This document is a valid document, however due to organisation change some references to organisations, organisational structures and roles have now been superseded.

**FOR OFFICE USE ONLY (Work Stream submission check)**

This document is compliant with current best practice guidance

☐ This document is compliant with legislation required in relation to its content

What change has this document undergone in the policy alignment process relating to the South Sefton Transaction?

☐ None  X Minor  ☐ Major  ☐ This is a new document

☐ This document has been reviewed and is no longer required

This document is a Trust Wide Policy for LOCAL, SECURE and SPECIALIST LD Division ONLY. A South Sefton Community Division specific policy has been recommended for adoption.

Does this document impact on any other policy documents?

☐ Yes, if yes, which policies are effected? Click here to enter text.  No

Signed:  
Date:
## RESUSCITATION (INCLUDING DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION)

<table>
<thead>
<tr>
<th>Policy Number:</th>
<th>SD07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of this Document:</td>
<td>All Staff</td>
</tr>
<tr>
<td>Recommending Committee:</td>
<td>Resuscitation Committee</td>
</tr>
<tr>
<td>Approving Committee:</td>
<td>Executive Committee</td>
</tr>
<tr>
<td>Date Ratified:</td>
<td>March 2017</td>
</tr>
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<td>March 2019</td>
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<td>Version Number:</td>
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<tr>
<td>Lead Executive Director:</td>
<td>Executive Director of Nursing</td>
</tr>
<tr>
<td>Lead Author(s):</td>
<td>Modern Matron – Physical Health Resuscitation Service Manager</td>
</tr>
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</table>

**TRUST-WIDE CLINICAL POLICY DOCUMENT**

**201 – Version 5d**

Quality, recovery and wellbeing at the heart of everything we do
## Further information about this document:

<table>
<thead>
<tr>
<th>Document name</th>
<th>SD-07 Policy and Procedure for Resuscitation (including Do Not Attempt Cardiopulmonary Resuscitation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document summary</td>
<td>This policy ensures that any service user suffering cardiac or respiratory arrest will receive appropriate care. It also contains the link to the NHS North of England, North West Unified Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) Adult Policy</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Joanne Scoltock – Modern Matron <a href="mailto:joanne.scoltock@merseycare.nhs.uk">joanne.scoltock@merseycare.nhs.uk</a> Pete Darley – Resuscitation Serive Manager <a href="mailto:Peter.darley@merseycare.nhs.uk">Peter.darley@merseycare.nhs.uk</a></td>
</tr>
<tr>
<td>Contact(s) for further information about this document</td>
<td></td>
</tr>
<tr>
<td>Published by</td>
<td>Mersey Care NHS FoundationTrust V7 Kings Business Park Prescot L34 1PJ</td>
</tr>
<tr>
<td>Copies of this document are available from the Author(s) and via the trust’s website</td>
<td>Your Space Extranet: <a href="http://nww.portal.merseycare.nhs.uk">http://nww.portal.merseycare.nhs.uk</a> Trust’s Website <a href="http://www.merseycare.nhs.uk">www.merseycare.nhs.uk</a></td>
</tr>
<tr>
<td>To be read in conjunction with</td>
<td>Medical Devices Policy SA19 Rapid Tranquilisation Policy SD11 Physical Health Policy SD29 Mental Capacity Policy MC01/02/03/04 Infection Prevention and Control Policy IC01</td>
</tr>
<tr>
<td>This document can be made available in a range of alternative formats including various languages, large print and braille etc</td>
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Copyright © Mersey Care NHS Foundation Trust, 2015. All Rights Reserved
<table>
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<tr>
<th>Version Control:</th>
<th>Version History:</th>
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<tr>
<td>Version 5</td>
<td>Circulated to Chief Operating Offices, - Local/Secure Divisions, Resus Lead – Specialist LD Services, Executive Director of Nursing, Head of Learning and Development.</td>
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</tbody>
</table>
SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, Safeguarding Ambassadors or the trust’s safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy/maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDa principles of Fairness, Respect, Equality Dignity, and Autonomy.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Purpose and Rationale</td>
<td>6</td>
</tr>
<tr>
<td>2. Outcome Focused Aims and Objectives</td>
<td>6</td>
</tr>
<tr>
<td>3. Scope</td>
<td>6</td>
</tr>
<tr>
<td>4. Definitions</td>
<td>6</td>
</tr>
<tr>
<td>5. Duties</td>
<td>7</td>
</tr>
<tr>
<td>6. Process</td>
<td>8</td>
</tr>
<tr>
<td>7. Consultation</td>
<td>11</td>
</tr>
<tr>
<td>8. Training and Support</td>
<td>11</td>
</tr>
<tr>
<td>9. Monitoring</td>
<td>12</td>
</tr>
<tr>
<td>10. Equality and Human Rights Analysis</td>
<td>12</td>
</tr>
<tr>
<td>11. Supporting Documents</td>
<td>12</td>
</tr>
<tr>
<td>12. Appendices</td>
<td></td>
</tr>
<tr>
<td>Appendix 1a – Local Division - First Responder Red Bag: Contents</td>
<td>13</td>
</tr>
<tr>
<td>Appendix 1b – Secure Division – First Responder Red Bag: Contents</td>
<td>14</td>
</tr>
<tr>
<td>Appendix 2a – Specialist Learning Disability Services – Lifeline Pro contents</td>
<td>15</td>
</tr>
<tr>
<td>Appendix 2b – Pictorial -Lifeline Pro contents</td>
<td>17</td>
</tr>
<tr>
<td>Appendix 2c – Specialist Learning Disability Services Resuscitation</td>
<td></td>
</tr>
<tr>
<td>Equipment Prompt</td>
<td>22</td>
</tr>
<tr>
<td>Appendix 2d – Specialist Learning Disability Services monthly equipment and Emergency Drug Box Checklist</td>
<td>24</td>
</tr>
<tr>
<td>Appendix 3 – Modified Early Warning Score (MEWS) procedure</td>
<td>25</td>
</tr>
<tr>
<td>Appendix 4 – Early Warning Systems for cardio-respiratory arrest</td>
<td>40</td>
</tr>
<tr>
<td>Appendix 5 – Signs and Symptoms of Opiate Overdose</td>
<td>42</td>
</tr>
<tr>
<td>Appendix 6 – NHS North of England North West Regional Unified Do Not Attempt Cardiopulmonary Resuscitation Policy</td>
<td>43</td>
</tr>
<tr>
<td>Appendix 8 – Equality and Human Rights Analysis</td>
<td>76</td>
</tr>
<tr>
<td>Appendix 7 – Implementation Plan</td>
<td>80</td>
</tr>
</tbody>
</table>
1. PURPOSE AND RATIONALE

1.1 Purpose - Healthcare organisations have an obligation to provide a high quality resuscitation service, and to ensure that staff are trained and updated regularly to a level of proficiency appropriate to each persons expected role.

1.2 Rationale - The Resuscitation Council (UK) Quality Standards for Cardiopulmonary Practice and Training for Mental Health Inpatient Care (2014) clearly sets out the expected standards for compliance with leadership, membership of the resuscitation committee and level of training for staff.

The CQC and NHSLA have made it clear that Trusts will be monitored in line with the RC(UK) standards

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

This policy also describes the trusts standards to resuscitation practice assessments. The policy contains a link to the NHS North of England, North West Unified ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) Adult Policy and clarity and decisions underlying service users who are considered as being “not for resuscitation” that safeguards their interest, respects their choices and maintains their dignity.

a) To ensure the safe delivery of resuscitation with the available resources.
b) To ensure compliance with national guidelines and standards.
c) To improve service users outcomes by detecting and acting upon early warning signs (MEWS) of physical health deterioration.

3. SCOPE

This policy applies to staff of all services within Mersey Care NHS Foundation Trust. The policy applies to staff whether they are on Trust premises or community settings.

4. DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AED – Automated external</td>
<td>A sophisticated, reliable, safe, computerised device that delivers electric shocks to a victim of cardiac arrest when the ECG rhythm is one that is likely to respond to a shock</td>
</tr>
<tr>
<td>Defibrillator</td>
<td></td>
</tr>
<tr>
<td>BLS – Basic Life Support</td>
<td>Implies that no equipment is required to give cardiopulmonary resuscitation, other than protective device to allow the responder to give ventilations without the risk of infection transmission. BLS training includes the management of choking</td>
</tr>
<tr>
<td>Cardiac Arrest</td>
<td>The sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness and apnoea or agonal gasping respiration.</td>
</tr>
<tr>
<td>CPR – Cardiopulmonary</td>
<td>An emergency procedure which may include chest compressions and ventilations in an attempt to maintain cerebral and myocardial perfusion, which follows recommended current Resuscitation council (UK) guidelines.</td>
</tr>
<tr>
<td>Resuscitation</td>
<td></td>
</tr>
<tr>
<td>DNACPR – Don Not</td>
<td>Refers to a decision not to make efforts to restart breathing</td>
</tr>
<tr>
<td>Attempt Cardiopulmonary Resuscitation</td>
<td>and/or the heart in cases of respiratory/cardiac arrest. It does not refer to any other interventions, treatment and/or care such as fluid replacement, feeding, antibiotic etc.</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>ILS – Intermediate Life Support</td>
<td>ABCDE assessment &amp; management. Undertaking the skills of quality CPR and defibrillation (manual and/or AED) and simple airway manoeuvres</td>
</tr>
<tr>
<td>MEWS – Modified Early Warning Score</td>
<td>An evidenced based system of care that identifies early deterioration in health using a minimum clinical data set of physiological parameters. MEWS should be used for initial assessment of acute illness and for the continuous monitoring of a patient’s well-being throughout their stay in hospital.</td>
</tr>
</tbody>
</table>

5. **DUTIES**

5.1 **Board of Directors** - Health care providers are under obligation to provide safe care to their patients and appropriate training to their staff. This duty encompasses ensuring the physical health care of patients whilst under the care of the organisation, and the Trust has an obligation to comply with its statutory and regulatory observations.

5.1.1 The Board of Directors has overall responsibility for ensuring that all staff are appropriately trained and competent to effectively fulfil their role within the organisation and to maintain the safety of patients.

