Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Resuscitation Policy**
Version:	**Version 9**
Reference Number:	**CL009**

Scope:

This policy applies to all Pennine Care NHS Foundation Trust sites although the policy mainly covers hospital inpatient sites. Community settings must call 999 in case of an emergency.

Purpose:

This document outlines the organisation of resuscitation within the Pennine Care NHS Foundation Trust. It remains the responsibility of all staff to be familiar with its contents and implementation. This document embraces the "Quality standards for cardiopulmonary resuscitation practice and training: Inpatient care" and Minimum equipment and drug lists for cardiopulmonary resuscitation: Inpatient care".
Access to these documents or any other National Resuscitation guidelines can be found on www.resus.org.uk.

Requirement for Policy

UK Resuscitation Council

Keywords:

Resuscitation, collapse, crash, BLS, ILS, PBLS, CPR

Supersedes:

Version 8

Description of Amendment(s):

To Reflect changes to the Resuscitation Council (UK) June 2015

Owner:

Medical Director – Henry Ticehurst

Individual(s) & group(s) involved in the Development:

This document has been developed in collaboration with the following interested parties:

- Members of the Resuscitation Committee

Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Resuscitation Committee	
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Responsibility of:	Trust Resuscitation Lead And First Aid Officer – Sally-Anne Denton
Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
CL039	Unified Do Not Attempt (UDNAR) Cardiopulmonary Resuscitation Policy
CL122	Safeguarding Families Policy
Policy Associated Documents:	

Other external documentation/resources to which this policy relates:	
	www.resus.org.uk
CQC Regulations **This guideline supports the following CQC regulations:**	
Regulation 9	Person centred care
Regulation 12	Safe care and treatment
Regulation 13	Safeguarding service users from abuse and improper treatment
Regulation 15	Premises and equipment
Regulation 18	Staffing

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1. INTRODUCTION

Hospitals have a duty of care to provide an effective resuscitation service to ensure that all staff are trained appropriately and regularly updated to a level compatible with their expected degree of competence. (Resuscitation Council (UK) June 2015)

It is essential that the following links in the chain of survival are in place:

a) Early access to the emergency services / Medical Emergency Team
b) Early basic life support
c) Early defibrillation
d) Early advanced life support

The following areas have been identified as main priorities:

- Identification and early recognition of patients who are at risk of cardiopulmonary arrest
- Increased multi-professional working
- Increased training opportunities / resources following Resuscitation Council (UK) guidance
- Equipment development
- Develop audit processes to monitor the efficacy of the service
- Risk management
- Communication
- Effective, accessible policies

2. PURPOSE

This document outlines the organisation of resuscitation within the Pennine Care NHS Foundation Trust. It remains the responsibility of all staff to be familiar with its contents and implementation. This document embraces the “Quality standards for cardiopulmonary resuscitation practice and training: Mental health – Inpatient care” and “Minimum equipment and drug lists for cardiopulmonary resuscitation: Mental health – Inpatient care” Access to these documents or any other National Resuscitation guidelines can be found on www.resus.org.uk

3. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

With respect to risk management issues associated with resuscitation, the Trust has a number of responsibilities.

Chief Executive – has overall responsibility for ensuring that the Trust provides an effective resuscitation service.

Non-Executive Director – will have responsibility on behalf of the Trust to ensure that the Resuscitation Policy is agreed, implemented and regularly reviewed within the clinical governance framework.

Medical Director – has lead responsibility for the Resuscitation Policy and strategies within the Trust.

The Medical Director is the Executive Lead for ensuring that the Trust Resuscitation Committee takes responsibility for all resuscitation issues within the Trust, including implementation of operational policies governing cardiopulmonary resuscitation training and practice.

The resuscitation committee under the chair of the Medical Director will be responsible for identifying the necessary resources to maintain and upgrade clinical and training equipment throughout the organisation for inclusion in the business plan.

Governance Lead for Resuscitation – The Core and Essential Skills Manager will be the Governance Lead for the Resuscitation Committee. They will take the lead for ensuring the overall governance of the Trust Resuscitation Committee.

Resuscitation Officer – is responsible for teaching and training of resuscitation techniques, auditing CPR performance, cardiopulmonary resuscitation and positioning of resuscitation equipment and to ensure that latest developments in resuscitation techniques and equipment are implemented across the Trust with regular clinical patient contact.

