cardiac arrest	☐	☐

Please give further details, if required:
(e.g. continue 'bagging' until parents are present)

Next steps:

If child deteriorates further and end of life phase is recognised, identify from within the team an 'end-of-life care coordinator' and medical lead to facilitate and implement end of life care pathway. (Refer to 'Information for Health Professionals' leaflet p2, for guidance about these roles)

Name/contact details of end of life care coordinator:

Name/contact details of medical lead:

Preferred place of care:

Inform Ambulance Service if DNA CPR (do not attempt cardio-pulmonary resuscitation) has been agreed and child is going/at home (tick when done) ☐

For families living in the former Avon area (Bristol, Bath, North and North East Somerset and South Gloucestershire), Cornwall, Devon, Dorset, Gloucestershire, the Isles of Scilly, Somerset or Wiltshire email a copy of the record to swasnt.Clinical-Alerts@nhs.net

WISHES FOR AFTER DEATH

Name of child	**Date of birth:**

Organ & tissue donation: (See https://www.organdonation.nhs.uk/ or http://www.nhsbt.nhs.uk/tissuedonation/ or tel. 0800 432 0559 for additional guidance)

Preferred place of care of child after death:

Funeral preferences:

(Seek detailed information or further advice if needed)

Spiritual & cultural wishes:

Other child & family wishes:

COMMUNICATION INFORMATION

People involved in the care of the child & family (NB check also page 2 where Lead Clinician and Care Coordinator are named)

Name:	
Post:	
Organisation:	
Tel no:	E-mail

Name:	
Post:	
Organisation:	
Tel no:	E-mail

Name:	
Post:	
Organisation:	
Tel no:	E-mail

Name:	
Post:	
Organisation:	
Tel no:	E-mail

Name:	
Post:	
Organisation:	
Tel no:	E-mail

Communication notes: use this space to record any other information you think is important

This plan discussed by:	
Child / Parent / Carer	
Professional [Name & job title]	
Date	
Updated on (new date)	

To have completed Wishes discussion records uploaded to the Bristol Children's Hospital database, email to: ubh-tr.WishesDocument@nhs.net

FURTHER INFORMATION & RESOURCES

'Information for Health Professionals' and **'Information for Families'** leaflets to support the use of the 'Child & Family Wishes: discussion record' are free to download from the Together for Short Lives website or request from;

[redacted],
Paediatric Palliative Care Liaison Nurse,
Bristol Children's Hospital
[redacted]
childrenspalliativecare@UHBristol.nhs.uk

[redacted],
Senior Research Fellow/Senior Lecturer,
UWE Bristol
[redacted]

End of life care planning - useful resources:

1. Together for Short Lives www.togetherforshortlives.org.uk
2. Child Bereavement Trust www.childbereavement.org.uk
3. Child Bereavement Network www.childhoodbereavementnetwork.org.uk
4. CLIC-Sargent (Cancer and leukaemia in childhood) www.clicsargent.org.uk
5. Children's cancer and leukaemia group (CCLG) www.cclg.org.uk
6. Winston's Wish child bereavement charity http://www.winstonswish.org.uk/
7. Department of Health guidance relating to child death: www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview

The Child & Family Wishes: discussion record was developed by members of the Avon Children's Palliative Care Partnership Group, with the intention that it is freely available to support, and promote, end of life care planning for children with life-limiting conditions.

We update the record regularly and are always pleased to receive suggestions about how it can be improved. Please email these to childrenspalliativecare@uhbristol.nhs.uk

Version date: Feb 2017

Standard Operating Procedure

DO NOT ATTEMPT RESUSCITATION FORMS: WHAT TO DO ON DISCHARGE (ADULTS)

SETTING	All clinical areas
FOR STAFF	Nursing / clinical / administrative staff in adult patient locations
PATIENTS	All adult patients with DNACPR forms (>18 years)

GUIDANCE

SHOULD THE DNACPR FORM GO WITH THE PATIENT?

When planning the discharge of a patient who has had a DNACPR form in hospital, the clinical team looking after the patient need to decide whether or not it is appropriate for the DNACPR to continue into the community. A form should never be sent home with the patient without prior discussion with the patient (if they have capacity) and their carers.

- **For patients who are going home (or to a nursing home or hospice) for end-of-life care -** it would be usual for the DNACPR form to continue into the community and it remains valid across all care settings in Bristol, North Somerset and South Gloucestershire (BNSSG). The team caring for the patient should ensure the patient (and their carer) is aware of the DNACPR form and the reasons for it going home with them.

- **If a patient was admitted with a DNACPR form from the GP**, please ensure it goes back out into the community with them.

- **For any other patients who have a DNACPR form** in hospital, the clinical team should consider whether or not it is appropriate for the patient to have the form at home. If appropriate for the DNACPR decision to continue out of hospital (for example, DNACPR has been discussed and the patient does not want CPR in the event of a cardiopulmonary arrest), then discuss with the patient and carers about taking the form home.

- **If the DNACPR is to be cancelled** on discharge, draw two diagonal lines across the DNACPR form and write 'CANCELLED' across it, and sign and date it. Leave it in the notes for filing/audit.

- If the clinical team think it would be appropriate for the form to go with the patient, but the patient (or their carer, if the patient lacks capacity) does not want to take the form home, explore their reasons and do not pressurise the patient to take the form. Contact the GP and explain the outcome of the discussions.

WHO SHOULD BE INFORMED IF THE DNACPR IS TO CONTINUE INTO THE COMMUNITY?

For the last few years, the process for patients who are going home with their DNACPR form is that the ward team fax the DNACPR to the GP and to SWAST A&E. This ambulance service then put a clinical alert on that patient's address on their database so that if there is a 999 call to that address, the ambulance crew will know in advance that there is a DNACPR in place. **Now that external faxing is being withdrawn, these notifications will need to be made by NHSmail instead.**

It is the responsibility of the nurse in charge of the ward to ensure that the DNACPR is communicated effectively to the appropriate people. This should include at least:

1. Ambulance Service

It is important to remember that the DNACPR form will contain patient information which means it must be emailed securely to the ambulance service in line with information governance requirements.

The DNACPR form should be scanned and e-mailed **from an NHSmail account** to the ambulance service on swasnt.clinical-alert@nhs.net. The nurse in charge of the ward holds overall responsibility for this process.

- In the unlikely event of a patient going home with a DNACPR out of hours (evenings or weekends), the ward should plan ahead for this and send these notifications in working hours.
- Where this has not been done, and the nurse in charge of the ward for that shift does not have a nhs email account (and these cases should be few and far between), the patient access team can be asked to email the electronic copy of the form to the ambulance service as above.

For PTS patients, the DNACPR status should be noted on the patient transport booking using the e-booking system. The UHB Transport Team will then pass this information on to the relevant PTS provider as part of the booking.

The ambulance crew will require sight of the form at handover on the ward, and the paper copy travels with the patient whilst on board.

2. GP

It is important to remember that the DNACPR form will contain patient ionformation which means it must be emailed securely to the GP in line with information governance requirements.

The DNACPR form should be scanned and e-mailed **from an NHSmail account** to the patient's registered GP practice. There is a list of BNSSG routinely checked generic NHSmail addresses on this link http://goto/psn. For any practice not listed, contact the practice to request an appropriate account to forward this document to them. If out of hours, they must be contacted on the next working day. It will remain the responsibility of the nurse in charge of the ward to ensure that this is carried out.

3. District Nursing Team

When booking district nursing using the electronic form available on the Trust Document Management Service, please ensure you indicate if the DNACPR is confirmed as continuing into the community.

RELATED DOCUMENTS

SAFETY

QUERIES For queries on the DNACPR process, contact the lead for resuscitation services / Resuscitation committee.
For queries on using nhsmail accounts, contact the matron for your clinical area.

University Hospitals Bristol NHS
NHS Foundation Trust

Do Not Attempt to Cardiopulmonary Resuscitation Guidance

Contents

Introduction

Survival following Cardiopulmonary Resuscitation (CPR) in adults is between 5-20% depending on the circumstances.[1] Although CPR can be attempted on any person prior to death, there comes a time for some people when it is not appropriate to do so. It is then necessary to consider making a Do Not Attempt CPR (DNACPR) decision to enable the person to die with dignity. This policy is based on a modified version of the Unified South Central policy and the Joint policy by the Resuscitation Council (UK), RCN and BMA.

Definitions

Cardiopulmonary Resuscitation (CPR).

Interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs.

Cardiac Arrest (CA)

Is the sudden cessation of effective cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness and apnoea or agonal gasping respiration. In simple terms, cardiac arrest is the point of death.

The Mental Capacity Act (2005) (MCA)

Was fully implemented on 1 October 2007. The aim of the Act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards.

Mental Capacity:

An individual over the age of 16 is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals that lack capacity will not be able to:

- understand information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate the decision, whether by talking or sign language or by any other means.

Advance Decision to Refuse Treatment (ADRT)

A decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding. [See: Advance Decisions Refusing CPR]

Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA)

The Mental Capacity Act (2005) allows people over the age of 18 years of age, who have capacity, to make a Lasting Power of Attorney by appointing a Personal Welfare Attorney who can make decisions regarding health and well - being on their behalf once capacity is lost. [See: Patient with a welfare attorney or court appointed deputy or guardian]

Independent Mental Capacity Advocate (IMCA)

An IMCA supports and represents a person who lacks capacity to make a specific decision at a specific time and who has no family or friends who are appropriate to represent them. [See: Adults who lack capacity and have no family, friends or other advocate]

A Court-appointed deputy

Is appointed by the Court of Protection (Specialist Court for issues relating to people who lack capacity to make specific decisions) to make decisions in the best interests of those who lack capacity. [See: Patient with a welfare attorney or court appointed deputy or guardian]

Advance Care Planning

Ensuring that the patient's wishes for the future are known and documented, where possible, is preferable to making decisions in a crisis when there may be insufficient time to gather and consider all of the relevant information relating to the patient's wishes and clinical condition. Resuscitation is one part of Advance Care Planning. Making such decisions in a crisis can be more stressful for patients, those close to the patient and staff caring for the patient.