5.2 **Lead Executive Director** - The lead Executive Director for this policy (Executive Director of Nursing) has strategic responsibility for ensuring that effective arrangements regarding the management of resuscitation across the organisation meets all statutory and national guidelines.

5.3 **Resuscitation Committee** – The Resuscitation Committee with delegated responsibility from and provide regular reports to, the Lead Executive Director, will manage all aspects of resuscitation across the trust, including but not limited to, Resuscitation Policy, Do Not Attempt Cardiopulmonary Resuscitation, incident reviews, training and equipment.

5.4 **Resuscitation/Policy Lead** - The Resuscitation/Policy Lead and the Modern Matron- Physical Health will oversee the implementation, promotion and governance of the policy across the Trust. They will be responsible for monitoring and reviewing the policy as necessary.

5.5 **Head of Learning and Development** – is responsible for ensuring that education governance arrangements are in place to ensure the effectiveness of the delivery of BLS and ILS across the trust and those models of teaching, learning and assessment are fit for purpose and inline with advice from the Resuscitation/policy lead and Modern Matron on national guidelines relating to training.

5.6 **Resuscitation Trainers** – are responsible for delivering high quality teaching, learning and assessment of staff in respect of resuscitation practice in line with national guidance. They are responsible for ensuring all attendance of training is recorded onto
the ESR/OLM system in line with Learning and Development Standard Operating Procedures (SOP).

5.7 The Associate Medical Director for Physical Health and Medicines Safety - will support and oversee the implementation and promotion of this policy, especially to medical staff and supporting the monitoring and review of the policy.

5.8 Chief Operating Officer and Associate Medical Director – are accountable for ensuring effective delivery within the service for which they have overall responsibility and ensuring adherence to the policy.

5.9 Service Care Leads, Modern Matrons and Ward Managers - are responsible for ensuring that high standards are maintained within their areas of responsibility and the standards set out in this policy are adhered to. It is the responsibility of each line manager to ensure staff attends all relevant statutory and mandatory training; and to monitor attendance on a routine basis, ensuring systems are in place for staff to be followed up in relation to resuscitation training. They must ensure all appropriate resuscitation equipment is available and in good working order.

5.10 Employee – it is the responsibility of each staff member to ensure they attend all relevant mandatory training and other training if relevant for their role (ILS for designated staff) and keep themselves up to date.

6. PROCESS

6.1 All clinical Trust staff will be provided with training in Basic Life Support (BLS) and Automated External Defibrillation (including use of ligature knife) as part of the organisations corporate induction and as an annual refresher.

6.2 All staff (Nurses and medics) in all clinical areas within Secure Division, Local Services Division and Specialist Learning Disability Division will be provided with Immediate Life Support training on induction and as an annual refresher.

6.3 SECURE DIVISION

6.3.1 High Secure Services - designated first responders are based on Forster, Shelley, the Gym and Health Centre. Trained staff allocated on these wards/areas will carry the response bleeps.

Additional response bags are held on the following areas - Blake, Carlyle, Gibbon, Johnson, Lawrence, Owen, Tennyson and PIPS Team.

6.3.2 Medium Secure Services – designated first responders are based on Ivy, Olive and Reed Lodge. The emergency response bags are held in the Treatment Room (Scott Clinic) and Reed Lodge. (An additional bag containing NO emergency medication is held at the John Parry Centre (MVA Team)

6.3.3 Low Secure Services – All qualified staff on Low Secure Unit are ILS trained.

6.3.4 In the event of a cardiac arrest being identified help must be summoned immediately; individuals must shout for help in the first instance.
6.3.5 For High Secure Services an emergency response will be summoned using 3333.

6.3.6 For Medium and Low Secure Services an emergency response will be summoned using (9)999

6.4 LOCAL DIVISION

6.4.1 All inpatient areas will have designated first responder and response bags. Early emergency support should also be sought to enable access to early defibrillation and other secondary forms of resuscitation from skilled practitioners. This emergency support will vary depending on the location but will include:

- Emergency paramedic services
- On-call doctor in Mersey Care’s clinical areas
- Immediate Life Support team in high risk areas

6.4.2 In the event of a cardiac arrest being identified help must be summoned immediately; individuals must shout for help in the first instance.

6.4.3 For ALL Local Division inpatient sites (except those located on the Aintree Site) - an emergency response will be summoned using (9)999.

6.4.4 For services located on the Aintree Site

- Windsor Clinic - an emergency response will be summoning the emergency service by IMMEDIATELY ringing 2222 to summons the Medical Emergency Team at Aintree and then IMMEDIATELY after summoning the emergency services using (9)999.
- Brain Injury Unit – an emergency response will be summoning the emergency service by IMMEDIATELY using the ‘Emergency Phone’ 4444. The Medical Emergency Team (MET) will respond to assess the situation and advice on further action to be taken.

6.4.5 All community hubs have access to an AED – emergency response will be summoning immediately the emergency services (9) 999.

6.5 SPECIALIST LEARNING DISABILITIES DIVISION

6.5.1 Designated first responders are based at Woodview, West Drive, Maplewood, Health Centre, and include all onsite Doctors. The yellow blicks are carried by trained staff in these areas and by all onsite Doctors. Location of the Green Lifeline Pro bags and AED’s are contained in Appendix 2.

- Staff must dial 2222 and ask reception to activate the first responders and summon the emergency services.
6.6 Designated trust premises will be equipped with appropriate resuscitation equipment (see Appendix 1 Local/Secure Division, Appendix 2a,b – Specialist Learning Disability Services).

6.7 Any occurrences of cardiac or respiratory arrest should be reported as adverse incidents.

6.8 EQUIPMENT

6.8.1 Within all clinical areas the exact location of the Resuscitation equipment (Responder Bags and AED’s) must be known to all members of staff and signs must be displayed detailing the location of AED’s.

6.8.2 Equipment checklists (appendix 1/2a,b,c,d,e) must be located with each individual Responder Bag.

6.8.3 All Trust sites that hold equipment used for resuscitation must have spare equipment available at all times.

6.8.4 In the event of a Responder Bag being used/seat broke (Local and Secure Division)

- During office hours - the Divisional Contact responsible for Resuscitation must be contacted to arrange replacement and re-sealing of the bag
- Out of hours – staff must contact Bronze on Call. Spare bags are held at Rathbone Rehabilitation Unit and Boothroyd Ward. Bronze on Call will be responsible for notifying the Divisional Lead (Local Division) / Health Centre (for Secure Division) who will replenish equipment the next working day.

6.8.5 In the event of a Responder Bag being used in Specialist Learning Disability Services

- During office hours it is the responsibility of the user to replace the item from the Health Centre
- Out of hours – the bag must be taken to the Health Centre and exchanged for the Health Centres green lifeline pro bag. The green lifeline pro bag must be left on the floor at the resuscitation station of the Health Centre. If there is a bag already there then the clinical lead must be contacted to obtain the Health Centre keys to replenish the utilised items.

6.8.6 In the event of Emergency Drugs and/or Intravenous Fluid being used please contact Pharmacy (24 hours) who will arrange for replacement.

6.9 AUTOMATED EXTERNAL DEFIBRILLATOR (AED’s)

6.9.1 A visual daily check of AED’s must be undertaken, documented, dated and signed for in the AED checking book.
6.9.2 In the event of an AED malfunctioning, staff must IMMEDIATELY contact the Divisional Contact/Health Centre who will arrange for a replacement.

6.10 UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION PROCEDURE (SEE APPENDIX 6)

Link to DNACPR Policy

6.10.1 All Divisions – A regional unified Do Not Attempt Cardiopulmonary Resuscitation (Lilac Form) must be completed and stored in the patients hand held paper notes along with one of the white carbonated copy forms. Once completed the electronic copy must be also completed either via EPEX or PACIS.

6.10.2 All Divisions – The patient, or where the patients lacks capacity, their relevant others must be given a copy of the DNACPR leaflet.

6.10.3 All Divisions – For any patient discharged/transferred from Mersey Care NHS Foundation Trust, the Lilac form must remain with the patient and the continuing care provider should be informed of the DNACPR status. The white carbon copy form will remain in the patients hand held paper notes as evidence of the decision having been in place during the patient’s admission.

6.10.4 All Divisions – Where a patients is admitted with Lilac form, this should be reviewed by the patients consultant and where it is felt appropriate that the DNACPR status remains, the form should be held in the patients hand held paper records and the electronic copy completed via either EPEX or PACIS.

6.10.5 Local Division, Medium and Low Secure Services - Do Not Attempt Cardiopulmonary Resuscitation forms can be located in EPEX.

6.10.6 High Secure Services – Do Not Attempt Cardiopulmonary Resuscitation forms can be located in PACIS within Documents Templates- Physical Health Care and Wellbeing.

6.10.7 Specialist Learning Disability Services – will print the relevant pages from the DNACPR Policy and kept in a file.

6.10.8 All Divisions – Once a DNACPR order has been instigated, or the patient is admitted to the Trust with such and order, then a Datix (Ulysses for SpLDD) needs to be completed. Once received the Trust Resuscitation Service will attend the unit and audit the form.

7. CONSULTATION

The following were consulted within the development of this policy

- Medical Staff
- Chief Operating Officers
- Executive Director of Nursing
- Head of Learning and Development
8. TRAINING AND SUPPORT

Training will be offered and should be agreed and planned in line with the information and course booking process found within the annual Learning & Development Prospectus. The training should be agreed annually with staff during their Personal Achievement and Contribution Evaluation (PACE) meeting.

9. MONITORING

A bi-annual audit of compliance to be undertaken on a 10% sample of DNACPR orders, using the associated audit tool (appendix 4) which will be submitted to the Trust’s Audit Committee and Resuscitation Committee.

10. EQUALITY AND HUMAN RIGHTS ANALYSIS

The Trust understands it’s responsibilities in relation to the Human Rights Act 1998 in relation to articles 2 and 3.

