The Family Practice Group

16. Resuscitation

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16. Resuscitation

16.1 Introduction

This document is designed to ensure that staff are trained and equipped to carry out cardiopulmonary resuscitation (CPR) in Family Practice Group when it is required. It also informs staff of the processes to follow when deciding whether or not CPR should be carried out. These processes acknowledge that patients should be involved in decisions relating to their treatment and that their views need to be taken into account. The role that people close to the patient can have in these decisions is also acknowledged. This policy takes into account the joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2001) and subsequent updates / amendments.

16.2 Aims and Objectives

The aims of the policy are to ensure that:

• Patients who require resuscitation receive CPR using the most up-to-date resuscitation methods.

• Decisions regarding resuscitation are made on an individual basis.

• The patient, their relatives, carers and all health care personnel involved in their care are well informed about decisions regarding resuscitation and that the patient is not resuscitated against their wishes.

16.3 Implementation of the Policy

16.3.1 All Practice Staff

This policy has been developed to guide Westminster Primary Care Trust (WPCT) staff and other authorised staff commissioned to provide this service on behalf of WPCT.

16.3.2 Resuscitation Training

All staff employed by the practice that has day-to-day contact with patients should attend a Basic Life Support (BLS) training course once a year. It is mandatory that all new practice staff attend the Basic Life Support for Healthcare Staff training as part of their general induction programme. If a new starter has recently (within preceding 12 months) completed resuscitation training with a previous employer they may omit this training, once they have provided proof of their attendance.

Staff working in specific services may be required to undertake courses in advanced resuscitation techniques, such as Advanced Life Support (ALS) or Paediatric Resuscitation.

The Practice's registered manager is responsible for ensuring that the practice staffs have attended Basic Life Support Training, where appropriate. They will also be responsible for identifying where advanced techniques are required.

16.3.3 Equipment

The minimum equipment to be held by the practice or by an individual who visits patients in their home is a pocket mask with one way valve, for example Laerdal mask or equivalent. In areas where it is more likely that resuscitation could take place, further equipment may be required. The Resuscitation Council recommends

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that a defibrillator should be available wherever and whenever sick patients are seen. The practice has a AED10 stored on the wall above the stairs from the lower ground floor. On sites where there are defibrillators, someone who is trained to use them should always be present when sick patients are being seen.
The defibrillator should be checked and recalibrated on an annual basis. The date when the equipment was checked and the signature of the person who checked the equipment should be recorded. All equipment should be regularly serviced in line with manufacturer's guidelines.

Minimum equipment required for primary care setting

a) Minimum recommended equipment:
All practice areas and home visits:

• Pocket Mask and one way valve
• Adrenaline (epinephrine) + needles and syringes Designated practice areas / sites
• Automated defibrillator with electrodes

b) Additional items
• Oxygen mask with reservoir bag
• Other additional equipment may be required for specific practice environments and where there is the appropriately trained staff able to use.
All equipment must be checked regularly to ensure it is fit for purpose. This includes checking batteries, charging units, electrodes, expiry dates etc.

16.4 Summoning help in an emergency

Staff should dial '999' and ask for an ambulance stating their exact location and the condition of the patient before commencing Cardio Pulmonary Resuscitation.

16.5 Making Resuscitation Decisions

Presumption in favour of attempting resuscitation
All patients should be given cardio pulmonary resuscitation unless:
• An explicit advance decision has been made by the multi-disciplinary team that resuscitation should not be attempted
• The express wishes of the patient are well known and that they did not wish to be resuscitated
• The patient has made a living will or an advance directive indicating that they do not want to be resuscitated.
• It is considered unreasonable by the multi-disciplinary team to attempt to resuscitate a patient who is in a terminal phase of illness or for whom the burdens of the treatment clearly outweigh the potential benefits.
The doctors/nurses involved in the care of the patient should make this decision on the basis of the individual case. This decision should be made before the event occurs if this is possible.

