

POLICY AND GUIDELINES ON CARDIOPULMONARY RESUSCITATION

1.1 INTRODUCTION

The purpose of this policy is to guide discussion and decisions regarding the use of cardiopulmonary resuscitation for service users in the care of DRH whose cardiac and respiratory functions cease.

1.2 CORE PRINCIPLES

- In the absence of any advanced decision to the contrary (a "Do Not Resuscitate" decision) DRH staff will *always* make reasonable efforts to resuscitate in the event of a service user's cardiac or respiratory failure and will immediately seek appropriate emergency support.
- A primary purpose of this policy is to ensure that individual staff are not forced, in an emergency, to make a decision about resuscitation that may well have been considered more fully in advance.
- DRH recognises that there will be situations where resuscitation is not in the service user's best interests and should not be attempted.
- Any decision not to resuscitate should always be taken following full and open discussion between nursing/ support staff, medical staff, family, friends or other advocates for the service user. Wherever possible the views of the service user themselves should, of course, be central to any decision. These views may be explicit or implied.

2.1 Essential aspects of decision-making

Each case involves an individual service user with his or her own particular circumstances and it is important to ensure that these circumstances are central to each decision rather than applying the same decision to whole categories of service users. An advance decision that CPR will not be attempted (a "do not attempt resuscitation", or "DNAR" order) should be made only after the appropriate consultation and consideration of all relevant aspects of the service user's condition. These include:

- the likely clinical outcome, including the likelihood of successfully restarting the service user's heart and breathing, and the overall benefit achieved from a successful resuscitation;
- the service user's known, or ascertainable, wishes; and

- the service user's human rights, including the right to life and the right to be free from degrading treatment.

The views of all members of the medical, nursing and support team, including those involved in the service user's primary and secondary care and, with due regard to patient confidentiality, people (including staff) close to the service user, are valuable in forming the decision. DRH Chief/Deputy Chief Executive should be kept fully informed of the nature of the discussion any decision. Once made, all decisions must be communicated effectively to the care and support team. DNAR decisions should be recorded on the form provided (Appendix 1)

A DNAR order only applies to CPR and does not apply to any other form of basic care or medical intervention which may be indicated. A DNAR order will only exclude 3 specific interventions:

- chest compressions
- respiratory assistance by "mouth to mouth" bag and mask or other ventilating equipment
- electrical defibrillation

3.0 ADVANCE DECISIONS NOT TO ATTEMPT RESUSCITATION

3.1 A decision not to attempt resuscitation will be appropriate in the following situations:

- **Where attempting CPR will not resuscitate the service user's heart and breathing.** If the multi-disciplinary team is as sure as it can be that CPR would not and the service user would not gain any clinical benefit from any attempt. This decision must be based on a current assessment of the service user's condition and clinical guidelines.
- **Where there is no benefit in restarting the service user's heart and breathing.** No benefit is gained if only a very brief extension of life can be achieved and imminent death cannot be averted. Similarly, if it is clearly known that the service user will not have the awareness to experience benefit then no benefit will be gained.
- **Where the expected benefit is outweighed by the burden to the service user** There are many situations that might meet this criteria. However, such situations can best be summarised as follows:

"When a service users has no or minimal levels of awareness or when the service user suffers severe and unmanageable pain".

Consideration should be given to the quality of life likely to be experienced after successful resuscitation. However, staff should exercise great caution to ensure that their own perspectives and values are not imposed on to that of the service user. The key question is whether the service user's general quality of life would be maintained or would deteriorate as a result of a CPR

attempt. The duty to protect life must be balanced with the obligation not to subject the service user to inhuman or degrading treatment.

- **When the service user has made an advanced statement (Living Will) that they do not wish to be resuscitated** - in the circumstances that pertain at the time of a cardio-pulmonary collapse.

3.2 Advance decisions not to resuscitate must be reviewed annually.

4.0 ADVANCE STATEMENTS

4.1 What is an advance statement?

People who understand the implications of their choices can state in advance how they wish to be treated if they suffer loss of capacity. An advance statement (sometimes known as a living will) can be of various types:

- A requesting statement reflecting an individual's aspirations.
- A statement of general beliefs and aspects of life which an individual values
- A statement that names another person who should be consulted at the time a decision has to be made
- A clear instruction refusing some or all medical procedures (advance directive)
- A statement which, rather than refusing any particular treatment, specifies a degree of irreversible deterioration after which no life sustaining treatment should be given or
- A combination of the above, including requests, refusals and the nomination of a representative

4.2 What form should an advance statement take?

An advance statement can be a written document, a witnessed oral statement, a signed printed card or note of a particular discussion recorded in the service user's file.