11. SUPPORTING DOCUMENTS


Resuscitation Council (UK) 2014, Minimum equipment and drug lists for cardiopulmonary resuscitation; Mental health- Inpatient care. RC(UK) London

Resuscitation Council (UK) 2014, Quality Standards for cardiopulmonary resuscitation practice and training for mental health inpatient settings. RC(UK) London

Mersey Care NHSFT Learning and Development Prospectus.
APPENDIX 1a - Local Division ONLY

First Responder Bag: Contents

First Responder Bag - back pack red

Front pocket
- Defibrillator
- 2 sets of pads
- Checking book

Attached to the bag - Sharps Bin

Middle Pocket – Green Emergency Drugs Bag (sealed)
- Adrenaline 1:10,000 (1mg in 10ml) x 4
- Atropine 1mg in 5ml (5ml syringe) x 1
- Amiodarone 30mg in 1ml (10ml syringe) x 1
- Flumazenil 100mcg in 1ml (5ml ampoule) x 5
- Adrenaline 1:1,000 (1mg in 1ml) x 2
- GTN Pump Spray (400mcg / dose) x 1
- Aspirin 300mg Disp Tablets 32 Tablet pack x 1
- Naloxone Mini Jet (400mcg in 1ml x 5)
- Sodium Chloride 0.9% w/v (5ml plastic amps) x 4

Ampoules or Mini Jets may be supplied according to availability

Main body of bag (sealed)
- Sodium Chloride 0.9% w/v (1000ml bag) x 2
- 1 Ambu Bag with Tubing and Mask
- 1 Geudel Airway size 2 (green)
- 1 Geudel Airway size 3 (orange)
- 1 Geudel Airway size 4 (red)
- 1 Nasopharyngeal Airway size 6
- 1 Nasopharyngeal Airway size 7
- 2 Sachets of Lubricating Gel for Nasopharyngeal Airway Insertion
- 4 IV Dressings
- 1 Pair Scissors
- 3 Purple Examination Gloves
- 1 Sphygmomanometer
- 2 Laerdal Pocket Mask & Filter
- 3 Disposable Tourniquet
- 1 Stethoscope
- 2 Non Rebreathing High Concentration Oxygen Masks with Bag and Tubing
- 1.3mtrs Oxygen Bubble Tubing - green
- 1 Handheld Portable Suction with Yankauer Catheter
- Cannulas - size14g (orange), 16g (grey), 18g (green), 20g (pink) three of each
- 3 Chlora Prep Skin Applicators
- IV Giving Sets
Appendix 1b - Secure Division ONLY

First Responder Bag: Contents

Front pocket
- Defibrillator
- 2 sets of pads
- Checking book

Attached to the bag - Sharps Bin

Main body of bag (sealed)
- Sodium Chloride 0.9% w/v (1000ml bag) x 2
- 1 Ambu Bag with Tubing and Mask
- 1 Geudel Airway size 2 (green)
- 1 Geudel Airway size 3 (orange)
- 1 Geudel Airway size 4 (red)
- 1 Nasopharyngeal Airway size 6
- 1 Nasopharyngeal Airway size 7
- 2 Sachets of Lubricating Gel for Nasopharyngeal Airway Insertion
- 4 IV Dressings
- 1 Pair Scissors
- 3 Purple Examination Gloves
- 1 Sphygmomanometer
- 2 Laerdal Pocket Mask & Filter
- 3 Disposable Tourniquet
- 1 Stethoscope
- 2 Non Rebreathing High Concentration Oxygen Masks with Bag and Tubing
- 1.3mtrs Oxygen Bubble Tubing - green
- 1 Handheld Portable Suction with Yankauer Catheter
- Cannulas - size14g (orange), 16g (grey), 18g (green), 20g (pink) three of each
- 3 Chlora Prep Skin Applicators
- IV Giving Sets

Green Emergency Drugs Bag (sealed) in main body of the bag
- Adrenaline 1:10,000 (1mg in 10ml) x 4
- Atropine 1mg in 5ml (5ml syringe) x 1
- Amiodarone 30mg in 1ml (10ml syringe) x 1
- Flumazenil 100mcg in 1 ml (5ml ampoule) x 5
- Adrenaline 1:1,000 (1mg in 1ml) x 2
- GTN Pump Spray (400mcg / dose) x 1
- Aspirin 300mg Disp Tablets 32 Tablet pack x 1
- Naloxone Mini Jet (400mcg in 1ml x 5)
- High Secure Only – 4 x 5 ml Sodium Chloride 0.9% ampoules
Ampoules or Mini Jets may be supplied according to availability
APPENDIX 2a - Specialist Learning Disability Services ONLY

Lifeline Pro (green bag): (see appendix for pictorial examples)

Main body of bag
- Oxygen cylinder
- 1 Bag / Valve / Mask + tubing
- 1 Geudel Airway size medium
- 1 Geudel Airway size large
- 1 Geudel Airway size extra large
- 1 Nasopharyngeal Airway 6mm
- 1 Nasopharyngeal Airway 7mm
- 1 Nasopharyngeal Airway 8mm
- 2 Sachets of water based gel
- 1 non-rebreathing masks with bag and tubing
- 1 battery operated aspirator with long and short nose canister
- Suction tubing
- Suction spoon
- Pulse oximeter
- Pen torch
- McGill forceps
- Tongue depressor

Contents of LifePak CR plus Automated External Defibrillator (AED)
- AED pads in device
- Spare pads in lid of protective cover of device

Contents of AED pouch attached to AED device
- Tuff cut scissors
- Towelette
- Razor
- Pocket mask
- 2 pairs of gloves

Orange Emergency Drug Box
- 2 Adrenaline 300mcg/0.3ml syringe IMI
- 5 Chlorphenamine 10mg/ml IMI
- Hydrocortisone sodium phosphate 100mg/ml IMI
- 1 box of 32 Asprin 300mg dispersible tablet
- 2 Naloxone 400 microgram/1ml minijet IMI
- 1 box 4 Midazolam 10mg/2ml buccal administration
- Glucagon 1mg IMI or subcutaneous injection
- Glyceryl Trinitrate spray 400micrograms/metered dose

Equipment within Orange Emergency Drug Box
• 2 x 2.5 ml luer lock syringe
• 5 Green safety needles 21 ga x 1.5 inch (0.8mm x 38.1mm)
• 5 Blue safety needles 23 ga x 1 inch (0.6mm x 25.4mm)
• 2 Gauze swabs 5cm
• 1 ALS Algorithm

**Location of Green Lifeline Pro bags and Automated External Defibrillators**
Scott House
Gisburn Lodge
Lancaster Daisy bank and North Lodge
Ravenswood
Pendle Drive
St Luke’s gym
Maplewood 1
Maplewood 2
3 West Drive
4 West Drive
PMVA Suite
Trust Office
Health Centre
Woodview Reception (Bank End Barn equipment is also maintained in reception)
2 Woodview

**Location of the orange Emergency Drug Boxes**
Ravenswood
Maplewood
Woodview
West Drive
Gisburn Lodge
Health Centre
Scott House
Appendix 2b - Specialist Learning Disability Services ONLY

Contents of the green Lifeline pro bag

Lifeline pro bag

Oxygen Cylinder

Bag valve and mask

Non re-breather mask
3 OP airways size
Medium, large and extra large

3 NP airways size 6, 7 and 8 mm

2 i-gels size 4 and size 5

Suction device with long nose canister
usually fitted (unless used) and short nose canister as a spare

Suction tubing as attached on photo above
Suction spoon
Pulse oximeter

Pen torch

Lubricant

McGill forceps

Tongue depressor
Contents of the AED device

AED pads in device

spare AED pads in lid of the protective cover

Contents of the AED pouch attached To the AED device

Tuff cut scissors in pouch
Towlette in pouch

Razor in pouch

Pocket mask in pouch
### RESUSCITATION EQUIPMENT PROMPT

All equipment to be checked monthly for expiry dates, calibration and serviceability by the area AED instructor

Name ___________________________ Date ___________________ Signature ___________________________

Please ensure the bag valve, mask and tubing correctly attach to the oxygen cylinder. Please report any damage or concerns to the Clinical Team Leader in the Health Centre

<table>
<thead>
<tr>
<th>Month</th>
<th>AED Daily</th>
<th>Oxygen Weekly</th>
<th>Pen torch Weekly</th>
<th>Pulse Oximeter Weekly</th>
<th>Aspirator Daily</th>
<th>Fault</th>
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<th>Initials</th>
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Once a month the equipment will be checked by the area AED Instructor (add name) for faults and expiry dates

Completed prompt sheets will be checked by the area AED Instructor and then forwarded to the Practice Educator
### Appendix 2d - Specialist Learning Disability Services Only

#### Monthly Equipment and Emergency Drug box checklist

<table>
<thead>
<tr>
<th>Masks</th>
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<th>Expiry date</th>
<th>Suction</th>
<th>Expiry date</th>
<th>Oxygen cylinder</th>
<th>Expiry Calibration date</th>
<th>AED device</th>
<th>x √</th>
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<td>Non re-breather mask</td>
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<td>Long nose canister present</td>
<td>Pulse oximeter</td>
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<td>AED pads in device</td>
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<td>Comments/issues</td>
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<td>OP airway extra large</td>
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<td>Short nose canister present</td>
<td>Pen torch</td>
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<td></td>
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<td></td>
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<td>NP airway size 6</td>
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<td>Suction tubing present</td>
<td>Lubricant</td>
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<td>Tuff cut scissors</td>
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<td>NP airway size 7</td>
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<td>Emergency Drug Box</td>
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<td>Gloves 2 pair</td>
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**Name of person completing form**

**Signature**

**Date**
MEWS PROCEDURE

PROCEDURE STATEMENT:

This procedure applies to all adult inpatients (over 16 years) under the care of Mersey Care NHS Foundation Trust in inpatient areas that have received training.

ACCOUNTABLE
DIRECTOR: Executive Director of Nursing and High Secure

PROCEDURE AUTHOR: Modern Matron for Physical Health
1. Executive Summary and Introduction

Numerous national reports have advocated the use of so-called early warning scores to efficiently identify and respond to service users who present with, or develop, acute physical illness. This is the case for service users in psychiatric settings presenting with physical illness where the Modified Early Warning Score (MEWS) is advocated.