Non-Discrimination

Any CPR decision must be tailored to the individual circumstances of the patient. It must not be assumed that the same decision will be appropriate for all patients with a particular condition.

Decisions must not be based solely on factors such as the patient's age, disability, or on a professional's subjective view of a patient's quality of life. When assessing whether attempting CPR may benefit the patient, decision-makers must not be unduly influenced by their own pre-existing (negative or positive) views about living with a particular condition or disability.

Legislation and Guidance

Mental Capacity Act (2005)

Under the Mental Capacity Act (2005) www.legislation.gov.uk/ukpga/2005/9/contents clinicians are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made.

Human Rights Act (1998)

Decisions about CPR must comply with the Human Rights Act 1998. This Act incorporates the bulk of the rights set out in the European Convention on Human Rights into UK law. www.legislation.gov.uk/ukpga/1998/42/contents

In order to meet their obligations under the Act, health professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention. Provisions particularly relevant to decisions about attempting CPR include the right to life (Article 2), to be free from inhuman or degrading treatment (Article 3), to respect for privacy and family life (Article 8), to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and to be free from discriminatory practice in respect of these rights (Article 14). The spirit of the Act, which aims to promote human dignity and transparent decision making, is reflected in these ethical guidelines.

Duty of care

Duty of Care-Registered Healthcare staff have a duty to ensure the decision making process is followed, the DNACPR form is completed accurately and the decision is communicated to the relevant people

Framework for Cardiopulmonary Resuscitation (CPR) Decisions

Is cardiac or respiratory arrest a clear possibility in this patient?

For example:

- Progressive cardiac or respiratory compromise.
- Patient has a long term condition with poor prognostic criteria.
- Patient dying from irreversible condition e.g. advanced cancer.
- Patient whose death is not unexpected.

NO

1. No clinical reason to discuss CPR (unless the patient would like to)

- In the event of cardiopulmonary arrest, carry out CPR unless it would clearly be unsuccessful.
- If the patient is not likely to have a cardiac or respiratory arrest, it is not necessary to initiate discussion with them about CPR. If however the individual wishes to discuss CPR, this should be respected.
- Review if circumstances change.

Advance Decision to Refuse Treatment.

YES

Are you as certain as you can be that CPR **would** have a medically successful outcome?

YES

2. Discuss options of CPR and DNACPR

- Sensitive exploration of the patient's wishes regarding resuscitation should be undertaken by the most experienced staff member available.
- **If the patient has capacity** to make this decision, discuss options of CPR and DNACPR with patient. Involve relevant others if appropriate (with patient's permission) but ultimately the decision lies with the patient.
- **If the patient does not have capacity** to make this decision, but has a valid and applicable Advanced Decision to Refuse Treatment, it must be respected. If a welfare attorney, deputy or guardian has been appointed, they should be consulted. Otherwise, the medical team should make the decision based on best interests after consulting with those close to the patient. If there is no-one to consult with, then an instruction to an Independent Mental Capacity Advocate must be made.
- Document the decision and any discussions.
- Continue to communicate with the patient and relevant others.
- Review if circumstances change.

NO

Are you as certain as you can be that CPR would **NOT** have a medically successful outcome?

YES

3. CPR medically inappropriate

- When a DNACPR decision is made on these clear clinical grounds, this should be explained to the patient (or their representative if the patient lacks capacity). Do not ask the patient or relevant others to make the CPR decision.
- As CPR would fail it should not be offered as a treatment option. Document the reasons for the decision and any relevant discussions.
- If a second opinion is requested, this should be arranged.
- Make sure relevant healthcare professionals are aware of DNACPR decision and patient and family are aware of goals of care.
- Continue to assess any concerns of the patient and relevant others (which may include discussion about why CPR is inappropriate).
- Where the patient is clearly dying (likely to die within days), ensure patient and family are aware of this, prescribe as required end of life medication and establish the patient's wishes for end of life care.
- Review if circumstances change.

NO

SEEK SENIOR ADVICE

Box 1: Advance Decisions Refusing CPR

CPR must not be attempted if it is contrary to valid and applicable Advance Decision to Refuse Treatment made when patients had capacity (see below for criteria for validity). If patient are admitted to UHBristol with a valid advance decision refusing CPR, a DNACPR form should be completed and filed in the front cover of the notes.
In England and Wales, ADRTs are covered by the Mental Capacity Act 2005. The Act confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:

- the patient was 18 years old or over and had capacity when the decision was made
- the decision is in writing, signed and witnessed
- it includes a statement that the advance decision is to apply even if the patient's life is at risk
- the advance decision has not been withdrawn
- the patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf
- the patient has not done anything clearly inconsistent with its terms
- the circumstances that have arisen match those envisaged in the advance decision.

If an advance decision does not meet these criteria but appears to set out a clear indication of the patient's wishes, it will not be legally binding but should be taken into consideration in determining the patient's best interests.

When Cardiac Arrest is not expected

For many patients receiving care in hospital, the likelihood of cardiorespiratory arrest is small and no clinical decision is made in advance of such an event. If cardiorespiratory arrest does occur unexpectedly, CPR should be attempted in accordance with the advice in these guidelines There is no ethical or legal requirement to discuss every possible eventuality with all patients and if the risk of cardiorespiratory arrest is considered very low it is not necessary to initiate discussion about CPR with the patient, or with those close to patients who lack capacity.

If there is a risk of cardiac or respiratory arrest it is desirable to make decisions about CPR in advance whenever possible. There should be a full clinical assessment of the chances of a successful outcome.

Box 2: Decisions about CPR Based On Benefits and Burdens when CPR may be successful

If CPR may be successful in re-starting the patient's heart and maintaining breathing for a sustained period, the benefits of prolonging life must be weighed against the potential burdens to the patient.

If the patient has capacity and CPR may be successful

When a patient with capacity is at foreseeable risk of cardiac or respiratory arrest, and the healthcare team has doubts about whether the benefits of CPR would outweigh the burdens, or whether the level of recovery expected would be acceptable to the patient, there should be sensitive exploration of the patient's wishes, feelings, beliefs and values. However, information should not be forced on unwilling recipients and if patients indicate that they do not wish to discuss CPR this should be respected. Any discussions with the patient about whether to attempt CPR and any decisions should be documented, signed and dated in the patient's health record. If a DNACPR decision is made and there has been no discussion with the patient because they have indicated a clear desire to avoid such discussion, this must be documented in the health record and the reasons must be recorded.

Patients should be informed in a sensitive manner of the facts and of the possible risks and adverse effects in order to make informed decisions about whether or not they would want CPR. Many people (including patients, those close to them and even some healthcare professionals) have unrealistic expectations about the likely success and potential benefits of CPR and lack detailed understanding of what is involved. The picture gained from the media (television drama for example) seldom reflects a realistic view of the success rate, or the physical nature of CPR. While health professionals, understandably, are reluctant to alarm patients or deter them from treatment which may be life prolonging, it is important that everybody involved in making decisions is aware of what is involved and of the factors that may affect the outcome. The patient should be provided with an information leaflet outlining the nature of CPR and the likely outcome.

see UHBristol patient leaflets Cardiopulmonary Resuscitation (CPR) EASY READ version
Do not attempt cardiopulmonary resuscitation decisions

In assessing the potential benefits of attempting to prolong life, it is not only legitimate but ethically appropriate to consider whether cardiorespiratory arrest is likely to recur and whether the patient is likely to experience unmanageable or long-term pain or other distressing adverse effects. Some patients may, however, despite potentially distressing adverse effects, have specific reasons for wanting to try to delay death, even if this is only for a very short period of time. If such a wish is expressed, accurate information must be provided about the likelihood and length of survival that might realistically be expected, and about the potential risks and effects of attempted CPR. The patient should be invited to discuss the risks and benefits of CPR in order to reach an agreed decision on whether or not it should be attempted.

Consideration of the balance of benefits and burdens in these cases also involves balancing rights under the Human Rights Act 1998. The Act guarantees protection for life (Article 2) but also declares that 'no one shall be subjected to torture or to inhuman or degrading

treatment or punishment' (Article 3). This terminology is intended to apply to situations in which human beings are deliberately ill-treated and have severe indignities inflicted upon them. However, some people have a profound abhorrence of being kept alive in a state of total dependency or permanent lack of awareness, or of an undignified death. If patients express such views, health professionals should take this into account when making decisions about CPR. They should not attempt to prolong life if it is clear that the patient would not want this or would not find the likely outcome acceptable. In the case of a mentally competent adult, this should be respected and a DNACPR order completed. This is based on the Principle of personal autonomy. Discussion with the patient should include:

- the likely clinical outcome, including the likelihood of successfully re-starting the patient's heart and breathing for a sustained period, and the level of recovery that can realistically be expected after successful CPR
- the patient's known or ascertainable wishes, including information about previously expressed views, feelings, beliefs and values
- the patient's human rights, including the right to life and the right to be free from degrading treatment
- the likelihood of the patient experiencing severe unmanageable pain or suffering
- the level of awareness the patient has of their existence and surroundings.

The views of members of the medical and nursing team involved in the patient's care, including those involved in a patient's primary and secondary care, are valuable in forming a decision about the likely clinical effectiveness of attempting CPR. Best interests' assessment is **not** applicable to the patient with capacity.

Adults who lack capacity and CPR may be successful

If a patient lacks capacity, any previously expressed wishes should be considered when making a CPR decision. Whether the benefit would outweigh the risks and burdens for the particular patient should be the subject of discussion and agreement between the healthcare team and those close to or representing the patient. Only relevant information should be shared with those close to patients unless, when they were previously competent to do so, a patient has expressed a wish that information be withheld.

Consulting with those close to the patient in these cases is not only good practice but is also a requirement of the Human Rights Act 1998(Article 8 – right to private and family life) and the Mental Capacity Act 2005 (England and Wales). Clinicians should ensure that those close to the patient, who have no legal authority, understand that their role is to help inform the decision-making process, rather than being the final decision-makers. Great care must be taken when people other than the patient make or guide decisions that involve an element of quality-of-life assessment, because there is a risk that health professionals or those close to the patient may see things from their own perspective and allow their own views and wishes to influence their decision, rather than those of the patient. These considerations should always be undertaken from the patient's perspective. The important factor is whether the patient would find the level of expected recovery acceptable, taking into account the invasiveness of CPR and its low likelihood of success,

not whether it would be acceptable to the healthcare team or to those close to the patient, nor what they would want if they were in the patient's position.