The Main responsibilities are:

- To ensure that all trust clinical staff (i.e. nurses, doctors, allied health professionals, pharmacists and all other persons who are involved in direct patient care) receives resuscitation updates regularly (see training needs analysis). This training should be appropriate to the role that the individual would take during the actual event.

- All training will follow the current Resuscitation Council (UK) guidelines and training standards.

- To ensure that the Trust can demonstrate that it has a resuscitation policy in place with respect to training and can provide evidence of the effectiveness of this policy.

- Equipment inventories must be available for each clinical area, and checking procedures must be documented.

- Sufficient equipment must be available and accessible at all times of the day and night, and systems of routine maintenance must be in place.

- The resuscitation officer will possess as a minimum a current Advanced Life Support (ALS) provider certificate, Immediate Life Support RC (UK) Instructor status and a Paediatric Immediate Life Support (PILS) certificate.

- The resuscitation officer will be responsible for the audit and maintenance of clinical equipment for resuscitation.

- The resuscitation officer will oversee the Basic Life Support training within Trust Induction for all newly appointed members of staff.

Service Managers - are responsible for ensuring that any Clinical Incidents relating to the delivery of resuscitation interventions are reported through the clinical incident reporting system.

Following each resuscitation service managers should ensure there is a period of debriefing with the staff involved.

Service Managers are responsible for ensuring that staff attend the required training.

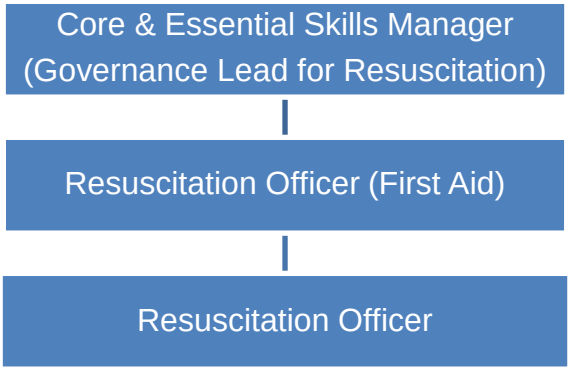
Ward Managers

The main responsibilities are:

- Managers must identify the location of their nearest resuscitation equipment, and ensure all staff are aware of how to summon the cardiac arrest team / emergency services.
- Managers must satisfy themselves that a sufficient number of appropriately trained staff are available at all times. Newly appointed staff must receive suitable training for their post
- Safe systems of communication should be in place.
- Wards / departments which have restricted access will ensure that the emergency services / Medical Emergency Team can enter.
- To prevent, where possible, respiratory or cardio-respiratory arrest from occurring:
    - By promoting the assessment and treatment of the sick patient by such training as is appropriate to the individual.
    - By promoting appropriate observation, recording and alerting, where appropriate, senior medical / nursing staff.

All Trust Employees - All Trust employees are responsible for ensuring they attend the required level of training and required update identified by their staff group.

Resuscitation Service Structure



4. RESUSCITATION TRAINING

All training will be delivered following current Resuscitation Council (UK) standards and guidelines.

Basic Life Support (BLS)

BLS training includes:

- Assessment of the unconscious casualty
- Expired air ventilation, including mouth to mouth and the use of a pocket mask (discussion only)
- How to summon appropriate help
- Appropriate manikin practice and assessment
- The treatment of the choking casualty

Paediatric Basic Life Support (PBLS)

PBLS training includes:

- Assessment of the unconscious casualty
- Expired air ventilation, including mouth to mouth
- How to summon appropriate help
- Appropriate manikin practice and assessment
- The treatment of the choking casualty

Immediate Life Support (ILS)

ILS training includes:

- Recognition and management of the seriously ill patient
- All aspects of BLS, with the addition of airway adjuncts except intubation
- Use of resuscitation equipment including the connection of monitors and use of a defibrillator
- Cardiac rhythm recognition *(where applicable)*
- Development of the Resuscitation Council (UK) Adult treatment algorithms / AED Algorithm
- Manikin CASTeach scenarios

Staff should undergo regular resuscitation training to a level appropriate to their expected clinical responsibilities. (Resuscitation Council (UK) 2015)

Emphasis will be placed on recognising patients at risk of cardiopulmonary arrest, and start treatment to prevent arrest occurring. (Resuscitation Council (UK) 2014)

Training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation. Training and facilities should ensure that, when cardiopulmonary arrest occurs, staff are able to:

- Recognise cardiopulmonary arrest;
- Summon help;

- Start CPR using airway adjuncts, and attempt defibrillation within 3 minutes of collapse. This is a minimum standard. (Resuscitation Council (UK) 2015)

Staff should NOT withhold administering CPR should their current certificate be 'out of date'. Staff with prior instruction in BLS/ILS should administer CPR to their current scope of knowledge.