Early warning scoring systems were originally developed with two specific aims:
- To facilitate timely recognition of service users with established or impending critical illness
- To empower nurses and medical staff to secure experienced help through the operation of a trigger threshold which, if reached, required mandatory attendance by a more senior member of staff within a set period of time

Use of MEWS can also:
- Improve the quality of service user’s observation and monitoring
- Improve communication within the multi-disciplinary team
- Allow for timely transfer to Acute assessment units
- Aid in securing appropriate assistance for the clinically deteriorating service user
- Give a good indication of physiological trends
- Be a sensitive indicator of abnormal physiology

**N.B: Staff must understand that MEWS is not a replacement for clinical judgement**

This document sets out the actions that staff need to take to ensure that thorough physical health assessment is conducted following admission, when service users become physically unwell, have an altered level of consciousness, head injury or suspected head injury, to ensure appropriate action is taken.

Thorough physical and neurological assessment following admission is also completed to enable clinical staff to have baseline measures to support them managing a service user in physical health deterioration or crisis. It is necessary for staff to have competent physical and neurological observation assessment skills in order to carry out these assessments completely.

### 2. Version control

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<tr>
<th>Version</th>
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<th>Author</th>
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<th>Ratified by</th>
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<td>Modern Matron Physical Health</td>
<td>Reviewed by Dr Allington Reviewed by J Scoltock</td>
<td>Policy review Group (on behalf of Quality Assurance Committee).</td>
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</tbody>
</table>

### 3. Purpose

The purpose of this procedure is to improve service user’s outcomes by detecting and acting upon early warning signs of physical health deterioration. Use of the MEWS will help clinical staff to:
- comprehensively assess a service user’s physical health status on admission
- to decide whether to call a doctor or emergency services for service users who have a sudden or deteriorating illness.
- to observe for change in the patient’s vital signs monitoring during and after the process of restraint and rapid tranquillisation for any changes that might indicate physical health deterioration. Remember, changes in the patient’s respirations and pulse are early indicators of physical health deterioration. If there is difficulty
obtaining a full set of vital signs during the restraint period and after, ensure the vital signs that can be obtained are documented and if the observations are unobtainable, accurately document as refused.

- ensure that service users are assessed for signs of physical health deterioration in the period following admission
- ensure that service users who become physically unwell receive appropriate assessment, review and treatment maximising their chances of survival
- identify trends in service user psychological observations
- support timely transfer to Acute trust services

4. What is MEWS?

The Modified Early Warning Score (MEWS) is a track and trigger scoring system. The triggers are based on routine physical observations and are sensitive enough to detect changes in a service user’s physiology which will be reflected in a change of score should the service user’s physical health improve or deteriorate.

MEWS is based on a simple scoring system in which a score is allocated to physiological measurements. Six physiological parameters from the basis of the scoring system:

- Pulse
- Respiratory rate
- Temperature
- Blood Pressure
- Conscious state (AVPU)
- Oxygen saturation

The MEWS evidence-base **does not apply to children** – therefore this guidance is only applicable to adults and older people.

5. When to use MEWS

All service users who are admitted to an inpatient ward must have the six parameters recorded and these converted into a score for each parameter and then added up to a total MEWS score as a baseline within **6 hours of admission**. If completion of assessment has not taken place within **6 hours you must** document and date each attempt, and reasons why the assessment was not completed within the time period.

Thereafter, the six parameters must be recorded and these converted into individual scores and then a total score **twice daily on the morning shift and after 7pm for**
72hrs then reviewed with the medical team who will set frequency of observations taken. As a minimum the same observations should be recorded weekly, but where clinically indicated, should be recorded on an on-going basis.

All adult inpatients including those deemed medically fit or in a rehabilitation environment must have observations taken weekly as a minimum, unless a decision has been made at a senior level to increase or reduce the frequency for an individual group of patients.

Any alteration to the minimum standards must be documented in the clinical notes.

The higher the score the more abnormal the physiological observations. If the score reaches a certain threshold the senior nurse must be informed. If the threshold reaches a MEWS score of 4 or more the nurse in charge must be informed and a doctor contacted to further assess the patient.

If the service user refuses vital signs observations to be taken, this should be documented as an ‘R’ and must be recorded on every attempt. From the point that the service user then co-operates the initial 72hr period of twice daily monitoring should be commenced. The code ‘A’ should be used to record when a service user is absent, off the ward or on leave. When the service user returns to the ward monitoring should then be continued.

The score is primarily designed to be used over a period of time at regular intervals and upon a significant change in the service users physiological observations. So after the 72 hour period following admission where there are concerns that a service user is unwell, the MEWS observations are carried out and the results used to gauge the severity of the deterioration as indicated. Other information such as blood sugar, urinary output may also need to be considered.

MEWS assessment must be recommenced immediately in the following situations:

The service user appears to be physically unwell.
The service user has fallen.
The service user has altered levels of consciousness e.g. head injury.
The service user is intoxicated with alcohol or drugs.
The service user is not responding to requests as expected.
The service user is commencing new medication that may affect physical health.

Previous recording will provide a baseline from which the new observations can be compared and thus provide important information on how the physical state of the service user has changed. The frequency and specifications of all baseline observations should be prescribed in the nursing care plan. It may also be necessary to assess a service user using the MEWS score prior to transferring them to external healthcare provider.

6. Recording Observation on the chart
The Trust has a standard Physical Observation Chart incorporating MEWS for use across Local Division MH and LD services for service users aged 16 and over. This replaces all other temperature, pulse and Blood Pressure recording charts (these charts are available to inpatient areas that have undergone MEWS training via the Executive Nursing Office at V7).

A refusal should be recorded as ‘R’, where a service user is absent it should be recorded as ‘A’.

Where a mistake is made in recording – ‘error’ should be written along the column and the values re-entered on the next column.

Once you have measured the observations the results need to be entered on to the chart carefully and clearly. Use only black ink, preferably with a biro pen. Pencil entries can be erased and other form of ink are more liable to run if anything is inadvertently spilled on the chart during use.

The way that most observations are written is illustrated in table one below. This shows a snapshot of a section for recording the temperature and the blood pressure. The temperature, pulse and respirations measurements are shown as black dots. A connecting line must be drawn between each value to help show the trends. For oxygen saturations the actual percentage value must be written. For AVPU the initial for the consciousness level i.e. AVP or U must be recorded.

For the blood pressure the values are marked with arrow heads. A dashed line is drawn between the cross and arrowhead.

Values should be recorded on the chart where they reach a value that would generate a score.
### PHYSICAL OBSERVATION CHARTS & Modified Early Warning Scoring System (MEWS)

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<tbody>
<tr>
<td>97-100</td>
<td>0</td>
</tr>
<tr>
<td>94-96</td>
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<td>&lt; 93</td>
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<table>
<thead>
<tr>
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<th>MEWS</th>
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</thead>
<tbody>
<tr>
<td>Alert</td>
<td>A</td>
</tr>
<tr>
<td>Voice</td>
<td>V</td>
</tr>
<tr>
<td>Pain</td>
<td>P</td>
</tr>
<tr>
<td>Unresponsive</td>
<td>U</td>
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Trigger scores
Pathway Early Warning Scoring System for Adult Service Users

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<tbody>
<tr>
<td>Temperature (Celsius)</td>
<td>&lt;34.9</td>
<td>35-36</td>
<td>36.1-37.4</td>
<td>37.5-38</td>
<td>&gt;38</td>
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<tr>
<td>Blood Pressure (Systolic)</td>
<td>&lt;79</td>
<td>80-99</td>
<td>100-139</td>
<td>140-169</td>
<td>170-199</td>
<td>&gt;200</td>
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<tr>
<td>Blood Pressure (Diastolic)</td>
<td>&lt;49</td>
<td>50-59</td>
<td>60-89</td>
<td>90-99</td>
<td>&gt;100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td>&lt;49</td>
<td>50-59</td>
<td>60-99</td>
<td>100-109</td>
<td>110-119</td>
<td>&gt;120</td>
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<tr>
<td>Respiratory Rate</td>
<td>&lt;8</td>
<td>9</td>
<td>10-11</td>
<td>12-20</td>
<td>21-29</td>
<td>&gt;30</td>
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<tr>
<td>Pulse Oximetry Saturation (%)</td>
<td>&lt;93%</td>
<td>&gt;93%</td>
<td>&gt;94-100%</td>
<td>&gt;100%</td>
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<tr>
<td>Conscious Level</td>
<td>Alert</td>
<td>V Voice</td>
<td>P Pain</td>
<td>U Unresponsive</td>
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</table>

ACTION PROTOCOL
The MEWS and action protocol have been designed to assist in identifying potential physical deterioration of the patient and acts as a trigger to ensure that appropriate interventions and management are commenced as soon as possible. Staff should always use their clinical judgement and seek advice from senior nursing/medical colleagues if there are any concerns about a patient, regardless of the calculated score.

Scores of 2 should be escalated to the shift co-ordinator

Single scores of 3 or combined scores of 4 and above should be escalated to medical team for assessment and recommendations regarding the patient’s treatment and care.

- **Total Score 0-1**
  - Yes
  - Continue observations as before and inform shift co-ordinator

- **Total Score 2-3**
  - Yes (and no single parameter score 3)
  - Inform shift co-ordinator immediately.
  - Shift Co-ordinator to review patient and decide on either the frequency of observation or to contact medical team.

- **Total Score 4 or above**
  - Yes (or any single parameter score 3)
  - Inform medical staff of patient deterioration, report, document and monitor observations every 15 minutes.
  - Medical staff to assess patient within 30 minutes. In the event of further deterioration or medical staff unable to attend phone (9)999

**N.B. A failure to attend a MEWS call within an acceptable timescale (<30 minutes)**
should result in the completion of an incident form.

A MEWS action plan must be agreed and documented for any service user reviewed.

Duties

The Trust will provide Modified Early Warning Scores training for all clinical staff. It will also investigate incidents that arise from situations that require medical emergencies.