Communication about CPR and DNACPR decisions is complex and sensitive. It should be undertaken by experienced members of the healthcare team who have the necessary skills and knowledge to undertake discussions with patients and with those close to or acting for patients. The sections above have set out the level of involvement of patients and those close to them in making or guiding decisions about CPR. This will vary depending on whether the decision not to attempt CPR is based solely on medical factors (i.e. CPR would not be successful) or on the balance of benefits and burdens, which involves a broader 'best interests' judgement. This section explains who should be consulted when adults lack capacity and explains the main provisions of the Mental Capacity Act 2005 (England and Wales) concerning proxy decision-makers.

Decision-making capacity refers to the ability that individuals possess to make decisions or to take actions that influence their life, from simple decisions about what to have for breakfast to far-reaching decisions about serious medical treatment, for example CPR. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person or for other people. Patients over 16 years of age are presumed to have capacity to make decisions for themselves unless there is evidence to the contrary. Individuals are, however, considered legally unable to make decisions for themselves if they are unable to:

- understand information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate the decision, whether by talking or sign language or by any other means.

Patient with a welfare attorney or court appointed deputy or guardian

If a patient lacks capacity and has a personal welfare attorney or guardian, this person must be consulted about CPR decisions.

In England and Wales the Mental Capacity Act (2005) allows people over 18 years of age who have capacity to make a lasting power of attorney (LPA), appointing a welfare attorney to make health and personal welfare decisions on their behalf once such capacity is lost. Before relying on the authority of this person, the healthcare team must be satisfied that:

- the patient lacks capacity to make the decision
- a statement has been included in the LPA specifically authorising the welfare attorney to make decisions relating to life-prolonging treatment
- the LPA has been registered with the Office of the Public Guardian
- the decision being made by the attorney is in the patent's best interests.

In England and Wales neither welfare attorneys nor deputies can demand treatment that is clinically inappropriate but where CPR may be able to re-start the heart nor breathing for a sustained period and a decision on whether or not to attempt CPR is based on the balance of benefits and burdens, their views about patients' likely wishes must be sought. Where there is disagreement between the healthcare team and an appointed welfare attorney or court-appointed guardian about whether CPR should be attempted in the event of cardiorespiratory arrest, and this cannot be resolved through discussion and a second clinical opinion, the Court of Protection may be asked to make a declaration.

More information about welfare attorneys, deputies and the Mental Capacity Act can be found in the Mental Capacity Act code of practice.6
http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1.htm

Adults who lack capacity and have no family, friends or other advocate whom it is appropriate to consult

In England and Wales, the Mental Capacity Act 2005 requires an Independent Mental Capacity Advocate (IMCA) to be consulted about all decisions about 'serious medical treatment' where patients lack capacity and have nobody to speak on their behalf and the decision is made by an NHS body or Local Authority.

This is only necessary where there is genuine doubt about whether or not CPR would have a realistic chance of success, or if a DNACPR decision is being considered on the balance of benefits and burdens, in order to comply with the law an IMCA must be involved in every case. See UHBristol Safeguarding Adults page for IMCA referral form:- http://connect/governanceandquality/Childprotection/SafeguardingAdults/Pages/default.aspx If a DNACPR decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made by the senior clinician and recorded in the patient's notes.

The decision should be discussed with an IMCA at the first available opportunity. An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician in charge of the patient's care as part of the determination of the patient's best interests.

Box 3: Clinical Decision Not To Attempt CPR

In some cases, the decision not to attempt CPR is a clinical decision. If the clinical team believes that CPR will not re-start the heart and maintain breathing, it should not be offered or attempted. CPR (which can cause harm in some situations) should not be attempted if it will not be successful. However, the patient's individual circumstances and the most up-to-date guidance must be considered carefully before such a decision is made. The responsibility for making the decision rests with the most senior clinician currently in charge of the patient's care, although they may delegate the task to another person who is competent to carry it out. Wherever possible, a decision should be agreed with the whole healthcare team. The most senior clinician could be a consultant or a GP. If there is genuine doubt or disagreement about whether CPR would be clinically appropriate a further senior clinical opinion should be sought.

When a patient is in the final stages of an incurable illness and death is expected within a few days, CPR is very unlikely to be clinically successful. In some cases it may prolong or increase suffering and subject the patient to traumatic and undignified death. In these circumstances, most patients want a natural death without unnecessary interventions that most consider to be undignified. Earlier discussions with patients about their general care and treatment aims may have addressed this issue.

For example, in the context of palliative care, where patients are known to have an incurable illness, discussion and explanation about the realities of attempting CPR should occur in advance of the last few days of life. The UHBristol End of Life Care Tool provides comprehensive guidance for the last days of life. It specifically prompts clinicians to consider and document the patient's CPR status. http://nww.avon.nhs.uk/dms/download.aspx?did=13652

Communicating DNACPR to Patients

When a clinical decision is made that CPR should not be attempted, because it will not be successful, the patient and /or those close to him should be informed of the decision under Article 8 HRA (1998). If the information is withheld, justification must be provided and may be challenged in court.

Although patients should be helped to understand the severity of their condition, whether they should be informed explicitly of a clinical decision not to attempt CPR will depend on the individual circumstances. In most cases a patient should be informed, but for some patients, for example those who know that they are approaching the end of their life, information about interventions that would not be clinically successful will be unnecessarily burdensome and of little or no value. Others indicate by their actions and involvement in decision-making that they want detailed information about their care and want to be fully involved in planning for the end of their life. Therefore an assessment should be made of how much information the individual patient (or, if the patient lacks capacity, those close to them) wants to know. The decision must be the one that is right for the patient and information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team.

Whilst the clinician has a duty to discuss a DNACPR decision with the patient, there are some situations in which a clinician thinks that the patient will be distressed by being

consulted and that that distress might cause the patient harm. The distress must be likely to cause the patient a degree of harm to warrant them not having the decision discussed with or explained to them. (Resus Council UK statement June 2014)

If the patient lacks capacity and has appointed a welfare attorney whose authority extends to making these clinical decisions, or if a court has appointed a deputy or guardian with similar authority to act on the individual's behalf, this person should be informed of the decision and the reason for it. If a second opinion is requested, this should be arranged, whenever possible.

Clinicians discussing or communicating such decisions should:

- offer patients as much information as they want
- provide information in a manner and format which patients can understand; this may include the need for an interpreter
- answer questions as honestly as possible
- explain the aims of treatment.
- Clinicians should document the reason why a patient has not been informed of a DNACPR order if the decision is made not to inform the patient. Clinicians may be asked to justify their decision.
- A decision not to attempt CPR applies only to CPR. It must be made clear to patients, people close to patients and members of the healthcare team that it does not apply to any other aspect of treatment and that all other treatment and care that are appropriate for the patient will continue.
- The BMA issues guidance decision making towards the end of life. http://www.gmc-uk.org/Treatment_and_care_towards_the_end_of_life___English_0513.pdf_48902105.pdf

Requests for CPR where it will not benefit the patient

Neither patients, nor those close to them, can demand treatment that is clinically inappropriate. If the healthcare team believes that CPR will not re-start the heart and breathing, this should be explained to the patient in a sensitive way. These discussions informing the patient of the healthcare team's decision may be difficult and where possible should be carried out by experienced senior clinicians.

If the patient does not accept the decision and requests a second opinion, this should be arranged whenever possible. Similarly, if those close to the patient do not accept a DNACPR decision in these circumstances, despite careful explanation for its basis, a second opinion should be offered.

Temporary Suspension of DNACPR decision

Uncommonly, some patients for whom a DNACPR decision has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking,

induction of anaesthesia, anaphylaxis or blocked tracheostomy tube. In such situations CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances.

In addition to readily reversible causes, it may be appropriate to temporarily suspend a decision not to attempt CPR during some procedures if the procedure itself could precipitate a cardiopulmonary arrest – for example, cardiac catheterisation, pacemaker insertion, or surgical operations. General or regional anaesthesia may cause cardiovascular or respiratory instability that requires supportive treatment. Many routine interventions used during anaesthesia (for example tracheal intubation, mechanical ventilation or injection of vasoactive drugs) may be regarded as resuscitative measures.

Under these circumstances, where there are often easily reversible causes of a cardiorespiratory arrest, survival rates are much higher than those following other causes of in-hospital cardiac arrest. DNACPR decisions should be reviewed in advance of the procedure. Ideally this should be discussed with the patient or their representative if they lack capacity, as part of the consent process. Some patients may wish a DNACPR decision to remain valid despite the increased risk of a cardiorespiratory arrest and the presence of potentially reversible causes; others will request that the DNACPR decision is suspended temporarily. The time at which the DNACPR decision is reinstated should also be discussed and agreed.

If a patient wishes an advanced decision refusing CPR to remain valid during a procedure or treatment that increases the risk of or induces cardiorespiratory arrest (e.g. cardiac surgery), this may significantly increase the risks of the procedure or treatment. If a clinician believes that the procedure or treatment would not be successful with the DNACPR order still in place, it would be reasonable not to proceed. For Further information regarding temporary suspension of DNACPR decisions during anaesthesia see http://www.aagbi.org/sites/default/files/dnar_09_0.pdf

Deactivation of Implantable cardioverter defibrillator (ICD)

If the patient is nearing the end of life and they have an ICD in situ, it may be appropriate for it to be deactivated to prevent any inappropriate shocks being given. This should be done in accordance with the trust operational guidelines for the deactivation of ICD in adult patients who may be approaching the end of life.