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16.6 Withholding Cardio Pulmonary Resuscitation; Do Not Attempt Resuscitation Orders (DNAR Order)

The application of a Do Not Attempt Resuscitation Order (DNAR Order) means that if the patient suffers a respiratory or cardiac arrest, CPR would not be administered and the emergency services would not be called.

16.6.1 Deciding to apply a DNAR Order

The decision to apply a DNAR order can be made by the care team, after taking into consideration the individual circumstances of the patient. This would usually be part of the long term care plan and would have been discussed with the patient and people close to them, where the patient has not expressed a preference to the contrary to their involvement.

The following criteria should be taken into account when the decision to withhold CPR is made:

- Whether CPR is likely to be successful.
- If CPR was to be successful; whether it would be followed by a quality of life which would be in the best interests of the patient.
- Whether the patient has recorded or made their wishes known that they do not want to be resuscitated.

This decision should be made with the patient's human rights in mind, balancing the right to life with the right to be free from degrading treatment.

16.6.2 Decision Making Responsibility

The overall responsibility for a DNAR decision rests with the doctor in charge of the patient's care; this will usually be the general practitioner most directly involved with the care of the patient. The opinions of other members of the medical and nursing team, the patient and their relatives should be taken into account when reaching the decision.

It is essential that all people who are involved in the patient's care should be informed of any decision relating to resuscitation. The team leader should ensure that everyone is aware that a patient is the subject of a DNAR order.

16.6.3 Other Treatment the patient is receiving

Where a patient is the subject of DNAR order, this does not hold any implications for any other care that the patient is receiving. This should continue as appropriate.

16.6.4 Involving the Patient - Competent Adults

The patient should be involved in any decisions relating to their care, and this is especially true with issues surrounding resuscitation. Any communications with patients should be carried out in a sensitive manner by the named nurse in consultation with the GP. The practice reasons for not carrying out resuscitation and the reality of CPR should be explained.

Some patients may not wish to discuss this issue, and this should be respected. It should be made clear that they can raise the issue at any point. If a patient is subject

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to a DNAR order but has made it clear that they do not want to discuss the issue, this should be made clear in their notes.

During the discussions patients may make it clear that they want CPR to be carried out, even if the practice judgement is that it would not be successful or that it would not lead to a good quality of life. Sensitive efforts should be made to convey the situation to the patient. However, if patients still insist that no DNAR order be made, then this should be respected. Doctors/Nurses cannot be required to carry out any treatment against their practice judgement. However, wherever possible, they should respect the patient's wishes to receive treatment, even if there is a very small chance of success or benefit.

16.6.5 Refusal of treatment by the Patient

If a patient is mentally competent, they legally have the right to refuse treatment, even if it results in their death. Therefore, resuscitation should not be attempted if it is the patient's recorded or sustained wish to make an advance decision that they do not want resuscitation carried out.

Some patients may express their wishes by producing an advance directive or a living will. However, this decision does not need to be written to be valid. It may be that this issue is discussed with one of the health professionals involved in their care and then recorded in their notes. Additionally, a clear and consistent expression that a patient would not want to be resuscitated is likely to be as valid as an advance directive. If a patient has made this decision, it should be clearly documented, and the health care team made aware of the patient's views. The named nurse is responsible for disseminating this information. The health care team should be assured that the patient has made their decision with all the information, and that they aware of the implications.

16.6.6 Incapacitated Adults

If a patient is unable to make their own decisions about their care because they lack decision-making capacity, no other person can make that decision for them. In this case the Doctors/Nurses with designated responsibility, usually the patient's general practitioner has the authority to act in the patient's best interest, whilst consulting the Multi Disciplinary Team. It is often thought that relatives of the patient can make decisions for them, but this is not the case. People close to the patient should be kept informed of the patient's health and any decisions relating to it, as they can reflect the patient's views and preferences, unless it is contrary to the patient's best interest.

16.6.7 Children and Young People

If a child or young person is deemed competent, they are entitled to give consent to treatment. Where a child lacks competence, it is generally their parents who make decisions on their behalf. In some cases, when a child has refused consent for treatment, the courts have overruled their decision.