The Medical Devices Committee will make recommendations to clinical staff and directorates on the standardisation of emergency medical equipment throughout the Trust and develop systems in which this can be implemented. They will also monitor incidents relating to medical devices and produce an annual summary of adverse incidents occurring with medical devices to the Trust’s Health and Safety Committee. The committee will also standardise equipment across the Trust and will make recommendations from local audits and national enquiries.

Team/Ward Managers
Will ensure that all staff responsible for recording physical observations have completed their MEWS training and that its use is implemented within their clinical area.

All registered nursing and medical staff will attend training in the Modified Early Warning Scoring system (MEWS) to recognise the deteriorating patient. They will ensure that high early warning scores are escalated appropriately in line with the Early Warning Scores protocol.

Scope

All staff are to apply the Modified Early Warning Scores (MEWS) system when patient observations are taken. It does not apply to children or young adults under the age of 16 years. It ONLY applies to people who are current in-patients in Mersey Care NHS Foundation Trust.

Monitoring compliance

<p>| Minimum requirements to be monitored | Process for monitoring e.g. audit | Responsible individual, group or committee | Frequency of monitoring | Responsible individual, group or committee for review of results | Responsible individual, group or committee for development of action plan | Responsible individual, group or committee for monitoring of action plan |</p>
<table>
<thead>
<tr>
<th>Annual</th>
<th>An audit of implementation of MEWS to be undertaken</th>
<th>Modern Matrons</th>
<th>Bi Monthly</th>
<th>Trust Physical Health Strategy Group</th>
<th>Trust Physical Health Strategy Group</th>
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<td>Trust Physical Health Strategy Group</td>
<td>Trust Physical Health Strategy Group</td>
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</table>
References

Royal College of Physicians (2012), National Early Warning Score (NEWS), Standardising the assessment of acute illness severity in the NHS.


South Maudsley NHS Foundation Trust (October 2010), Cardio- Pulmonary Resuscitation Policy.

Healthcare Quality Improvement Partnership (July 2012), Multi-site audit of MEWS Implementation across Mental Health Trusts and Development of a Failure to Rescue Indicator in Mental Health.

Associated documents (Mersey Care NHS Foundation Trust)

Medical Devices Policy SA19
Rapid Tranquilisation Policy SD11
Resuscitation Policy SD07
Physical Health Policy SD29
Mental Capacity Policy MC01/02/03/04
Infection Prevention and Control Policy IC
Appendix 1  LOCAL DIVISION USER ONLY
PHYSICAL OBSERVATION CHARTS & Modified Early Warning Scoring System (MEWS)

<table>
<thead>
<tr>
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<td>40 3</td>
</tr>
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<td>39 3</td>
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Temperature (36.1-37.4°C)

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Systolic Blood Pressure (90-139)

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<td>50</td>
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Diastolic Blood Pressure (60-89)

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Pulse (60-99)

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Respirations (12-20)

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<td>17-20</td>
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SPO²

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<td></td>
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<td>94-96</td>
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Conscious level

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<tr>
<td></td>
<td>11.1.14</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Alert A A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Voice V</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pain P</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unresponsive U</td>
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</table>
### TO BE USED BY SECURE DIVISION ONLY

<table>
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<th>Score</th>
<th>3</th>
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<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>Pulse Per Minute</td>
<td>40 or below</td>
<td>41-50</td>
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<td>91-110</td>
<td>111-130</td>
<td>131 or above</td>
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</tr>
<tr>
<td>Resp Per minute</td>
<td>8 or below</td>
<td>9-11</td>
<td>12-20</td>
<td>21-24</td>
<td>25 or above</td>
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<tr>
<td>Temp °C</td>
<td>35 or below</td>
<td>35.1-36</td>
<td>36.1-38</td>
<td>38.1-39</td>
<td>Greater than 39.1</td>
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<tr>
<td>Systolic BP</td>
<td>90 or below</td>
<td>91-100</td>
<td>101-110</td>
<td>111-129</td>
<td>220 or above</td>
<td></td>
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<tr>
<td>Oxygen Saturation (%)</td>
<td>91 or below</td>
<td>92-93</td>
<td>94-95</td>
<td>96 or above</td>
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<tr>
<td>Inspired oxygen</td>
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<td>NO</td>
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<tr>
<td>AVPU</td>
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<td>Voice (v) Pain (P) Unresponsive (U)</td>
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**AN EARLY WARNING SCORE OF 3 ON ANY SINGLE PARAMETER MUST BE REPORTED TO A DOCTOR/NURSE PRACTITIONER**
# MEWS Assessment Tool

### SCOTT CLINIC / LSU

<table>
<thead>
<tr>
<th>0-3 (GREEN)</th>
<th>0-3 or patients causing concern (AMBER)</th>
<th>6 or above (RED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm score</td>
<td>Confirm score</td>
<td>Immediate Transfer to Hospital via 999 Ambulance</td>
</tr>
<tr>
<td>In hours: contact emergency co-ordinator Ward Doctor</td>
<td>Out of hours: contact Bronze on call</td>
<td>IMMEDIATE TRANSFER TO HOSPITAL VIA 999 AMBULANCE</td>
</tr>
<tr>
<td>Repeat review by Doctor if Early Warning Score remains above 4 or is increasing</td>
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ROUTINE PHYSICAL OBSERVATIONS  
HOURLY OBSERVATIONS

**AN EARLY WARNING SCORE OF 3 ON ANY SINGLE PARAMETER MUST BE REPORTED TO A DOCTOR**

### HIGH SECURE

<table>
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<th>6 or above (RED)</th>
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<tbody>
<tr>
<td>Confirm score</td>
<td>Confirm score</td>
<td></td>
</tr>
<tr>
<td>In hours: contact emergency co-ordinator Ward Doctor</td>
<td>Out of hours: contact Bronze on call</td>
<td>IMMEDIATE TRANSFER TO HOSPITAL VIA 999 AMBULANCE</td>
</tr>
<tr>
<td>Repeat review by Doctor if Early Warning Score remains above 4 or is increasing</td>
<td>3333 IMMEDIATE TRANSFER TO HOSPITAL VIA 999 AMBULANCE</td>
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ROUTINE PHYSICAL OBSERVATIONS  
HOURLY OBSERVATIONS

**AN EARLY WARNING SCORE OF 3 ON ANY SINGLE PARAMETER MUST BE REPORTED TO A DOCTOR**
### Routine Monthly Health Checks – Form A2

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<tbody>
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<td>Hospital No:</td>
</tr>
<tr>
<td>Ward:</td>
<td>Date:</td>
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</table>

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Baseline</th>
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<td>Pulse</td>
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<tr>
<td>Respirations</td>
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<tr>
<td>Temperature</td>
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<tr>
<td>Blood Pressure</td>
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<td></td>
</tr>
<tr>
<td>Oxygen saturation (%)</td>
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<tr>
<td>Inspired oxygen</td>
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<tr>
<td>AVPU</td>
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<td>MEWS</td>
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<tr>
<td>MUST Score / Care Plan</td>
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<td>BMI</td>
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<td>Waist circumference</td>
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<tr>
<td>Healthy eating discussed</td>
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<td></td>
</tr>
<tr>
<td>Physical activity discussed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any abnormalities should be reported to the Health Centre for example:
- BP > 140/90; 130/80 (if diabetic); Pulse > 100; Oxygen saturation below 96%; BMI < 20 or >27 refer to Dietician and follow MUST Care Plan; Waist circumference >102 cm
- >3kg weight gain over 3m period

It is good practice to discuss Diet and Physical Activity, record ‘YES’ or ‘NO’ to indicate this occurred and enter details on PACIS
Appendix 4

Early Warning Systems in Place for the Recognition of Patients at Risk of Cardio-respiratory Arrest

Signs and Symptoms of Cardiac Arrest

- Unconscious
- Unresponsive
- Not breathing normally (agonal breathing, gasping or respirations of less than 2 in 10 seconds are abnormal respiratory patterns and will not sustain life).

At this point emergency help is required. **Ring the following:**

- **High Secure Services** an emergency response will be summoned using 3333.
- **Medium and Low Secure Services** an emergency response will be summoned using (9)999
- **ALL Local Division sites (except those located on the Aintree Site)** - an emergency response will be summoned using (9)999.
  - For services located on the Aintree Site
- **Windsor Clinic** - an emergency response will be summoning the emergency service by IMMEDIATELY ringing 2222 to summons the Medical Emergency Team at Aintree and then IMMEDIATELY after summoning the emergency services using (9)999.
- **Brain Injury Unit** – an emergency response will be summoning the emergency service by IMMEDIATELY using the ‘Emergency Phone’ 4444. The Medical Emergency Team (MET) will respond to assess the situation and advice on further action to be taken.

- **Specialist Learning Disability Services** – Staff must dial 2222 and ask reception to activate the first responders and summon the emergency services

In inpatient areas, commence immediate cardio-respiratory resuscitation (BLS) and defibrillation if appropriately trained.

In community settings, commence immediate cardio-respiratory resuscitation (BLS).

**Signs and Symptoms of a Heart Attack**

- Persistent vice-like central pain often spreading to the jaw and down one or both arms
- Breathlessness but still breathing
- Discomfort occurring high in the abdomen which may feel similar to indigestion
- Collapse often without warning
  - Sudden faintness or dizziness
  - Patient feels a sense of impending doom
  - Ashen skin and blueness at the lips
  - A rapid weak or irregular pulse
  - Profuse sweating
  - Extreme gasping for air
Immediate Actions if you suspect a Heart Attack

Make the casualty as comfortable as possible to ease the strain on their heart. A half-sitting position with their head and shoulders supported and their knees bent is often best. Place cushions behind and under knees of the casualty.

1. Summons help as above.
2. Tell the response team (Reception staff) if at Specialist learning Disability Division) that you suspect a heart attack.
3. Assist the casualty to take one full dose of aspirin tablet (300mg in total). Advise them to chew it slowly.
4. If the casualty has angina medication such as tablets or a pump-action aerosol spray, let them administer it – help them if necessary. Encourage them to rest.
5. Monitor and record vital signs – level of response breathing and pulse, while waiting for the help to arrive.
6. Avoid undue stress by staying calm.
7. Appendix 5

Signs and Symptoms of Opiate Overdose

- Nausea and vomiting
- Reduced heart rate
- Pin point pupils (Not universal especially in children)
- Drowsiness
- Cold clammy bluish skin
- Bradycardia and hypertensive
- Respiratory depression/apnoea with a pulse.