References

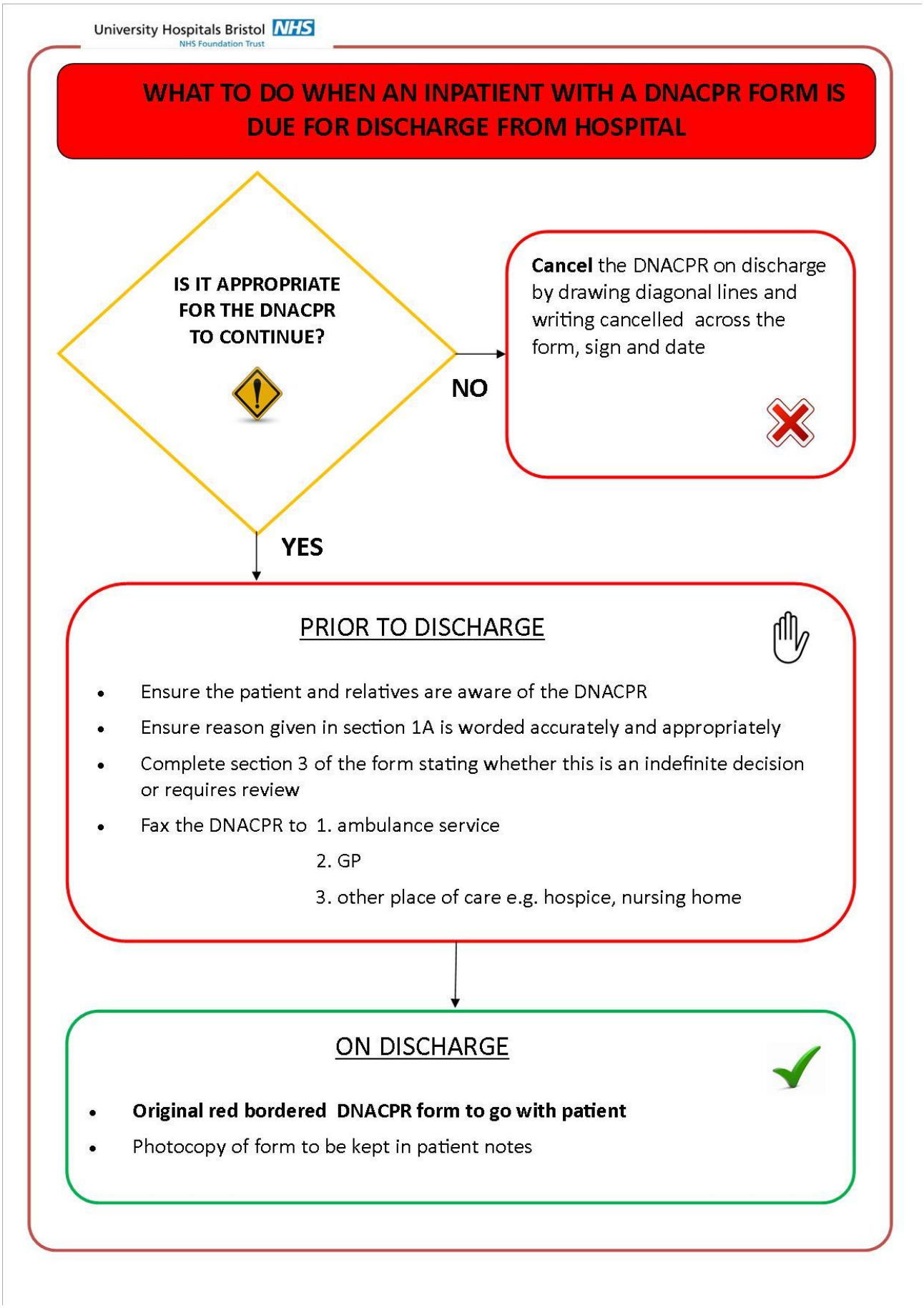
[1] Resuscitation Council UK (2007) Decisions relating to cardiopulmonary resuscitation; a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. RC (UK)

[2] LJ Longmore in: R (David Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014] EWCA Civ 822

Appendix 1: Use of DNACPR Forms

Documentation: Pad of 50 forms ordered on EROS no. UBHT212

- When a DNACPR decision has been made the Unified DNACPR form should be completed legibly in black ink
- The patient's full name, NHS or hospital, date of birth and address should be handwritten clearly
- The date of writing the decision should be entered
- Any discussion with the patient or relatives entered in the notes should be cross referenced on the form.
- The form should be filed inside the front of the current notes where it is immediately visible.
- The DNACPR order should be reviewed if there is an improvement in the condition unless 'Indefinite' at point 3 is circled.
- If the DNACPR order is still valid when the patient is discharged or transferred to another healthcare setting, the original form with the red border should accompany the patient and a photocopy filed chronologically in the notes. If the patient is travelling by ambulance, section 5 should be completed and a copy sent to GWAS by fax to 08451 204340 or e-mail to GWASNT.clinical-alerts@nhs.net
- If the decision is cancelled the form should be crossed through with 2 diagonal lines and "CANCELLED" written clearly between them, signed and dated by the healthcare professional.
- It is the responsibility of the healthcare professional cancelling the DNACPR order to communicate this to all relevant parties.
- The form should then be filed chronologically in the notes.
- If a patient is re-admitted and is in possession of a valid DNACPR form, it should be filed in the front of the notes or re-written on a new form if it is in poor condition.
- Further guidance for completion is found on the reverse of the form.


University Hospitals Bristol NHS
NHS Foundation Trust
WHAT TO DO WHEN AN INPATIENT WITH A DNACPR FORM IS DUE FOR DISCHARGE FROM HOSPITAL
IS IT APPROPRIATE FOR THE DNACPR TO CONTINUE?
NO
Cancel the DNACPR on discharge by drawing diagonal lines and writing cancelled across the form, sign and date
YES
PRIOR TO DISCHARGE
Ensure the patient and relatives are aware of the DNACPR
Ensure reason given in section 1A is worded accurately and appropriately
Complete section 3 of the form stating whether this is an indefinite decision or requires review
Fax the DNACPR to 1. ambulance service
2. GP
3. other place of care e.g. hospice, nursing home
ON DISCHARGE
Original red bordered DNACPR form to go with patient
Photocopy of form to be kept in patient notes

Appendix 2: DNACPR Form

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION FORM

NHS Bristol North Somerset South Gloucestershire

DNACPR valid across all adult care settings in Bristol, N Somerset and S Gloucester PCTs
In the event of cardiac or respiratory arrest, no attempts at CPR will be made.
All other appropriate treatment and care will be provided.

Name
Address

Postcode
Date of birth
NHS number

Before completing form, see explanatory notes overleaf.

Date of DNACPR decision: __ / __ / ____

Record the full extent of discussions in the notes

1. Reason for DNACPR decision (tick A,B or C):

☐ A) CPR is unlikely to be successful due to.....

.....

.....

This has been explained to the patient Yes ☐ No ☐
Reason why not.....
This has been explained to the relevant other Yes ☐ No ☐ Name .....

☐ B) CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the patient.

- Patient involved in discussions? Yes ☐ No ☐
- If no, state reason: .....
- Patient lacks mental capacity and a best interests decision has been made after consulting with
  - their legally appointed Welfare Attorney: Name .....
  - the patient's representative (eg relative or IMCA): Name .....

☐ C) DNACPR is in accord with the sustained wishes of the patient.

- Patient has capacity and does not want to be for CPR. (Record full extent of discussion in notes) Yes ☐ No ☐
  OR
- Patient lacks capacity; a valid and applicable Advance Decision to Refuse Treatment has been seen. Yes ☐ No ☐

2. Healthcare professional making this DNACPR decision:

Name Position
Signature Date / / Time :

Healthcare professional verifying if original decision made by a professional without overall responsibility for the patient:
Name Position
Signature Date / / Time :

3. Review: ☐ This is an indefinite decision
☐ This needs review if clinical situation changes

Review date if appropriate / / Outcome of review: DNACPR to continue? Yes ☐ No ☐
Name Position
Signature Date / / Time :

4. Who has been informed of this DNACPR decision? Please inform all relevant parties and tick when informed:
☐ GP ☐ Out of Hours ☐ Other care provider (please state)
☐ Fax this form to the ambulance service on 08451 204340 or email to GWASNT.clinical-alerts@nhs.net

5. Other important information:
For example, ambulance crew instructions, Advance Care Plans such as preferred place of care/death, ceilings of treatment.

.....
.....
.....

Red-bordered original form to travel with the patient. Photocopy of form to be kept in medical notes.

BNSSG unified DNACPR form Aug 2014 Version 4. [redacted]

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FORM

This form has been approved for use across all care settings in Bristol, N Somerset and S Gloucester (BNSSG) PCTs.

Guidance for completion:

- This form should be completed legibly in black ink.
- The patient's full name, NHS or Hospital number, date of birth, address and date of decision should be written clearly.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines and "CANCELLED" written clearly between them, signed and dated by the healthcare professional.
- It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision (see section 4 on form).

The original form should remain with the patient, but keep a copy in the patient's notes for audit purposes.

1.	Reason for DNACPR decision	
1A	CPR is unlikely to be successful	• Summarise the main clinical problems and reasons why CPR would be unsuccessful. Be as specific as possible. • Explain the decision to the patient (and relatives/carers if the patient lacks capacity) and ensure that they are aware of their current condition. • Record the details of discussion or the reason for not discussing in the patient's notes.
1B	CPR may be successful, but may be followed by a length and quality of life which would not be of overall benefit to the patient	State clearly what was discussed and agreed. **If the patient has capacity**, they should be involved in discussions. State the names and relationships of relatives / relevant others with whom this decision has also been discussed. Ensure that discussion with others does not breach confidentiality. Details of discussions should be recorded in the clinical notes. **If the patient does not have capacity**, but has a valid and applicable Advance Decision to Refuse Treatment (ADRT), it must be respected. If the patient has a Lasting Power of Attorney (LPA), appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. If there is no ADRT or LPA, the decision should be made in the best interests of the patient after consulting with their relatives / friends as to what the patient's wishes might have been. Those close to the patient should not be asked to make the decision. If there is no one appropriate to consult and the patient lacks capacity then an instruction to an Independent Mental Capacity Advocate must be made. All decision-making should be in keeping with the Mental Capacity Act 2005.
1C	DNACPR is in accord with the sustained wishes of the patient.	Record the assessment of capacity in the clinical notes. If the patient has capacity, they may state that they do not want CPR in the event of a cardiopulmonary arrest. If they lack capacity, any Advanced Decision to Refuse Treatment must be valid and applicable for the patient's current circumstances.
2.	Healthcare professional making this DNACPR decision/ verification	State name and position. This should be the most senior healthcare professional immediately available. The decision must be verified by the most senior healthcare professional responsible for the patient's care at the earliest opportunity (within 48 hours in Acute Trusts). If the person making the decision is the most senior person, verification is not required.
3.	Review	State whether the decision is indefinite or needs review. It should be reviewed if: i) there are changes in the patient's condition ii) the patient's expressed wishes change and CPR is likely to be successful Reviewer needs to complete all details on the form and document the outcome in the notes.
4.	Who has been informed of this DNACPR decision?	Ensure that all healthcare professionals who have been informed are aware of their responsibility to document the decision in their own records, as the original stays with the patient. Fax the form to the ambulance service and the GP practice.
5.	Other information	Prior to ambulance transfer, document any instructions for transfer such as name, address, telephone number of destination and next of kin. Document any known patient's wishes / Advance Care Plans such as preferred place of care etc.