Clinical staff should update their skills in Immediate Life Support//Basic Life Support yearly (Resuscitation Council (UK) 2015).

Extension of nursing skills e.g. airway management, rhythm recognition, semi-automated defibrillation and administration of specific drugs will be encouraged. (Where appropriate)

Resuscitation Training Guidance

All nurses in charge within inpatient areas must have a current Resuscitation Council (UK) Immediate Support provider status. The Trust provides access to this level of training; the nurses must take on an equal responsibility to maintain their skills.

This also applies to Consultant Psychiatrists who work in an in patient capacity, Dental Nurses and Dentists, community Services Intermediate Care Nursing Teams, Cardiac Rehabilitation Physiotherapists

All staff, other than those highlighted above, who have access to AED's as part of their work, must be, to a minimum standard, have gained Adult Basic Life Support with AED training.

All training episodes carried out in the hospital by any member of staff must follow the Resuscitation Council (UK) current standards and guidelines.

Formal resuscitation training events should be co-ordinated through the Centralised Learning and Development Department. For each session, a training record event sheet should be submitted for inclusion in the OLM database.

It remains the responsibility of direct line managers / department managers to release staff for training and monitor annual updates.

Staff new to the trust must receive a resuscitation update appropriate to their role as soon as possible upon commencement of employment.

All doctors in the foundation programme will be assessed using Resuscitation Council (UK) ILS standards / assessment formats.

Staff that do not reach the required standards will be informed at the time of the training event. Both the candidate and candidate's manager will also be informed in writing of the candidate's shortfall. Remedial training will be offered to the candidate on an individual based assessment. The candidates manager will be responsible for undertaking a risk assessment to ensure there is sufficient resuscitation competencies in the other service staff (to the required minimum) to ensure no service user is put at risk by the absence of resuscitation competencies in the team on shift at any time. This requirement also applies

to temporary staffing when hired to cover shifts from Pennine Cares own temporary staffing or an outside agency provider.

All training must include practice and assessment on a manikin.

Training manikins are available to borrow by arrangement with the Resuscitation Officer.

Please see the Trust Training Needs Analysis (TNA) in CO5 Education, Training and Development Policy for training in BLS, PBLS, ILS and ILSr for all staff groups and the frequency of updates

Seconded staff will be considered for training courses upon application.

If you are unable to identify your staff group or need further clarification on any issue regarding resuscitation training, please contact the Compliance Information Officer or Resuscitation Officer.

5. MEDICAL EARLY WARNING SYSTEM (NEWS 2)

Medical Early Warning systems are available on all inpatient areas.

NEWS 2 are to be used in identifying when to summon emergency assistance to an acutely ill patient, and to what level of assistance is required.

NEWS 2 are only to be completed by staff, who have received the appropriate training in completing the tool and undertaking physical observations

As with any medical risk emergency situation or general risk situation staff summoning assistance by telephone will utilise the S.B.A.R.D. medical risk communication tool. Use of the S.B.A.R.D. and associated documentation are trained within the ILS courses and NEWS 2 training (also within NEWS 2 training on the PMVA restrictive Interventions Courses.

6. INITIATION OF RESUSCITATION

On sites that are shared with Acute Hospitals the Resuscitation Team should be summoned by dialling 2222. All other areas and community an ambulance must be summoned using 999 (+/- external prefix)

CPR must be commenced immediately and the defibrillator attached at the earliest opportunity by those who have been trained to use it. Oxygen must also be administered at the earliest opportunity, via a Bag-mask valve by those trained to use it. CPR should continue until it is decided by a Dr that the attempt should cease, with the agreement of all those involved in the resuscitation attempt, or until the paramedic crew arrive and state to cease or take over.

In the event of an emergency a member of staff must be sent to the unit / departments entrance to unlock the door upon the arrival of the cardiac arrest team or paramedics and direct them to the emergency.

Fast access to advanced life support is part of the chain of survival in cases of cardiac arrest.

It is the responsibility of each line manager to determine the location of the nearest resuscitation equipment. This information should be disseminated to all individuals working within that area.