Large Dose

- Breathlessness
- Respiratory depression/apnoea
- Pulmonary Oedema
- Convulsions due to hypoxia
- Respiratory arrest with pulse
- Death

Action

- High Secure Services an emergency response will be summoned using 3333.
- Medium and Low Secure Services an emergency response will be summoned using (9)999
- ALL Local Division sites (except those located on the Aintree Site) - an emergency response will be summoned using (9)999.
  - For services located on the Aintree Site
- Windsor Clinic - an emergency response will be summoning the emergency service by IMMEDIATELY ringing 2222 to summons the Medical Emergency Team at Aintree and then IMMEDIATELY after summoning the emergency services using (9)999.
- Brain Injury Unit – an emergency response will be summoning the emergency service by IMMEDIATELY using the 'Emergency Phone' 4444. The Medical Emergency Team (MET) will respond to assess the situation and advice on further action to be taken.
- Specialist Learning Disability Services – Staff must dial 2222 and ask reception to activate the first responders and summon the emergency services
- Ensure patient has their physical observations/vital signs monitored as per MEWS procedure
- Ensure emergency equipment is made available (In-patient areas only)
- Contact the bleep holder / line manager
Unified
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
Adult Policy
## CHANGE RECORD FORM

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<th>Date of Release</th>
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<td></td>
<td>Steve Barnard</td>
<td>Document development. Legal review and Approval of policy NHS England</td>
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<td>01/01/2013</td>
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<td>Maria Kane</td>
<td>Inclusion of Review date and Change control form for version control</td>
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1. INTRODUCTION

1.1 This policy must only be used by individuals who are trained and competent in the application of the Mental Capacity Act (2005) ("MCA") and in full accordance with organisational MCA policy and related guidance or procedures (Appendix 4).

1.2 The chance of survival following Cardiopulmonary Resuscitation (CPR) in adults is relatively low depending on the circumstances. Although CPR can be attempted on any person, there comes a time for some people when it is not appropriate to do this. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision to enable the person to die with dignity. This policy should be read and applied in conjunction with the MCA.

2. POLICY STATEMENT

The North West Unified DNACPR policy will ensure the following:

2.1 All people are presumed to be “For CPR” unless:

- A valid DNACPR decision has been made and documented or;
- A valid and applicable Advance Decision to Refuse Treatment (ADRT) prohibits CPR. (For further guidance see section 5.6)
- A personal welfare attorney ("PWA"), appointed by the patient to make life-sustaining treatment decisions when s/he lacks the capacity to do so themselves or has refused consent to CPR.

2.2 Please note if there is clear evidence of a recent verbal refusal of CPR whilst the person had capacity then this should be carefully considered when making a best interests decision. Good practice means that the verbal refusal should be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The person should be encouraged to make a written ADRT, complying with the requirements of the MCA, to ensure the verbal refusal is adhered to.

2.3 There will be some patients for whom attempting CPR is inappropriate; for example, a patient who is at the end stages of a terminal illness. In these circumstances CPR would not restart the heart and breathing of the individual, and should therefore not be attempted. The patient and/or relatives/carers should be informed of this.

2.4 All DNACPR decisions are based on current legislation and guidance.

2.5 In patients where cardiac arrest might be expected to occur and where it is expected that there is a reasonable chance of success of CPR then the patient should be asked whether they would want it to be performed. The patient may ask for family or friends to be involved in the decision.

2.6 If the patient lacks mental capacity to take part in the discussion and make decisions then the relatives, others close to the patient and recognised carers should be asked if the patient had made a previous decision about resuscitation. All discussion and
subsequent decisions should be accurately and clearly documented. Patients, family or friends have a right to refuse to take part in the discussions.

2.7 A standardised form for adult DNACPR decisions will be used (See Appendix 1).

2.8 Effective communication concerning the individual’s resuscitation status will occur among all members of the multidisciplinary healthcare team involved in their care and across the range of care settings. This should include carers and relatives where appropriate.

2.9 Patients have a right, under Article 8 of the European Convention on Human Rights, to have DNACPR decisions explained to them by care staff, and be consulted/informed about DNACPR decisions - the presumption lies in favour of patient involvement in these decisions. Clinicians have a legal duty to consult the patient. The fact that the patient may find the topic distressing is not a sufficient reason on its own to warrant their exclusion. Such exclusion will only be justified where there are reasonable grounds to believe that the discussion will cause the patient a degree of physical or psychological harm. Where this view is reached, clear and comprehensive reasons for excluding the patient from the discussions, and the decision to make a DNACPR order should be recorded.

2.10 Where a patient lacks capacity under the MCA to make decisions regarding DNACPR, there is a duty to consult with the patient’s family and those close to the patient, unless there is a good reason not to do so (e.g., the patient has previously, when he/she had capacity, requested that no such discussion take place). Where a patient who lacks capacity has no one close to them with whom health professionals can consult, and decisions are being made about serious medical treatment (such as the implementation of a DNACPR order), a referral should be made to the local Independent Mental Capacity Advocacy service for an IMCA to be appointed for the patient. In such cases, the role of the IMCA is to check that the best interests principle has been followed ensure that the person’s wishes and feelings have been appropriately considered and to seek a second opinion if necessary. The input of an IMCA may not be available immediately and, if urgent decisions are required to be made before the involvement of an IMCA can be arranged then they should be made in accordance with the patient’s best interests; the referral process should not prevent appropriate care planning taking place whilst the input of an IMCA is awaited. However, any decisions made prior to the IMCA’s involvement should be reviewed following receipt of the IMCA’s report. Information provided by the IMCA must be taken into account when considering a patient’s best interests.

2.11 DNACPR decisions should be subject to ongoing monitoring to ensure they remain appropriate – 
It is recommended that a review date be considered and entered on the DNACPR decision form if appropriate. It is important to note that a review date does not equate to an expiry date for ongoing decisions and remains clinically appropriate and valid. All reviews should be documented in the patient’s records. Reassessing the decision regularly does not mean burdening the patient and their family with repeated decisions, but it does require staff to be sensitive in recognising any change of views during discussions with the patient or their family.

2.12 The DNACPR decision-making process is measured, monitored and evaluated to ensure a robust governance framework.
2.13 Training at a local/regional level will be available to enable staff to meet the requirements of this policy.

2.14 This policy has been reviewed by NHS England (North) legal advisers to ensure it provides a robust framework underpinned by relevant national guidance and legislation. Organisations should also ensure the policy is reviewed by their local legal services.

3. PURPOSE

3.1 This policy will provide a framework to ensure that DNACPR decisions:

- Respect the wishes of the individual, where possible
- Reflect the best interests of the individual
- Provide benefits which are not outweighed by burden.

3.2 This policy will provide clear guidance for health and social care staff.

3.3 This policy will ensure that DNACPR decisions refer only to CPR and not to any other aspect of the individual’s care or treatment options.

4. SCOPE

4.1 This policy where adopted, applies to all of the multidisciplinary health, social and tertiary care teams involved in patient care across the range of settings within the North West area.

4.2 This policy is applicable to all individuals aged 18 and over.

4.3 This policy forms part of Advance Care Planning for patients and should work in conjunction with end of life care planning for individuals.

5. DEFINITIONS

5.1 **Cardiopulmonary resuscitation (CPR)** is an emergency procedure which may include chest compressions and ventilations in an attempt to maintain cerebral and myocardial perfusion, which follows recommended current Resuscitation Council (UK) guidelines.

5.2 **Cardiac Arrest (CA)** is the sudden cessation of mechanical 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.

5.3 **Respiratory Arrest** is the cessation of normal respiration due to failure of the lungs to contract effectively.

5.4 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. (See Mental Capacity guidance in Appendix 4)
5.5 **Mental Capacity:** An individual aged 16 (between 16-18 years are treated under the Children and Young person’s Advance Care Planning Policy) or over is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals will lack capacity if they are suffering from an impairment of, or disturbance in, the functioning of the mind or brain and are unable to demonstrate that they can do any of the following:

- understand information relevant to the decision provided to them in the most appropriate way for the individual; or
- retain that information for long enough to make a decision; or
- use or weigh that information as part of the process of making the decision; or
- communicate the decision, whether by talking or sign language or by any other means.

5.6 **Advance Decision to Refuse Treatment (ADRT):** The MCA provides the framework for people aged 18 or over to make an ADRT and confirms the requirements that must be met to ensure that it is valid and applicable. An ADRT is a decision by an individual to refuse a particular treatment in the future should they lose capacity to make the decision at that time. A valid and applicable ADRT is legally binding. In order for an ADRT relating to refusal of life-sustaining treatment, such as CPR, to be valid, it must: 1) be in writing; 2) be signed by the patient; 3) be witnessed and signed by the witness; and 4) include a statement that it is to apply even where the patient’s life is at risk. The clinical team must also be satisfied that there is no evidence that the patient has withdrawn their decision since making it or done anything clearly inconsistent with its terms.

5.7 **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)** refers to a decision not to make efforts to restart breathing and/or the heart in cases of respiratory/cardiac arrest. It does not refer to any other interventions, treatment and/or care such as fluid replacement, feeding, antibiotics etc.

5.8 **Lasting Power of Attorney (LPA):** The Mental Capacity Act (2005) allows people aged 18 years or over, who have capacity, to make a LPA by appointing a Personal Welfare Attorney (PWA) who can make decisions regarding health and wellbeing on their behalf once capacity is lost. Note – Not all PWAs have authority to make life-sustaining treatment decisions. All LPA documentation should be checked and, if in doubt, contact should be made with the Office of the Public Guardian to clarify the validity of the LPA.