BNSSG unified DNACPR form Aug 2014 Version 4. Author: [redacted]

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION FORM

DNACPR valid across all adult care settings in Bristol, N Somerset and S Gloucester PCTs

In the event of cardiac or respiratory arrest, no attempts at CPR will be made.
All other appropriate treatment and care will be provided.

NHS Bristol North Somerset South Gloucestershire

Name
Address

Postcode
Date of birth
NHS number

Before completing form, see explanatory notes overleaf.

Date of DNACPR decision: __ / __ / ____

Record the full extent of discussions in the notes

1. Reason for DNACPR decision (tick A,B or C):

☐ **A) CPR is unlikely to be successful due to**.....
.....
.....

This has been explained to the patient Yes ☐ No ☐
Reason why not.....
This has been explained to the relevant other Yes ☐ No ☐ Name .....

☐ **B) CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the patient.**

- Patient involved in discussions? Yes ☐ No ☐
- If no, state reason: .....
- Patient lacks mental capacity and a best interests decision has been made after consulting with
  - their legally appointed Welfare Attorney: Name .....
  - the patient's representative (eg relative or IMCA): Name .....

☐ **C) DNACPR is in accord with the sustained wishes of the patient.**

- Patient has capacity and does not want to be for CPR. (Record full extent of discussion in notes) Yes ☐ No ☐
  OR
- Patient lacks capacity; a valid and applicable Advance Decision to Refuse Treatment has been seen. Yes ☐ No ☐

2. Healthcare professional making this DNACPR decision:

Name Position
Signature Date / / Time :

Healthcare professional verifying if original decision made by a professional without overall responsibility for the patient:
Name Position
Signature Date / / Time :

3. Review:

☐ **This is an indefinite decision**
☐ **This needs review if clinical situation changes**

Review date if appropriate / / Outcome of review: DNACPR to continue? Yes ☐ No ☐
Name Position
Signature Date / / Time :

4. Who has been informed of this DNACPR decision?

Please inform all relevant parties and tick when informed:

☐ GP ☐ Out of Hours ☐ Other care provider (please state)

☐ **Fax this form to the ambulance service on 08451 204340 or email to SWASNT.clinical-alerts@nhs.net**

5. Other important information:

For example, ambulance crew instructions, Advance Care Plans such as preferred place of care/death, ceilings of treatment.

.....
.....
.....

Red-bordered original form to travel with the patient. Photocopy of form to be kept in medical notes.

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FORM

This form has been approved for use across all care settings in Bristol, N Somerset and S Gloucester (BNSSG) PCTs.

Guidance for completion:

- This form should be completed legibly in black ink.
- The patient's full name, NHS or Hospital number, date of birth, address and date of decision should be written clearly.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines and "CANCELLED" written clearly between them, signed and dated by the healthcare professional.
- It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision (see section 4 on form).

The original form should remain with the patient, but keep a copy in the patient's notes for audit purposes.

1.	Reason for DNACPR decision	
1A	CPR is unlikely to be successful	• Summarise the main clinical problems and reasons why CPR would be unsuccessful**.** Be as specific as possible. • Explain the decision to the patient (and relatives/carers if the patient lacks capacity) and ensure that they are aware of their current condition. • Record the details of discussion or the reason for not discussing in the patient's notes.
1B	CPR may be successful, but may be followed by a length and quality of life which would not be of overall benefit to the patient	State clearly what was discussed and agreed. **If the patient has capacity**, they should be involved in discussions. State the names and relationships of relatives / relevant others with whom this decision has also been discussed. Ensure that discussion with others does not breach confidentiality. Details of discussions should be recorded in the clinical notes. **If the patient does not have capacity**, but has a valid and applicable Advance Decision to Refuse Treatment (ADRT), it must be respected. If the patient has a Lasting Power of Attorney (LPA), appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. If there is no ADRT or LPA, the decision should be made in the best interests of the patient after consulting with their relatives / friends as to what the patient's wishes might have been. Those close to the patient should not be asked to make the decision. If there is no one appropriate to consult and the patient lacks capacity then an instruction to an Independent Mental Capacity Advocate must be made. All decision-making should be in keeping with the Mental Capacity Act 2005.
1C	DNACPR is in accord with the sustained wishes of the patient.	Record the assessment of capacity in the clinical notes. If the patient has capacity, they may state that they do not want CPR in the event of a cardiopulmonary arrest. If they lack capacity, any Advanced Decision to Refuse Treatment must be valid and applicable for the patient's current circumstances.
2.	Healthcare professional making this DNACPR decision/ verification	State name and position. This should be the most senior healthcare professional immediately available. The decision must be verified by the most senior healthcare professional responsible for the patient's care at the earliest opportunity (within 48 hours in Acute Trusts). If the person making the decision is the most senior person, verification is not required.
3.	Review	State whether the decision is indefinite or needs review. It should be reviewed if: i) there are changes in the patient's condition ii) the patient's expressed wishes change and CPR is likely to be successful Reviewer needs to complete all details on the form and document the outcome in the notes.
4.	Who has been informed of this DNACPR decision?	Ensure that all healthcare professionals who have been informed are aware of their responsibility to document the decision in their own records, as the original stays with the patient. Fax the form to the ambulance service and the GP practice.
5.	Other information	Prior to ambulance transfer, document any instructions for transfer such as name, address, telephone number of destination and next of kin. Document any known patient's wishes / Advance Care Plans such as preferred place of care etc.

Do not attempt Cardiopulmonary Resuscitation (DNACPR) Guidance

University Hospitals Bristol NHS
NHS Foundation Trust

Is cardiac or respiratory arrest a clear possibility in this patient?

For example:

- Progressive cardiac or respiratory compromise.
- Patient has a long term condition with poor prognostic criteria
- Patient dying from irreversible condition e.g. advanced cancer.
- Patient whose death is not unexpected.

NO

No clinical reason to discuss CPR (unless the patient would like to)

- In the event of cardiopulmonary arrest, carry out CPR unless it would clearly be unsuccessful.
- If the patient is not likely to have a cardiac or respiratory arrest, it is not necessary to initiate discussion with them about CPR. If however the individual wishes to discuss CPR, this should be respected.
- Review if circumstances change.

YES

Are you as certain as you can be that CPR **would** have a medically successful outcome?

YES

Discuss options of CPR and DNACPR

- Sensitive exploration of the patient's wishes regarding resuscitation should be undertaken by the most experienced staff member available.
- **If the patient has capacity** to make this decision, discuss options of CPR and DNACPR with patient. Involve relevant others if appropriate (with patient's permission) but ultimately the decision lies with the patient.
- **If the patient does not have capacity** to make this decision, but has a valid and applicable Advanced Decision to Refuse Treatment, it must be respected. If a welfare attorney, deputy or guardian has been appointed, they should be consulted. Otherwise, the medical team should make the decision based on best interests after consulting with those close to the patient. If there is no-one to consult with, then an instruction to an Independent Mental Capacity Advocate must be made.
- Document the decision and any discussions.
- Continue to communicate with the patient and relevant others.
- Review if circumstances change.

NO

Are you as certain as you can be that CPR would **NOT** have a medically successful outcome?

YES

CPR medically inappropriate

- When a DNACPR decision is made on clear clinical grounds, this should be explained to the patient (or their representative if the patient lacks capacity). Do not ask the patient or relevant others to make the CPR decision.
- As CPR would fail it should not be offered as a treatment option. Document the reasons for the decision and any relevant discussions.
- If a second opinion is requested, this should be arranged.
- Make sure relevant healthcare professionals are aware of DNACPR decision and patient and family are aware of goals of care.
- Continue to assess any concerns of the patient and relevant others (which may include discussion about why CPR is inappropriate).
- Where the patient is clearly dying (likely to die within days), ensure patient and family are aware of this, prescribe as required end of life medication and establish the patient's wishes for end of life care.
- Review if circumstances change.