The cardiac arrest team will not bring resuscitation equipment with them. Therefore, areas must facilitate the collection of equipment from the nearest identified location.

The resuscitation team should assess, treat and stabilise the patient at the scene where possible.

If the emergency services are then required to support a resuscitation attempt or transfer a casualty to A&E, then the ambulance needs to be summoned.

Please refer to the following site specific cardiac arrest protocols.

6.1 ROYAL OLDHAM HOSPITAL

If a cardiac arrest/sudden collapse occurs on an inpatient unit, then the cardiac arrest team should be summoned using 2222. CPR must be started by staff immediately, once assistance has been summoned. An ambulance can be summoned at the request of the resuscitation team, should the resuscitation team require this or the patient requires transfer.

If a cardiac arrest / sudden collapse occurs within the hospital grounds then the cardiac arrest team should be summoned using 2222, and in addition may need to summon an ambulance by dialling 999 in order to transfer the patient.

Where it is geographically difficult or impractical for the emergency team to respond e.g. Mediscreen, Cannon Street, Orchard House, Clinical Psychology, Bradbury's Car park then staff must call for an ambulance by ringing 999.

6.2 FAIRFIELD GENERAL HOSPITAL

If a cardiac arrest/sudden collapse occurs on Ramsbottom ward, Horizons unit or Hope unit, then the cardiac arrest team should be summoned using 2222. CPR must be started by staff immediately, once assistance has been summoned.

Should a cardiac arrest/sudden collapse occur on Hope/Horizon ward, then an ambulance should be summoned at the same time as the cardiac arrest team.

If a cardiac arrest / sudden collapse occurs within North or South Ward, or within the Irwell unit, then the cardiac arrest team should be summoned using 2222, and an ambulance should be summoned to support the situation, should the resuscitation team require this

6.3 BIRCH HILL SITE

If a cardiac arrest / sudden collapse occurs within any inpatient area, day hospital, the hospital grounds, or anywhere on the Birch Hill Site, then an ambulance should be summoned on 9999 via an internal phone or 999 via a mobile.

Staff must immediately commence CPR once it has been confirmed an ambulance has been summoned.

6.4 TAMESIDE GENERAL HOSPITAL

If a cardiac arrest/sudden collapse occurs in an inpatient unit, then the cardiac arrest team should be summoned using 2222. CPR must be started by staff immediately, once assistance has been summoned.

An ambulance can be summoned at the request of the resuscitation team, should the resuscitation team require this or the patient requires transfer.

If a cardiac arrest / sudden collapse occurs within the hospital grounds, or exposed non-clinical areas, then the cardiac arrest team should be summoned using 2222, and an ambulance should be summoned to support the situation. Equipment can be accessed from the nearest clinical area until paramedics arrive.

6.5 STEPPING HILL HOSPITAL

If a cardiac arrest/sudden collapse occurs on a inpatient unit, then the cardiac arrest team should be summoned using 2222. CPR must be started by staff immediately, once assistance has been summoned. An ambulance can be summoned at the request of the resuscitation team, should the resuscitation team require this or the patient requires transfer.

The following is the operational procedure for the management of a cardiac arrest in any non-clinical department, road or car park on the Stepping Hill site.

The person raising the alarm will elicit help by contacting switchboard on 2222 via an internal phone or 0161 419 5555 via a mobile phone giving them the location of the collapse, the caller should be as specific as possible about the location.

In all cases Switchboard will raise the cardiac arrest team and if the location given is not within the main hospital block proceed to call for an ambulance on 999.

The cardiac arrest team will attend. The doctor leading the team may, at their discretion, decide if it is feasible to transport the patient to the A&E department on a trolley or wait for the ambulance.

Upon hearing the location of the arrest over the bleep a porter will collect the portable defibrillator and emergency pack from the nearest station and transport it to the arrest. They should then arrange the delivery of the trolley of required.

6.6 RHODES PLACE, HEATHFIELD HOUSE, STANSFIELD PLACE

If a cardiac arrest / sudden collapse occurs, then an ambulance should be summoned on 9999 via an internal phone or 999 via a mobile.

Staff must immediately commence CPR once it has been confirmed an ambulance has been summoned.

6.7 COMMUNITY

If a cardiac arrest / sudden collapse occurs, then an ambulance should be summoned on 999.

Staff must immediately commence CPR once it has been confirmed an ambulance has been summoned.