- An attorney can only consent to or refuse life-sustaining treatment on behalf of the donor, if when making the LPA, the donor has specifically stated in the LPA document that they want the attorney to have this authority. (MCA Code of Practice, para 7.28)

5.9 **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. They must be consulted when a decision about either serious medical treatment or a long term move is being made.
5.10 A **Court Appointed Deputy** is appointed by the Court of Protection, to make decisions in the best interests of those who lack capacity but they cannot make decisions relating to life-sustaining treatment.

5.11 **Health and Social Care Staff**: Anyone who provides care, or who will have direct contact with a person within a health care setting. This includes domiciliary care staff.

5.12 In accordance with **The Mental Health Act (2007)** any Advanced Decision and LPA decisions are not binding if the treatment in question is authorised under Part 4 of the MHA.

### 6. LEGISLATION AND GUIDANCE

#### 6.1 Legislation

6.1.1 Health and social care staff are expected to understand how the MCA works in practice and the implications for each patient for whom a DNACPR decision has been made.

6.1.2 The following provision of the Human Rights Act 1998 are relevant to this policy:

- the individual’s right to life (article 2)
- to be free from inhuman or degrading treatment (article 3)
- respect for privacy and family life (article 8)
- freedom of expression, which includes the right to hold opinions and receive information (article 10)
- to be free from discriminatory practices in respect to those rights (article 14).

6.1.3 Clinicians have a professional duty to report some deaths to the Coroner and should be guided by local practice as to the circumstances in which to do so but must always report when the deceased has died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention.

   For more information see:
   Coroner, post-mortems and inquests: Directgov - Government, citizens and rights

6.1.4 Each organisation who implements this policy requires the completion of an Equality Impact Assessment (EIA), each organisation will need to carry out an EIA in line with their organisational policy.

#### 6.2 Guidance

6.2.1 The Resuscitation Council (UK):

- Recommended standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)
7. ROLES AND RESPONSIBILITIES

7.1 This policy and its forms/appendices are relevant to all health & social care staff across all sectors and settings of care including primary, secondary, independent, ambulance and voluntary. 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.

7.2 The decision to complete a DNACPR form should be made by a Consultant or General Practitioners.

7.3 Health and social care staff should encourage the individual or their representative, where able, to inform those looking after them that there is a valid documented DNACPR decision about themselves and where this can be found.

7.4 The Chief Executive of each organisation is responsible for:

- ensuring that this policy adheres to statutory requirements and professional guidance
- supporting unified policy development and the implementation in other organisations
- ensuring that the policy is monitored
- reviewing the policy, form and supporting documentation every two years
- compliance, both clinical and legal with the regional policy and procedure
- ensuring the policy is agreed and monitored by the organisation’s governance process

7.5 Directors or Managers responsible for the delivery of care must ensure that:

- staff are aware of the policy and how to access it
- the policy is implemented
- staff understand the importance of issues regarding DNACPR
- staff are trained and updated in managing DNACPR decisions
- the policy is audited and the audit details are fed back to a nominated Director
- DNACPR forms, leaflets and policy are available as required.

7.6 Consultants / General Practitioners making DNACPR decisions MUST:

- be competent to make the decision
- verify any decision made by a delegated professional at the earliest opportunity
- ensure the decision is documented (See 8.6)
- involve the individual, following best practice guidelines when making a decision, (See 8.4) and, if appropriate, involve relevant others in the discussion
- communicate the decision to other health and social care providers
- review the decision if necessary.

7.7 Health & social care staff delivering care must:
  - adhere to the policy and procedure
  - notify their line manager of any training needs
  - sensitively enquire as to the existence of a DNACPR or an ADRT
  - check the validity of any decision
  - notify other services of the DNACPR decision or an ADRT on the transfer of a person
  - participate in the audit process.

7.8 Ambulance staff must ensure they adhere to the policy including relevant organisational policies, procedures and guidance.

7.9 Commissioners and provider organisations must ensure:
  - that commissioned services implement and adhere to the policy and procedure as per local contracts
  - that pharmacists, dentists and others in similar health and social care occupations are aware of this policy
  - that DNACPR education and training is available and provided. This should be the subject of regular audit
  - audit of provider organisations’ compliance with regional DNACPR paperwork, record of decision making, and any complaints/ clinical incidents involving the policy.

8. PROCESS

8.1 For the majority of people receiving care in a hospital or community setting, the likelihood of cardiopulmonary arrest is small; therefore no discussion of such an event routinely occurs unless raised by the individual.

8.2 In the event of an unexpected cardiac arrest, CPR will take place in accordance with the current Resuscitation Council (UK) guidelines unless:
  - a valid DNACPR decision or an ADRT is in place and made known (NB – where there is recorded evidence that a patient has clearly expressed that he/she would not wish to receive CPR but has not made a formal ADRT which meets the requirements under the MCA, it is nonetheless important to consider the patient’s wishes. In such circumstances, it is unlikely that it would be appropriate to perform CPR. However, if there is any doubt as to whether the patient’s views remain the same, the balance lies in favour of preserving life).
- a PWA who has the authority to make the decision is present at the point of the arrest. This individual will then make the decision regarding discontinuation of CPR

- It is concluded, having considered all necessary factors under the best interests’ checklist that it is not in the patient’s best interests.

8.3 The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:

- where the individual’s condition indicates that effective CPR is unlikely to be successful
- when CPR is likely to be followed by a length and quality of life not acceptable to the individual
- where CPR is not in accord with the recorded, sustained wishes of the individual who is deemed mentally competent or who has a valid applicable ADRT.

8.4 The decision-making framework is illustrated in Diagram 1 on page 15. When considering making a DNACPR decision for an individual it is important to consider the following:

- is cardiac arrest a clear possibility for this individual? If not, it may not be necessary to go any further
- if cardiac arrest is a clear possibility for the individual, and CPR may be successful, will it be followed by a length and quality of life that would not be of overall benefit to the person? The person’s views and wishes in this situation are essential and must be respected.
- If the person lacks capacity, check whether they have made a valid and applicable ADRT or have appointed a PWA with appropriate authority. If so, follow this decision or consult with the PWA accordingly. If a PWA for personal welfare has not been appointed a best interests decision will be made. In making a best interest decision, the health professional must seek the views of those interested in the welfare of the patient, such as the patients family and close friends or an appointed IMCA (where a patient is “unbefriended” and has no one else, other than paid professionals, for the treating team to consult with).
- if the person has an irreversible condition where death is the likely outcome, they should be allowed to die a natural death. The patient should be informed of the DNACPR decision unless they will clearly be harmed by this information; in which case the rationale for not discussing it should be fully documented. Please note that the fact such a conversation may be distressing for the patient is not sufficient to justify their exclusion from the process. 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. If this is the case, you should seek their agreement to share relevant information with those close to them (such as relatives and carers) so that they may support the person’s treatment or care. If the person wishes for this information to remain confidential, this should be respected and recorded within their notes.
Where the patient lacks capacity, those close to the patient should be informed of a DNACPR decision unless there is a good reason not to. Please note, it is only in very rare circumstances that a DNACPR decision should be placed in a patient’s notes without the patient and/or their family being informed. The reasons for doing so should be fully documented.

8.5 If a DNACPR discussion and decision is deemed appropriate, the following need to be considered:

- the DNACPR decision is made following discussion with patient/others, this must be documented in their notes
- the DNACPR decision has been made and there has been no discussion with the individual because they have indicated a clear desire to avoid this. If you conclude that the patient does not wish to know about or discuss the DNACPR decision, you should seek their agreement to share with those close to them, with carers and with others, the information they may need to know in order to support the patient’s treatment and care
- if a discussion with a mentally competent person, regarding DNACPR is deemed inappropriate by medical staff, this must be clearly documented in their notes
- the DNACPR information leaflet (See Appendix 2) should be made available where appropriate to individuals and their relatives or carers. It is the responsibility of each individual organisation to ensure that different formats and languages can be made available
- the DNACPR decision is required for a person who lacks capacity to assist in the decision making process. This decision must be discussed with friends/family and their views taken into consideration when making a best interest decision. For those who have no one to consult with an IMCA referral must be made.

8.7 Documenting and communicating the decision

8.7.1 Once the decision has been made, it must be recorded on the North West Adult DNACPR form (See Appendix 1) and written in the person's notes.

8.7.2 The LILAC form must stay with the person at all times:

- The person’s full name, NHS or hospital number, date of birth, date of writing decision, review date if applicable and institution name should be completed and written clearly. Address may change due to person’s deterioration e.g. into a nursing home. If all other information is correct the form remains valid even with incorrect address

- In an inpatient environment e.g. hospitals, Specialist Palliative Care inpatient units, the triplicate form stays together in the front of the person’s notes until death or discharge. On discharge (from the care setting instigating the form):

- the lilac copy of the form stays with the person
- one white copy remains in the medical notes and;
- one white copy is retained for audit purposes

- For deceased people – lilac and one white copy stay in medical notes and one white copy is retained for audit purposes

- For people in their homes:
  - The lilac form is placed in their home
  - A white copy remains in their notes at the GP’s surgery (ensure that the DNACPR decision is recorded in the individual’s electronic problem list using appropriate red code) and:
  - The third white copy is retained for audit purposes.

- Where ‘message in a bottle’ schemes exist, the tear-off slip on the lilac form may be completed and placed in the “message in a bottle” in the person’s refrigerator. The location of the DNACPR form needs to be clearly stated on the tear off slip (e.g. my form is located in the nursing notes in the top drawer of the sideboard in the dining room). If a “message in a bottle” is not available, a system must be put in place to ensure effective communication of the DNACPR forms location to all relevant parties including the ambulance service

http://www.lionsmd105.org

Please note:

- Where the form has been initiated in another institution it will only be the lilac copy that will be in the front of the care notes
- If using an electronic North West Adult DNACPR form ensure one copy is printed on lilac paper, signed and given to the person. A second copy needs to be stored for audit purposes
- If using the North West Adult DNACPR pad ensure that the lilac copy remains with the person and the white copy is retained for audit purposes
- Information regarding the background to the decision, the reasons for the decision, those involved in the decision and a full explanation of the process, must be recorded in the individual’s notes, additionally these can be recorded in care records, care plans etc.