4.3 Who can make an advance statement?

Any person can make an advance statement including an individual under the age of 18, although advance statements will only be legally binding in certain circumstances (see below).

4.4. Are advance statements legally binding?

A clear refusal of treatment by a competent adult, acting free from pressure, has potential legal force. General statements of preferences should be respected, if appropriate, but are not legally binding. Any advance statement is superseded by a clear and contemporaneous decision by the individual concerned.

4.5. Are all advance refusals of treatment legally binding?

An advance refusal is legally binding providing that the service user is an adult, the service user was competent and properly informed when reaching the decision, the statement is clearly applicable to the present circumstances and there is no reason to believe that the service user has changed his or her mind. If doubt exists about what the individual intended, the law supports presumption in favour of providing clinically

appropriate treatment, but where the situation that has arisen is clearly that which was envisaged by the service user, treatment should not be provided contrary to a valid advance refusal.

(From BMA practical guide to gaining service user consent, March 2001)

5.0 MENTAL CAPACITY

A mentally competent service user has an absolute right to refuse treatment – including CPR. If a service user states that they do not wish to be resuscitated in the event of cardio-pulmonary collapse their wishes should be respected. However, the service user's permission should be sort to discuss their wishes with close family members. Where there are significant doubts as to the service users mental capacity to take such a decision independently the support of an Independent Mental Capacity Advocate should be sought.

Consideration of capacity should always be based on the Five Statutory Principles (Mental Capacity Act)

- a presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise
- the right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions
- that individuals must retain the right to make what might be seen as eccentric or unwise decisions
- best interests - anything done for or on behalf of people without capacity must be in their best interests
- least restrictive intervention - anything done for or on behalf of people without capacity should be an option that is less restrictive of their basic - as long as it is still in their best interests.

A service user's capacity to consent should be assessed and clearly documented whenever a decision not to resuscitate is considered.

6.0 DOCUMENTING DECISIONS

Managers should ensure that the key points of any discussion regarding the possibility of a non-resuscitation agreement should be clearly recorded on the Cardiopulmonary Resuscitation Decision Record (Appendix 1) and a copy sent to the DRH Chief Executive/Deputy Chief Executive.

Managers should ensure that Advance Statements are cross-referenced clearly in the service users file. Any DNR request should be clearly marked and communicated to all staff.

7.0 BASIC LIFE SUPPORT

Basic Life Support consists of four elements:

- initial assessment;
- airway maintenance;
- expired air ventilation (rescue breathing and chest compression).
- It may additionally include Automated External Defibrillation although AED is only authorised for use at DRH's two Independent Mental Health Hospitals i.e. Elsadene and Fairfield House.

7.1 Basic life support should be provided in accordance with the Resuscitation Council(UK)Guidelines (Appendix 2)

It is essential that someone is delegated to telephone 999 immediately it is established that the victim is unresponsive.

8.0 PHYSICAL RESTRAINT - SAFEGUARDS

Two DRH facilities (193 St. Andrews Road and Fairfield House) currently support service users whose individual support plans allow for the use of limited physical restraint. Appendix A identifies the particular precautions and safeguards that should be in place.

9.0 TRAINING

- CPR Training: 1.5 hrs training to be undertaken during induction period for all new staff.
- Initial CPR training to be followed by an annual update

One day First Aid training day for NVQ will substitute for one annual CPR update.

- Defibrillator training will be undertaken by all new staff at Fairfield and Elsadene
- Initial defibrillator training to be followed by an annual update. Mandatory training requirements will be reviewed and amended to take account of any changes to national/European recommendations

10.0 RESPONSIBILITIES:

DRH Chief Executive is responsible for the communication and implementation of this policy

Home managers are responsible for:

- ensuring that any decisions regarding the appropriateness of CPR for a particular service user are clearly identified and recorded.
- ensuring that appropriate consultation takes place regarding any proposed non-resuscitation decision.

- ❑ involving an independent advocate in any discussions when the service user does not appear to have the capacity to make a decision for themselves and it is inappropriate or impossible to involve close family members.
- ❑ recording and communicating the decisions of primary and secondary care medical staff regarding an advance agreement not to attempt CPR
- ❑ ensuring that the decision not to attempt resuscitation is communicated effectively to all staff – including any bank or agency staff who may be in charge of a shift at the Home.
- ❑ informing the DRH Chief Executive/Deputy of issues relating to this policy.
- ❑ ensuring that resuscitation equipment is available and maintained effectively
- ❑ ensuring that all staff receive mandatory basic life support training and are capable of fulfilling their particular responsibilities.