6.8 BEALEYS HOSPITAL & BUTLER GREEN INTERMEDIATE CARE SERVICES

If a cardiac arrest / sudden collapse occurs, then an ambulance should be summoned on 9999 via an internal phone or 999 via a mobile.

Staff must immediately commence CPR and deploy the defibrillator (if trained to do so) once the paramedic crew has been summoned.

6.9 PAEDIATRIC RESUSCITATION

Cardiopulmonary arrest is fortunately uncommon in infants and children. The fundamental difference between resuscitation of a child compared to an adult is that most children have a healthy heart, it is usual therefore that cardiac arrest occurs following respiratory arrest.

Rescuers who have been taught adult CPR and who have no specific knowledge of paediatric resuscitation should use the adult sequence. Health Care professionals who have been taught paediatric CPR should administer the paediatric sequence.

6.10 CAMBECK PLACE

If a cardiac arrest / sudden collapse occurs, then an ambulance should be summoned on 999.

Rescuers have been taught Paediatric and Adult Basic Life Support. The Adult Basic life Support at Cambeck also includes the use of an Automated External Defibrillator (BLS with AED only) as an AED is available at Cambeck Close

7. POST RESUSCITATION CARE

Following the successful resuscitation of an individual the resuscitation team/ambulance crew will decide on transfer to an acute environment.

In all incidents staff must remain with the patient and continue to monitor the following every 5 minutes, until further directed by medical staff / CRASH team.

- Respirations
- Oxygen saturation (SPO2)
- Pulse
- Blood Pressure
- Neurological Observations (AVPU)
- Temperature
- Urinary output.

The decision to transfer and how to transfer (ambulance, escorted transfer via stretcher, etc.) will be made by the resuscitation team/ambulance crew.

Staff must assist the resuscitation team/ambulance crew to arrange this transfer and provide appropriate escort if required.

Staff must make the next of kin aware of the transfer, to where, and if possible, to which department.

8. RESUSCITATION EQUIPMENT

Resuscitation equipment should remain in designated areas and only moved if required to support an emergency situation elsewhere.

Pocket masks should be readily available in all clinical and non–clinical areas (unless the pose a risk, e.g. ligature risk).

Following use, equipment must be replaced / restocked at the earliest opportunity.

Departments that require ILS have access to equipment for resuscitation events, which are laid down by the Resuscitation Council (UK) – within their document, “Minimum equipment and drug lists for cardiopulmonary resuscitation: Mental health – Inpatient care” May 2014.

Storage, re-stocking and brands of equipment may vary across the Trust at present.

See TAD_CL009_02 – TAD_CL009_08 for Resuscitation Equipment according to site and restocking procedure.

9. CHECKING RESUSCITATION EQUIPMENT INPATIENT UNITS/CONTINUAL AVAILABILITY OF RESUSCITATION EQUIPMENT

All available resuscitation equipment must be checked on a **DAILY** basis and following each use, by a qualified member of staff. **These checks must be performed by the night duty staff Monday until Thursday and by day duty staff on the remaining days.**

After checking the equipment, the checklist must be signed and dated, and any action taken documented. (See Appendix 8 for Guidelines for Checking of equipment).

Should any resuscitation equipment found to be missing, faulty or expired then the ward manager should be notified immediately and a replacement sourced as soon as possible.

ALL EQUIPMENT CHECKS MUST COMPLY WITH THE STANDARDS SET OUT IN THIS DOCUMENT; THE CHECK SHEET MUST BE SIGNED DAILY AS EVIDENCE OF THIS.

GENERAL CHECKS:

- All equipment is within date i.e. defibrillator pads, drug boxes, ECG Electrodes, contents of the trolley or orange / red box.
- All electrical equipment is in working order; any faults must be reported to the Medical Equipment Management Service (MEMS).
- All electrical equipment must have an up to date safety sticker in place from the MEMS department.
- Following use, resuscitation equipment used must be disposed of appropriately and restocked.
- Gloves and sharps bins are available with the equipment.
- Pocket masks are available throughout the clinical area.

SUCTION

Check that:

- The suction machine is clean and in working order
- The suction tubing is connected to the machine.
- A Yankeuer suction catheter is and suction tubing is available.
- An extension cable is available.

OXYGEN

Check that:

- The cylinder in use is at least half full, with the on/off key attached.
- The reserve oxygen cylinder is full.
- The flow meter is functional i.e. the float rises to indicated litres per minute flow.