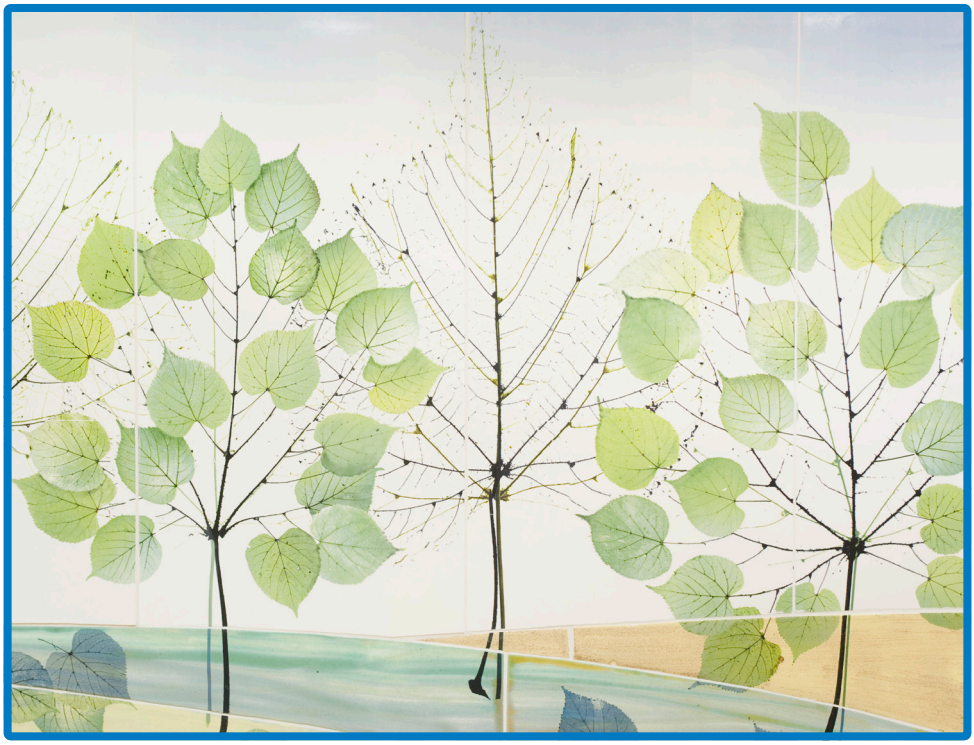
NO

SEEK SENIOR ADVICE

University Hospitals Bristol NHS
NHS Foundation Trust

Patient information service
Bristol Royal Hospital for Children

Is resuscitation right for my child?



Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Above + Beyond
For Patients. For Health. For Bristol.

This information booklet is for families and carers having conversations about resuscitation.

Talking about your child's resuscitation can be very difficult. This booklet aims to make it easier for you to understand what will happen, and how you can be involved in making decisions about your child's care.

What is this booklet about?

This booklet is about deciding in advance with your healthcare team what should happen if your child's health suddenly gets worse. It tells you:

1. what resuscitation is, and
2. how decisions about your child's resuscitation are made.

What is resuscitation?

The word 'resuscitation' describes a range of emergency treatments that are used to try and revive a child who has suddenly collapsed; for example, if their heart or breathing has stopped. It may include:

1. repeatedly pressing down firmly on your child's chest – this is called cardiac massage

2. using powerful drugs or electric shocks to try to restart the heart

3. holding a mask over their face or placing a tube down their throat and into their lungs to help them breathe.

In some circumstances, resuscitation can be successful, and the child survives. A period of time spent in intensive care always follows the resuscitation attempt. Your child may experience some physical or cognitive difficulties as a result of their

collapse and resuscitation, which may lead to more permanent disabilities. However, resuscitation is not always successful, and we may reach a point where it is agreed that the resuscitation attempt should stop.

Why do we need to decide about resuscitation?

Your child may be very sick, or about to undergo an elective but high-risk procedure. When children are very sick, they can sometimes collapse suddenly and unexpectedly.

To make sure that the doctors and nurses looking after your child in hospital know what you want to happen if your child's breathing or heart suddenly stop, it is important for you to talk with them about resuscitation before an emergency situation develops.

In England, children and young people under 16 who have appropriate mental capacity should also be involved in discussions about their health care. This is called consent.

You can find out more about mental capacity and consent for young people on the webpage **'Consent – your rights'** (see page 10 of this booklet for the web address).

How will decisions about my child's resuscitation be made?

You and the health professionals who look after your child will always make decisions together. Children and young people should also be involved in decisions about their resuscitation, if this is appropriate and that is what you want.

Your child's healthcare team will explain what may happen if your child is resuscitated, and they should give you all the information you need to help you decide.

You can, of course, talk to the healthcare team who look after your child at any time, but advance decisions about your child's resuscitation are usually discussed at a multidisciplinary team (MDT) meeting. As part of this meeting, you will have an opportunity to discuss your wishes with the team. The team and you should reach a decision together on the best course of action from the variety of options available .Your child's best interests remain the most important priority.

You may wish to bring a friend or relative with you to the MDT meeting, or someone else to speak for you, if you think this would be helpful. We encourage you to do what you feel comfortable with, as we recognise this can be a very emotional time for you. Sometimes, more than one MDT meeting may be needed to plan your child's care.

If you and the health professionals can't agree on a decision, a member of NHS staff involved in your child's care will explain what you can do. Ask someone in your child's healthcare team about this.

What happens if we decide that resuscitation is not right for my child at this time?

This decision will be clearly written on a special document called a personal resuscitation plan. This is kept in your child's notes.

If your child's heart and breathing stop, they will be allowed to die naturally. The team will not resuscitate your child, but they will ensure your child is kept as comfortable and pain-free as possible. It is important that you recognise this decision is only about resuscitation. Your child will continue to get all other treatments and care that they need, and their healthcare team will give them the best possible care.

If your child leaves the hospital, this form will be converted into what we call a 'wishes document'. At that time, the team will discuss the wishes document with you.

Copies of the wishes record will also be held by all the key health professionals who care for your child, such as your child's GP, your key worker, and the hospice team, if you have one. If your child has a hospital passport, it will also be added to this. However, it is also important that you keep your copy of the record to show to health professionals if there is an emergency situation.

What happens if I change my mind?

You can change your mind about your child's resuscitation at any time.

If you change your mind about your child's resuscitation, tell someone in your child's healthcare team straight away.

Your child's healthcare team will again discuss with you what is best for your child.

This discussion and any decisions will be written in your child's medical notes.

Who else can I talk to about this?

You can talk to:

- any member of staff involved in your child's care
- your family or friends
- the hospital chaplain
- your spiritual adviser
- organisations that provide support for children, young people and their families – for example, Together For Short Lives, CLIC Sargent, Jessie May, and Lifetime staff if your child is known to them.

Notes and queries

How can I find out more?

For more information about anything in this booklet, contact:

- a member of NHS staff involved in your child's care
- the LIAISE team on the ground floor of the Bristol Royal Hospital for Children – **0117 342 8065**
- the hospital palliative care liaison nurse – **0778 533 3014**.

For information and support for children and young people with life-limiting and life-threatening conditions, and their families and carers, these local and national contacts may be helpful:

Contact-a-Family (National)

Helpline: 0808 808 3555

Website: www.cafamily.org.uk

Together for Short Lives (National):

Helpline: 0845 108 2201

Phone: 0117 916 6422 for general enquiries

Email: info@act.org.uk

Website: www.togetherforshortlives.org.uk

Action for Sick Children (National)

Website: www.actionforchildren.org.uk

Children's Hospice South West (Local)

Phone: 01275 866611

Website: www.chsw.org.uk

Jessie May (Local)

Phone: 0117 961 6840

Website: www.jessiemay.org.uk

Sirona – Lifetime nurses

Phone: 01225 731624

Website: www.sirona-cic.org.uk/services/childrens-nursing-and-psychology

Rainbow Trust

Rainbow Trust Children's Charity provides emotional and practical support to families who have a child with a life-threatening or terminal illness.

Spittleborough Farm House
Swindon Road
Royal Wootton Bassett
Wiltshire
SN4 8ET

Tel: 01793 841 204
Fax: 01793 250 134

Website: www.rainbowtrust.org.uk

Martha Care

www.marthacare.co.uk

CLIC Sargent (for children and young people with cancer)

Can be contacted through the hospital team at Bristol Royal Hospital for Children.

Website: www.clicsargent.org.uk

Child Cancer Helpline

Helpline: 0800 197 0068 (you can call the helpline Monday to Friday from 9am to 5pm)

Helpline email: helpline@clicsargent.org.uk

Information on health rights

For information for young people about their health rights see **'Consent – your rights',** which explains how you should be involved in decisions about your healthcare and treatment.

www.nhs.uk/conditions/consent-to-treatment/pages/introduction.aspx

Please note that if for any reason you would value a second opinion concerning your diagnosis or treatment, you are entirely within your rights to request this.

The first step would usually be to discuss this with the doctor or other lead clinician who is responsible for your care.

As well as providing clinical care, our Trust has an important role in research. This allows us to discover new and improved ways of treating patients.

While your child is under our care, you may be approached about them taking part in research. To find out more please visit: **www.uhbristol.nhs.uk/research-innovation** or call the research and innovation team on **0117 342 0233**.

For access to other patient leaflets and information please go to the following address:

www.uhbristol.nhs.uk/patients-and-visitors/information-for-patients/

Hospital switchboard: 0117 923 0000

Minicom: 0117 934 9869

www.uhbristol.nhs.uk

For an interpreter or signer please contact the telephone number on your appointment letter.

For this leaflet in large print, audio or PDF format, please call the patient information service: 0117 342 3728 / 3725

 Published: **23/07/15** Expires: **31/07/18** WACD/CHS/AIC/IRRFMC/JUL15

PERSONAL RESUSCITATION PLAN (Children)

Before completing this form, please see explanatory notes overleaf

Name

Address

Date of birth / /

NHS or hospital number

University Hospitals Bristol NHS
NHS Foundation Trust

Before completing form, see explanatory notes overleaf.

Date of Resuscitation Plan: __ / __ / ____

1. In the event of a Life Threatening Event, the following Actions should be taken

	Yes	No
Oxygen via face mask	☐	☐
Airway management using basic airway adjuncts	☐	☐
Bag Valve Mask Ventilation	☐	☐
ET tube and ventilation	☐	☐
External Cardiac Compressions	☐	☐
Defibrillation and Adrenaline	☐	☐
Advanced Life Support and transfer to PICU	☐	☐

A) Additional comments (e.g. parental expectations, duration cardiac massage, number of rounds of adrenalin).....

.....

.....

B) Summary of key Clinical Problems and reason for plan.....

.....

.....

.....

C) This plan has been discussed with the patient **Yes** ☐ **No** ☐

If No, state reason.....

.....

D) This decision has been discussed with person(s) with parental responsibility **Yes** ☐ **No** ☐

If No, state reason .....

Name(s) of persons.....

Summary of Discussions (continue in notes) .....

.....

.....