If the views of a child and their parent's conflict, this should be taken into consideration when making the final decision. All decisions around children and young people should be carried out sensitively and involve their families.
The doctor in charge of the child's or young person's care (usually this is their GP) is responsible for taking this decision and should share it with other members of the multidisciplinary team.

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16.6.8 Involving People Close to the Patient

It is good practice to involve people close to the patients / advocates in their decisions. Those close to the patient should be informed of the reasons why a DNAR order would be applicable. They should also have access to this policy.

16.6.9 Documentation of Decisions and Discussions

The following should be documented and dated clearly in the patient's record:
• The reason for withholding CPR should be documented in the notes by the person who has made the decision.
• The discussions relating to the decision to withhold resuscitation which took place between the patient and / or people close to the patient and the health professionals. Also, it should be made clear if there was any reason for not involving the patient in the decision.
• The patient's wish that they do not want to be resuscitated, if relevant.

16.6.10 Practice Review of Patient's situation

Any significant change in the patient's practice condition should be coupled with a review of the resuscitation decision. The review should be documented in the patient's notes.

16.6.11 Cancellation of DNAR Order

If a DNAR order is no longer applicable, this should be clearly documented in the notes.

16.6.12 In-Patient Facilities

If a patient's notes do not make it explicit that the patient is subject to a DNAR order, they should be resuscitated if they experience cardio-pulmonary arrest.
Where patients are admitted to the Trust's nursing homes for residence, a decision should usually be transferred from the hospital where they have previously been treated as to whether they were a subject to a DNAR order. This should be discussed with the patient during their admission procedure.

If patients are admitted to a Trust nursing home for long term residency without an indication of whether they are subject to a DNAR order, the response to an arrest would be to attempt resuscitation. The resident should be assessed within 72 hours of arriving to decide on their resuscitation status. A discussion about resuscitation should normally form part of the admissions procedure with residents and where appropriate, people close to them.

Where patients are admitted to in-patient facilities for respite care, they should bring with them a form which indicates whether they are subject to a DNAR order or not. If there is no indication of a DNAR order, in the event of arrest resuscitation should be attempted.

16.6.13 Patients in the Community

When patients are being seen in the community, and there becomes awareness by their care team that a DNAR order might be appropriate, steps should be taken to

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discuss the possibility of implementing one. The patient's GP has the responsibility for deciding whether the patient should be subject to a DNAR order in discussion with the patient's care team.

Ideally, a GP should visit their patient within a week of the recognition of the possible need for a DNAR. This would also go some way to ensuring that a GP has seen their patient within two weeks of their death, to prevent a coroner becoming involved. A record of the DNAR decision should be conveyed through the patient held notes.

When a patient has been sent home from hospital suffering from a terminal illness, there should be information on their record as to whether they are subject to a DNAR order or not. The patient's care team should take a view as to whether this is still appropriate, taking into account any change in the patient's condition. Any recommendation by the hospital should be taken into account, but if the order is seen to be contrary to the patient's state of health at that time, the GP should become involved to review the decision. Any decision should be reviewed when appropriate in line with any changes in the patient's condition.

If there is no note on the record of any decision having been made regarding resuscitation on the record, it should be assumed that the discussion has not taken place and that unless the patient has expressed that they do not wish to be resuscitated, then resuscitation should take place.

16.6.14 Audit and monitoring

There should be routine monitoring of the taking of decisions relating to resuscitation. Examples of audits that could be undertaken include record keeping of CPR decisions, and the communications relating to these decisions.

16.7 References

Decisions Relating to Cardiopulmonary Resuscitation. *A Joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing*
(February 2001)

Cardiopulmonary Resuscitation Guidance for practice practice and training in Primary Care. *Resuscitation Council*
(July 2001 & 2005)

NHS Executive. Resuscitation Policy (HSC 2000/028) London: Department of Health,
(September 2000)

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