DRUGS

Check that:

- Drugs and IV Fluids are in date on the last date of the month in which being checked.
- Seals on drug boxes are intact.
- At least one cardiac arrest box and one peri-arrest drug box (if on checklist) are available.

ORANGE BOX / RED TROLLEY / BAG CONTENTS

Check that:

- The contents are correct according to the checklist.
- The bulb in the laryngoscope is working.
- Spare batteries are available and in date.

DEFIBRILLATOR

Check that:

- The unit is clean.
- External cables are intact (if appropriate to your defibrillator).
- Defibrillator pads appropriate to your defibrillator are available.
- ECG Paper is in the machine and a spare roll is available (if applicable to your defibrillator).
- Defibrillator has performed it's self-test
- Perform defibrillator function / operational test (if applicable to your defibrillator).

Where a defibrillator is not available within a designated area, **all staff must know where the nearest available machine is located.**

10. AUDIT AND MONITORING

It is essential that resuscitation procedures and equipment be audited annually so that any problems and good practice are identified and information shared.

Safeguard (Ulysses) Incident Forms / Cardiac arrest audit forms **must** be completed every time a 2222 / 4444 call is made, even if the patient has not experienced a cardio-respiratory arrest. All emergency situations are audited when the 2222 / 4444 system is activated.

Safeguard (Ulysses) Incident Forms / Cardiac arrest audit forms **must** be completed every time a 999 Ambulance call is made, even if the patient has not experienced a cardio-respiratory arrest.. This applies to the non-acute site based services for Dental Services, Community Services Intermediate Care and Rehabilitation and High Support Mental Health services based in the Community.

All areas must record, where possible, the details of any individual who experiences a cardio-respiratory arrest.

An annual report of the Resuscitation Service will be provided through the Resuscitation Committee and the Risk and Clinical Governance Group.

Each resuscitation incident form will be reviewed by the Resuscitation Committee and the Resuscitation Officer. This will include any decisions where uDNACPR has been agreed signs and symptoms of the patient leading to the cardio respiratory arrest and observations taken and actions taken following the cardio respiratory arrest.

Service areas will do a daily check on the availability and use of the equipment including drugs.

An audit across Trust premises where resuscitation equipment is cited will be conducted on the availability and use of the equipment including drugs by the resuscitation officer on an annual basis. The results of the audit will be shared at the Resuscitation Committee and an action plan developed to be disseminated to the Borough/Divisional Governance Groups and Risk and Clinical Governance Group

An Audit will be conducted annually by the Resuscitation Officer to ensure that staff are completing daily checks on the resuscitation equipment. The results will be shared at the Resuscitation Committee for action where required.

All newly appointed staff should attend the appropriate level of life support training as per their role, as soon as possible following commencement within the Trust.

The Learning and Development department will keep a record of attendance of staff for all other training such as Immediate Life Support which will be discussed at the resuscitation committee.

Service managers/authorising managers will be informed by email of any non-attendance at training by the Learning and Development Department for their action.

Any deficiencies found following an audit will be addressed with the ward manager and reported to the resuscitation committee.

An annual report of the Resuscitation Services will be provided through the Resuscitation Committee and the Risk and Clinical Governance Group.

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

11. RELATIVES WITNESSING RESUSCITATION

Guidelines exist relating to this controversial issue, prepared by the Resuscitation Council (UK).

There are some situations where the relative may wish to witness the resuscitation of a loved one, and where possible, these wishes should be accommodated.

A member of staff should be designated to take charge of any relatives present, ensuring that they do not impede the proceedings, and do not come to harm themselves. It must be stated in the patients' medical notes if relatives were present and who those relatives were.

THE FINAL DECISION RESTS WITH THE TEAM LEADER.

12. DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION GUIDANCE (uDNACPR)

The Unified Do not Attempt Cardio-Pulmonary Resuscitation (Adult) Policy can be found on the hospital intranet, under Trust Policies, reference number CL039.

13. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure.

14. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

15. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

16. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

17. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

18. REFERENCES

'Should Relatives Witness Resuscitation?' A report from the project team of the Resuscitation Council (UK). October 1996 London: Resuscitation Council (UK).

Copies available from Resuscitation Council (UK), Fifth Floor, Tavistock House North, Tavistock Square, London. WC1H 9HR

Freedom of Information Act (2000)

Equality Act 2010

Resuscitation Council (UK) June 2015