2. Healthcare professional making this Resuscitation plan:

Name and GMC number Position

Signature Date / / Time :

3. Review: This is a long-lasting decision/needs review (delete as appropriate)

Review date if appropriate / /

Outcome of review: PRP to continue Yes ☐ PRP not to continue ☐ PRP to be modified (new form) ☐

Name and GMC number Position

Signature Date / / Time :

4. Who has been informed of this Resuscitation Plan? Please inform all relevant parties and tick when informed:

☐ Patient ☐ Nursing staff ☐ SWAS ☐ Health Visitor ☐ Community team

☐ GP ☐ Other (please state) .....

PERSONAL RESUSCITATION PLAN (Children)

Guidance for completion:

- This form should be completed legibly in black ink.
- This form should be completed by the consultant in charge of the child's care but, where applicable, also discussed with other key healthcare professionals involved in the child's management.
- The patient's full name, NHS or Hospital number, date of birth and address should be written clearly.
- The date of completing the plan should be entered.
- If the plan is no longer appropriate, the form should be crossed through with 2 diagonal lines and "CANCELLED" written clearly between them, and signed and dated by the healthcare professional.
- It is the responsibility of the healthcare professional cancelling the plan to communicate this to all parties informed of the original plan.
- If the child is leaving hospital, consideration should be given to the content of the Child and Family Wishes Discussion record, and to alerting the relevant organisations and ambulance authorities.

The Form should be filed in the front of the current notes, just inside the cover. It should not be photocopied in black and white.

1A	Additional comments	Parents often wish for a more sensitive approach to their child's resuscitation than that summarised in the preceding 'Actions' column. For example, they may wish resuscitation to continue until they are present, and then stop if unsuccessful. This section allows the Consultant to record such facts.
1B	Reason for Resuscitation Plan	Summarise the main clinical problems and reasons why the Resuscitation Plan should be in place. Be as specific as possible.
1C	Discussion with patient	State clearly what was discussed and agreed. If this decision was not discussed with the child state the reason why. The child should be involved in discussions about treatment if practically possible, whilst taking into consideration his/her age and understanding. If a child (<16 years) has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment plan their views should be respected. In a child aged 16-17, capacity is assumed. If a person with parental responsibility disagrees with a competent child's wishes, legal advice should be sought. More detailed description of such discussion should be recorded in the clinical notes where appropriate.
1D	The plan has been discussed with a person with parental responsibility for the child.	The plan should be discussed and agreed with person(s) with legal parental responsibility. Please refer to the below link to confirm who holds this status. https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility . All discussions with those with parental responsibility and the child should be recorded.
2.	Healthcare professional recording Plan	The Resuscitation Plan should be completed by the consultant in charge of the child's care. However the Plan should be discussed with the multidisciplinary team involved in the child's care.
3.	Review	The Plan should ideally be reviewed on a weekly basis or earlier if there is a significant change in the child's condition. In some children with long term conditions it may be more appropriate to review the plan on an annual basis or translate its detail to a Child and Family Wishes Discussion record.
4.	Who has been informed of this Resuscitation Plan?	Ensure that all health care professionals who have been informed are aware of their responsibility to document the plan in their own records.

University Hospitals Bristol NHS
NHS Foundation Trust

Resuscitation Policy, incorporating guidance on Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and the Deteriorating Patient

Document Data	
Subject:	Procedural Documents
Document Type:	Policy
Document Status:	Approved
Executive Lead:	Medical Director
Document Owner:	Resuscitation and Clinical Skills Services Lead
Approval Authority:	Clinical Quality Group
Document Reference:	0031
Review Cycle:	36 Months
Next Review Date:	31/01/2017
Estimated Reading Time:	16 Minutes

Extended to September 2017

Document Abstract

The purpose of the policy is to provide direction for the planning and implementation of a high-quality and robust resuscitation service to all Health Care Professionals within University Hospitals Bristol NHS Foundation Trust (UHBristol). In addition, it provides the principles in relation to end of life decisions.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
Sep 2014	5	[redacted]	Review	Document rewritten into new policy template. Detailed procedures and guidelines removed into separate documents, with embedded links from this document.
Jul 2009	4		Review	Minor review with updates
Sep 2008	3		Review	Minor review with updates
Sep 2007	2		Review	Minor review with updates
Mar 2005	1		Original	Original document

Table of Contents

1. Introduction

1.1 The Resuscitation Group of University Hospitals Bristol NHS Foundation Trust (UHBristol) supports the Quality Standards for Cardiopulmonary Resuscitation Practice and Training of Resuscitation Council (UK) (September 2013) see RC Quality standards for cardiopulmonary resuscitation.

1.2 Rates of survival and complete physiological recovery following in-hospital cardiac arrest are poor in all age groups. For example, fewer than 20% of adult patients having an in-hospital cardiac arrest will survive to go home.[1]

1.3 The scientific evidence to support early defibrillation is overwhelming; the delay from collapse to delivery of the first shock is the single most important determinant of survival. If defibrillation is delivered promptly, survival rates as high as 75% have been reported.[2, 3] The chances of successful defibrillation decline at a rate of about 10% with each minute of delay[4]. Basic life support will help to maintain a shockable rhythm but is not a definitive treatment.

1.4 Although resuscitation can be attempted on any person, there comes a time for some people when it is not appropriate to do so. It is then necessary to consider making a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decision or, in the case of a child, a Personal Resuscitation Plan, in order to facilitate a dignified death. see Do Not Attempt to Cardiopulmonary Resuscitation Guidance or Personal Resuscitation Plan (PRP) Children or Treatment Escalation Personalized Plan, as appropriate.

2. Purpose and Scope

2.1 The purpose of the policy is to provide direction for the planning and implementation of a high-quality and robust resuscitation service to all Health Care Professionals within UHBristol. In addition, it provides the principles in relation to end of life decisions.

2.2 This policy and its associated procedures and guidance documents are relevant to all clinical staff across UHBristol sites. It applies to all designations and roles. It applies to all people employed in a caring capacity, including those employed by the local authority or employed privately by an agency.

3. Definitions

3.1 *Resuscitation*

For the purposes of this policy, the phrase 'resuscitation' also includes the management of the deteriorating patient.

For Management of the Deteriorating Patient, see Recording patient observations, pain level and early warning score in adults using the UHBristol Adult Observation Chart

3.2 ***Cardio pulmonary Resuscitation (CPR)***

Interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs. see RC (UK) Guidelines

3.3 ***Cardiac Arrest (CA)***

CA is the sudden cessation of effective cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness and apnoea or agonal, gasping respiration. In simple terms, cardiac arrest is the point of death.

3.4 ***The Mental Capacity Act (2005) (MCA)***

The MCA was fully implemented on 1 October 2007. The aim of the Act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards. see Do Not Attempt to Cardiopulmonary Resuscitation Guidance

3.5 ***Mental Capacity:***

An individual over the age of 16 is presumed to have mental capacity to make their own decisions unless there is evidence to the contrary. Individuals that lack capacity will not be able to:

- Understand information relevant to the decision
- Retain that information
- Use or weigh that information as part of the process of making the decision
- Communicate the decision, whether by talking or sign language or by any other means. see Do Not Attempt to Cardiopulmonary Resuscitation Guidance

3.6 ***Advance Decision to Refuse Treatment (ADRT)***

ADRT is a decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding. see Do Not Attempt to Cardiopulmonary Resuscitation Guidance

3.7 ***Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA)***

The Mental Capacity Act (2005) allows people over the age of 18 years of age, who have capacity, to make a Lasting Power of Attorney by appointing a Personal Welfare Attorney who can make decisions regarding health and well-being on their behalf, once capacity is lost. see Do Not Attempt to Cardiopulmonary Resuscitation Guidance

3.8 ***Independent Mental Capacity Advocate (IMCA)***

An IMCA supports and represents a person who lacks capacity to make a specific decision at a specific time and who has no family or friends who are appropriate to represent them.

A Court-appointed deputy is appointed by the Court of Protection (Specialist Court for issues relating to people who lack capacity to make specific decisions) to make decisions in the best interests of those who lack capacity see Do Not Attempt to Cardiopulmonary Resuscitation Guidance

4. Duties, Roles and Responsibilities

4.1 *The Chief Executive of University Hospitals Bristol Trust*

(a) Ensures that this policy adheres to statutory requirements and professional guidance

(b) Ensures that this policy is monitored

4.2 *Directors or Managers responsible for the delivery of care:*

(a) Ensure staff are aware of the policy and how to access it

(b) Ensure that the policy is implemented

(c) Ensure that staff understand the importance of issues regarding DNACPR (Adults) or Personal Resuscitation Plan (Children)

(d) Ensure that DNACPR and Personal Resuscitation Plan (Children) forms, patient leaflets and policy are available as required

(e) Ensure that resuscitation equipment is routinely checked and kept clean and in good working order. For trolley contents, see Clinical Skills and Resuscitation Services (Connect)

4.3 *Consultants responsible for making DNACPR or Personal Resuscitation Plan (Children) decisions:*

(a) Be fully conversant with the current policy

(b) Verify any decisions made by junior medical staff at the earliest opportunity

(c) Document the decision

(d) Make every effort to involve the individual in the decision and, if possible and appropriate, involve relevant others in the making of the decision

(e) Ensures that the decision is communicated to other relevant healthcare providers

(f) Review the decision when appropriate

4.4 *Clinical Staff delivering care:*

(a) Adhere to the policy and procedure

(b) Ensure that they are adequately and regularly trained in cardiopulmonary resuscitation appropriate to their role see Core Mandatory Standards for Resuscitation Training in UHBristol

(c) Notify their line manager of any training needs

(d) Sensitively enquire about the existence of a DNACPR, Personal Resuscitation Plan (Children) or an ADRT

(e) Check the validity of any decision

(f) Notify other services of the DNACPR decision, Personal Resuscitation Plan (Children) or an ADRT on the transfer of a patient to another ward, department, e.g. Physiotherapy Gym, X-ray, or community location, e.g. Nursing Home, Patient's own home (GP)