Individual DRH staff are responsible for:

- ❑ undertaking mandatory basic life support training and for maintaining an appropriate level of competence
- ❑ ensuring that any advance decisions made in respect of a service user are respected.
- ❑ being aware of the location and use of resuscitation equipment within their workplace

References:

- ❑ Decisions Relating to Cardiopulmonary Resuscitation: Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing
- ❑ Considerations of “quality of life” in cases of medical decision-making for people with severe learning disabilities: Mencap
- ❑ Living Wills: A Guide for patients. Patients Association
- ❑ Independent Health Care: National Minimum Standards & Regulations. 2002. Department of Health
- ❑ Resuscitation and your right to refuse it. DirectGov: http://www.direct.gov.uk/en/HealthAndWellBeing/HealthServices/AccidentsAndEmergencies/DG_10029742
- ❑ National Minimum Standards and Care Home Regulations for Care Homes for Adults: 2002. Department of Health

January 2003
February 2006 Reviewed & Revised

Reviewed November 2009
Review date November 2012

APPENDIX A

PHYSICAL CARE AND OBSERVATION DURING RESTRAINT

All staff who may be involved in the restraint process must be trained in:

- Basic life support
- Physical risks associated with restraint i.e.: asphyxia/sudden collapse
- Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action.
- Use of emergency equipment
- Knowing how to summon appropriate assistance.

There will be access to basic life support equipment, which is regularly checked (at least weekly) and maintained in working condition.

During physical intervention, one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

Under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well-being of the service user should be continuously monitored throughout the process.

Any person subject to physical restraint should be medically assessed at the earliest opportunity

The medical assessment should be recorded in the service user's notes. Any injuries must be reported through established reporting systems – incident reporting.

Any person subject to restraint should be physically monitored continuously during the restraint and at least every 2 hours post restraint for the period of 24hours. This check should include:

- Care in the recovery position where appropriate
- Pulse
- Blood pressure
- Respiration
- Temperature
- Fluid and food intake and output.

The 2-hourly physical checks post restraint should be recorded on the service user's physical observation chart and fluid balance chart.

If consent and co-operation for these observations is not forthcoming from the person subject to the process, then this should be clearly documented in their records why checks could not be performed and what alternative actions have been taken.

Physical monitoring is especially important:

- Following a prolonged or violent struggle
- If the service user has been subject to enforced medication.
- If the service user is suspected to be under the influence of alcohol or illicit substances
- If the service user has a known physical condition which may inhibit cardiopulmonary function e.g. asthma, obesity (when lying in prone position)

Whenever possible, restraining service users on the floor should be avoided. If, however the floor is used, this should be for the shortest period of time (not exceeding 5 minutes) and for the central reason to gain control of the situation. In exceptional circumstances where the service user needs to be placed in the prone position this should be for the shortest possible period of time to bring the situation under control – not exceeding 5 minutes.

A crash bag (including an automatic external defibrillator, a bag, valve, mask, oxygen delivery system, and suction) will be available. This equipment should be maintained and checked weekly.

APPENDIX I

Cardiopulmonary Resuscitation Decision Record

Service User's Surname	Service User's Forename	Date of Birth	Hospital/Home	
In the event of a cardiopulmonary arrest, the above named service user should be:				
1	FOR CARDIOPULMONARY RESUSCITATION			<input type="checkbox"/>
2	NOT FOR CARDIOPULMONARY RESUSCITATION for the following reason: Service User Decision: <ul style="list-style-type: none"> • Service user has given informed consent not to undergo CPR <input type="checkbox"/> • Service user has an advance directive not to undergo CPR <input type="checkbox"/> Medical Decision: <ul style="list-style-type: none"> • Where attempting CPR will not restart the service user's heart and breathing <input type="checkbox"/> • Where there is no benefit in restarting the service user's heart and breathing <input type="checkbox"/> • Where the expected benefit is outweighed by the burdens <input type="checkbox"/> 			<input type="checkbox"/>
This decision means chest compressions, assisted ventilation, resuscitative drugs, defibrillation and cardioversion will not be provided. All other medical and nursing interventions (see policy for details) may still be provided if appropriate.				
Clinician making the decision:				
Signature			Print Name	
Designation			Date	
The above decision has been discussed with (if not discussed, document reason in service users notes):				
Service User	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date	
Relatives	Yes <input type="checkbox"/>	No <input type="checkbox"/> N/A <input type="checkbox"/>	Name(s)	Date
Advocate	Yes <input type="checkbox"/>	No <input type="checkbox"/> N/A <input type="checkbox"/>	Name(s)	Date