(g) Participate in the audit of CPR and DNACPR process

4.5 ***Resuscitation Group and Resuscitation Services***

a) Meet at least twice a year as a Group

b) Be responsible for the Terms of Reference of the Resuscitation Group

c) Define the role and composition of the Resuscitation Teams, including that of South Bristol Community Hospital (SBCH)

for more information see the following local guidelines;

Adult medical emergency calls (including SBCH)
Paediatric medical emergency calls
Newborn life support
Local guidance for provision of newborn life support

d) Prepare and implement policies and procedures relating to prevention of cardiac arrest see Recording patient observations, pain level and early warning score in adults using the UHBristol Adult Observation Chart

e) Prepare and implement policies and procedures relating to resuscitation and the treatment of anaphylaxis see Anaphylaxis Guidelines

f) Determine the level of resuscitation training required by staff members see Core Mandatory Standards for Resuscitation Training in UHBristol

g) Ensure national guidelines and standards are implemented and adhered to see RC (UK) Guidelines

h) Ensure that there are systems in place for maintaining Trust-wide resuscitation equipment in good working order. This will mean the delegation of routine checking of equipment to other members of staff. For trolley contents, see Clinical Skills and Resuscitation Services (Connect)

i) Ensure that appropriate resuscitation drugs, including those for peri-arrest situations, are available and ready for use **For first/second line drug lists and locations** , see Clinical Skills and Resuscitation Services (Connect)

j) Responsible for ensuring that there are systems in place for the cleaning and maintenance of Resuscitation Training equipment

k) Prepare and implement a policy on resuscitation decisions, i.e. DNACPR and Personal Resuscitation Plan (Children) and Advanced Care Planning see Do Not Attempt to Cardiopulmonary Resuscitation Guidance and Personal Resuscitation Plan (PRP) Children

l) Ensure that DNACPR decisions are audited and the results are reported to the Resuscitation Group

m) For Quality Improvement, prepare action plans based on audits – e.g. review of data using National Cardiac Arrest Audit (NCAA) data for benchmarking

n) Record and report Patient Safety incidents in relation to resuscitation

o) Ensure that there is defined financial support for the resuscitation service

4.6 ***The Resuscitation Officers:***

a) When possible, respond to and participate in cardiac arrest management as an integral part of clinical responsibility

b) Be responsible for the maintenance of the Advanced Life Support (ALS) provider qualification (or equivalent; e.g. APLS/NLS/EPLS)

c) Ideally, be an ALS (or equivalent; e.g. APLS/NLS/EPLS) instructor and be responsible for the maintenance of their Instructor qualification

d) Be responsible for ensuring that a Clinical Incident Form is completed for each 2222 call

e) Be responsible for Incident Review when appropriate

4.7 ***Adult Medical Emergency/Resuscitation Team***

To attend all emergency calls for adults in main precinct of the Trust including Bristol Royal Infirmary, Bristol Dental Hospital, Bristol Eye Hospital, Bristol Haematology and Oncology

Centre, Bristol Royal Hospital for Children (See 'Clinical Protocol for Adult Emergency Calls) see Adult medical emergency calls (including SBCH)

4.8 ***Paediatric Medical Emergency/Resuscitation Team***

To attend all emergency calls for children in the main precinct of the Trust including Bristol Royal Hospital for Children, Bristol Royal Infirmary, Bristol Dental Hospital, Bristol Eye Hospital, Bristol Haematology and Oncology Centre. (See 'Clinical Protocol for Paediatric Emergency Calls, including Paediatric Medical Emergency and Paediatric Neuro Emergency Calls) see Paediatric medical emergency calls

4.9 ***Porters***

To provide appropriate practical support to the Resuscitation Teams, e.g. transporting equipment, samples etc.

5. Policy Provisions

5.1 UHBRISTOL acknowledges its obligation to provide an effective and safe resuscitation service to its patients and to provide appropriate training to its staff

5.2 It is the Trust's policy to provide a framework to ensure that DNACPR decisions and Personal Resuscitation Plans (Children):

- respect the wishes of the individual, where possible
- reflect the best interests of the individual
- provide benefits that are not outweighed by burden

5.3 The same core standards apply in all settings throughout the Trust

5.4 All settings must have systems in place to ensure:

- Early recognition of the deteriorating patient and a system to summon help in order to prevent cardiac arrest.
- Defibrillation, when needed, is attempted as rapidly as possible; preferably within 3 minutes of identifying cardiac arrest
- Appropriate equipment is available for resuscitation
- Post resuscitation care is provided for those who are successfully resuscitated, including safe transfer. **For post-resuscitation care algorithm** see Clinical Skills and Resuscitation Services (Connect)
- Staff are trained and updated in CPR to an appropriate level, based on their roles see Core Mandatory Standards for Resuscitation Training in UHBristol
- Staff have an understanding of end-of-life care and decisions regarding CPR see Do Not Attempt to Cardiopulmonary Resuscitation Guidance or Personal Resuscitation Plan (PRP) Children or Treatment Escalation Personalized Plan as appropriate.

- All resuscitation attempts are recorded on the Safeguard Clinical Incident Reporting System

5.5 All resuscitation procedures and guidelines will follow acknowledged best practice, in particular, those of the Resuscitation Council (UK) see RC (UK) GUIDELINES

5.6 The organisation will provide sufficient and appropriate resuscitation training for each of the main staff groups. Profession-specific resuscitation training will be directed by their respective functional role and the guidelines and directives issued by their professional bodies (e.g. The Royal College of Anaesthetists) in collaboration with their manager.

6. Standards and Key Performance Indicators

6.1 Target percentage of all relevant Staff Members compliant with Resuscitation Training as agreed by the Resuscitation Group

6.2 DNACPR forms must be completed fully

7. References

1. Meaney PA, Nadkarni VM, Kern KB, Indik JH, Halperin HR, Berg RA. Rhythms and outcomes of adult in-hospital cardiac arrest. Crit Care Med 2010; 38:101-8.

2. Valenzuela TD, Roe DJ, Nichol G, Clark LL, Spaite DW, Hardman RG. Outcomes of rapid defibrillation by security officers after cardiac arrest in casinos. N Engl J Med 000;343:1206-9.

3. Colquhoun MC, Chamberlain DA, Newcombe RG, et al. A national scheme for public access defibrillation in England and Wales: early results. Resuscitation 2008;78:275-80.

4. Valenzuela TD, Roe DJ, Cretin S, Spaite DW, Larsen MP. Estimating effectiveness of cardiac arrest interventions: a logistic regression survival model. Circulation 1997;96:3308-13.

Appendix A – Monitoring Table for this Policy

Compliance with this policy will be monitored by the Resuscitation Services Lead and the General Ward Workstreams Group through a programme of monitoring, which will monitor compliance with policy statements in the relevant sections of the policy, as shown in the schedule below:

Process	Tool	Responsibility of:	Frequency of review	Responsibility of: (including timescales)			
				Review of results	Development of action plan and recommendations	Monitoring of action plan and implementation	Making improvement and sharing lessons
All appropriate staff are trained in CPR every two years	Training records	Resuscitation and Clinical Skills Services Lead	Quarterly	Resuscitation Group - quarterly	Resuscitation Group - quarterly	Resuscitation Group - quarterly	Resuscitation Group - quarterly
Resuscitation equipment kept clean and appropriately stocked	Annual checking of trolleys plus adhoc checks throughout the year	Operational leads for Adult and Paediatric Resuscitation	Quarterly	Resuscitation Group - quarterly	Resuscitation Group - quarterly	Resuscitation Group - quarterly	Resuscitation Group - quarterly
DNACPR forms are completed accurately	Annual audit	[redacted]/Resuscitation Group	Annual	Resuscitation Group - quarterly	Resuscitation Group - quarterly	Resuscitation Group - quarterly	Resuscitation Group - quarterly
Cardiac arrest attempts are audited	Resuscitation events reported via Ulysses. Daily cross-checking using switchboard records	Resuscitation and Clinical Skills Services Lead	Daily and monthly	General Ward Work Streams Group- 8 weekly	Resuscitation Group - quarterly	Resuscitation Group - quarterly	Resuscitation Group - quarterly

Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Resuscitation and Clinical Skills Services Lead
This document replaces existent documentation:	Yes
Existing documentation will be replaced by:	Rescinding of superseding documents
This document is to be disseminated to:	Trust-wide to all Clinical Staff
Training is required:	Yes
The Training Lead is:	Resuscitation and Clinical Skills Services Lead

Additional Comments
Not Applicable

Appendix C – Document Checklist

The checklist set out in the following table confirms the status of 'diligence actions' required of the 'Document Owner' to meet the standards required of University Hospitals Bristol NHS Foundation Trust Procedural Documents. The 'Approval Authority' will refer to this checklist, and the Equality Impact Assessment, when considering the draft Procedural Document for approval. All criteria must be met.

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
Title	The title is clear and unambiguous:	Yes
	The document type is correct (i.e. Strategy, Policy, Protocol, Procedure, etc.):	Yes
Content	The document uses the approved template:	Yes
	The document contains data protected by any legislation (e.g. 'Personal Data' as defined in the Data Protection Act 2000):	Not Applicable
	All terms used are explained in the 'Definitions' section:	No
	Acronyms are kept to the minimum possible:	Yes
	The 'target group' is clear and unambiguous:	Yes
	The 'purpose and scope' of the document is clear:	Yes
Document Owner	The 'Document Owner' is identified:	Yes
Consultation	Consultation with stakeholders (including Staff-side) can be evidenced where appropriate:	Yes
	The following were consulted:	Resuscitation Group Clinical Quality Group
	Suitable 'expert advice' has been sought where necessary:	Yes
Evidence Base	References are cited:	Yes
Trust Objectives	The document relates to the following Strategic or Corporate Objectives:	Adherence to CQC requirements maintain Patient and Staff Safety
Equality	The appropriate 'Equality Impact Assessment' or 'Equality Impact Screen' has been conducted for this document:	Yes

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
Monitoring	Monitoring provisions are defined:	Yes
	There is an audit plan to assess compliance with the provisions set out in this procedural document:	No
	The frequency of reviews, and the next review date are appropriate for this procedural document:	Yes
Approval	The correct 'Approval Authority' has been selected for this procedural document:	Yes

Additional Comments
Not Applicable