8.7.3 Where a DNACPR decision is implemented the following records process must be followed:

9. **All Divisions** – A regional unified Do Not Attempt Cardiopulmonary Resuscitation (Lilac Form) must be completed and stored in the patients hand held paper notes along with one of the white carbonated copy forms. Once completed the electronic copy must be also completed either via EPEX or PACIS.

10. **All Divisions** – The patient, or where the patients lacks capacity, their relevant others must be given a copy of the DNACPR leaflet.
11. **All Divisions** – For any patient discharged/transferred from Mersey Care NHS Foundation Trust, the Lilac form must remain with the patient and the continuing care provider should be informed of the DNACPR status. The white carbon copy form will remain in the patients hand held paper notes as evidence of the decision having been in place during the patient's admission.

12. **All Divisions** – Where a patient is admitted with Lilac form, this should be reviewed by the patients consultant and where it is felt appropriate that the DNACPR status remains, the form should be held in the patients hand held paper records and the electronic copy completed via either EPEX or PACIS.

13. **Local Division, Medium and Low Secure Services** - Do Not Attempt Cardiopulmonary Resuscitation forms can be located in **EPEX**.

14. **High Secure Services** – Do Not Attempt Cardiopulmonary Resuscitation forms can be located in **PACIS** within Documents Templates- Physical Health Care and Wellbeing.

15. **Specialist Learning Disability Services** – will print the relevant pages from the DNACPR Policy and kept in a file.

16. **All Divisions** – Once a DNACPR order has been instigated, or the patient is admitted to the Trust with such and order, then a Datix (Ulysses for SpLDD) needs to be completed. Once received the Trust Resuscitation Service will attend the unit and audit the form.

8.7.4 **Confidentiality**: If the individual has the mental capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing this with family and friends. Refusal by an individual with capacity to allow information to be disclosed to family or friends must be respected. Where individuals lack capacity, and their views on involving family and friends are not known, health and social care staff may disclose confidential information to people close to them where this is necessary to discuss the individual’s care. However, without exception such a decision must be justified on the grounds that it is in the person’s best interests to disclose the information to the relevant party or parties.

8.7.5 It is the health care staff’s responsibility to ensure communication of the form to other relevant organisations. The use of an end of life care register is recommended to ensure communication of the decision across settings. It is recommended where the person is at home, the ambulance service is informed, using their warning flag procedure.

8.8 **Discharge/ Transfer process**

8.8.1 Prior to discharge, the person, or relevant other if the person lacks capacity, **MUST** be informed of the DNACPR decision. If the person is competent and it is considered that informing them of the decision would not be likely to cause distress then this should be sensitively done. The same approach should be taken towards discussion with family members.

8.8.2 If such discussion is likely to cause the patient harm then it is usually impossible to place a DNACPR form in the person’s home.

8.8.3 When transferring the person between settings all staff involved in the transfer of care of a person need to ensure that:
- the receiving institution is informed of the DNACPR decision and provided with the patient’s lilac DNACPR Form on arrival
- where appropriate, the person (or those close to the person if they lack capacity) has been informed of the DNACPR decision
- the decision is communicated to all members of the health and social care teams involved in the person’s ongoing care
- the decision has been documented on the end of life care register
- the ambulance service has been informed via the warning flag procedure.

Ambulance transfer: If discussion has taken place regarding deterioration during transfer the ‘Other Important Information’ section must be completed by any health care staff, stating; the preferred destination (this cannot be a public place), the name and telephone number of next of kin or named contact person. If there are no details and the patient is being transferred, should they deteriorate, they will be taken to the nearest Emergency Department.

Non ambulance transfer: other organisations transferring patients between departments, other healthcare settings and home should be informed of, and abide by, the DNACPR decision.

8.8.4 Current discharge letters must include information regarding this decision. If the DNACPR decision has a review date it is mandatory that the discharging doctor speaks to the GP to inform them of the need for a review. This should be followed up with a discharge letter.

8.8.5 Cross Boundaries: If a patient is discharged from an institution that does not use the North West Adult DNACPR form, providing their form is agreed following clear governance and legal process, it will be recognised by health and social care staff, until a time that the information is transferred onto the North West Adult DNACPR form. Therefore, a patient who lives on the North West borders may have 2 forms, (i.e. NHS North of England Deciding Right DNACPR), depending on where they go in the region. Whenever a patient comes back into the North West region, the original form is replaced in the patient’s notes or a new form written if the original is not available.
Decision Making Framework

Is cardiac or respiratory arrest a clear possibility for the patient?

- NO

Is there a realistic chance that CPR could be successful?

- NO

Does the patient lack capacity AND have an advanced decision specifically refusing CPR OR have an appointed attorney, deputy or guardian?

- NO

Does the patient lack capacity?

- NO

Is the patient willing to discuss his/her wishes regarding CPR?

- NO

The patient must be involved in deciding whether or not CPR will be attempted in the event of cardiorespiratory arrest.

- YES

It is not necessary to discuss CPR with the patient unless they express a wish to discuss it.

If a DNACPR decision is made on clear clinical grounds that CPR would not be successful should be a presumption in favour of informing the patient of the decision and explaining the reason for it. Subject to appropriate respect for confidentiality those close to the patient should also be informed and offered an explanation.

Where the patient lacks capacity and has a welfare attorney or court appointed attorney deputy or guardian, this representative should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussion about the patients care.

If the decision is not accepted by the patient, their representative or those close to them, a second opinion should be offered.

If a patient has made an advanced decision refusing CPR, and the criteria for applicability and validity are met, this must be respected.

If an attorney, deputy or guardian had been appointed they should be consulted.

Discussion with those close to the patient must be used to guide a decision in the patient’s best interests.

Respect and document their wishes. Discussion with those close to the patient may be used to guide a decision in the patient’s best interests, unless confidentiality restrictions prevent this.

- YES

Adapted from Guidance from the British Medical Association, the Resuscitation Council (UK) and The Royal College of Nursing (Previously known as the “Joint Statement”) Decisions relating to cardiopulmonary resuscitation 3rd Edition, October 2014
9. REVIEW

9.1 This decision will be regarded as ongoing unless:

- a definite review date is specified
- there are improvements in the person’s condition
- their expressed wishes change where a 1b & 1c decision is concerned.

All DNACPR decisions are subject to ongoing monitoring to ensure they remain appropriate; it is recommended that a review date be considered and entered on the DNACPR form if appropriate. It is important to note that a review date does not equate to an expiry date for ongoing decisions and remains clinically appropriate and valid.

9.2 It is important to note that the person’s ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, each time that a DNACPR decision is reviewed, the reviewer must consider whether the person can contribute to the decision-making process. It is not usually necessary to discuss CPR with the person each time the decision is reviewed, if they were involved in the initial decision. Where a person has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.

10. SITUATIONS WHERE THERE IS LACK OF AGREEMENT

10.1 A person with mental capacity may refuse CPR, even if they have no clinical reason to do so. This should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives. In these circumstances they should be encouraged to write an ADRT. An ADRT is a legally binding document which has to be adhered to, it is good practice to have a DNACPR form with the ADRT but it is not essential.

10.2 Please note if the person had capacity prior to arrest, a previous clear verbal wish to decline CPR should be carefully considered when making a best interests decision. The verbal refusal should be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The person should be encouraged to make an ADRT to ensure the verbal refusal is adhered to (See Mental Capacity Act guidance Appendix 5)

10.3 Individuals may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. In such circumstances, a comprehensive discussion with the patient should be held in order to better understand the reasons for their views. A second opinion may assist in reaching agreement. Individuals do not have a right to demand that doctors carry out treatment against their clinical judgement. However, generally, where a patient requests for CPR to be attempted then their wishes should be respected, except in extreme cases where the clinicians are clear that it would not work and providing it would be deemed unethical. In all such cases, legal advice should be sought before a DNACPR order is implemented.
11. CANCELLATION OF A DNACPR DECISION

11.1 In rare circumstances, a decision may be made to cancel or revoke the DNACPR decision. If the decision is cancelled, the form should be crossed through with two diagonal lines in black ball-point ink and the word ‘CANCELLED’ written clearly between them, dated, signed and name printed by the health care staff. The cancelled form is to be retained in the person’s notes. It is the responsibility of the health care staff cancelling the DNACPR decision to communicate this to all parties informed of the original decision.

11.2 Electronic versions of the DNACPR decision must be cancelled with two diagonal lines and the word ‘CANCELLED’ typed between them, dated, signed and name printed by the health care staff.

11.3 On cancellation or death of the person at home, if the ‘ambulance service warning flag’ has been ticked on section 4 of the form, the health and social care staff dealing with the person, MUST inform the ambulance service that cancellation or death has occurred.

12. SUSPENSION OF DNACPR DECISION

12.1 Uncommonly, some patients for whom a DNACPR decision has been established may develop Cardiac Arrest from a readily reversible cause. In such situations CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances.

12.2 Acute: Where the person suffers an acute, unforeseen, but immediately life threatening situation, such as anaphylaxis or choking. CPR would be appropriate while the reversible cause is treated.

12.3 Pre-planned: Some procedures could precipitate a Cardiac Arrest, for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc. Under these circumstances, the DNACPR decision should be reviewed prior to procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people, including the person if appropriate, will need to take place. This will also include ECT.

13. AUDIT

13.1 Individual organisations will measure, monitor and evaluate compliance with this policy through audit and data collection using the Key Performance Indicators.

13.2 All organisations will have clear governance arrangements in place which indicate individuals and Committees who are responsible for this policy and audit. This includes:

- data collection
- ensuring that approved documentation is utilised
- managing risk
- sharing good practice
- monitoring of incident reports and complaints regarding the DNACPR process
- developing and ensuring that action plans are completed

13.3 Frequency:
- compliance with the policy will be audited annually using the DNACPR Audit Tool (See Appendix 3)
- local leads will decide the number of DNACPR forms to be examined
- all institutions must store the audit copy of the DNACPR form so that it is easily accessible when the local lead requests the information.

13.4 Information will be used for future planning, identification of training needs and for policy review.

14. REFERENCES


NHS End of Life Care Programme & the National Council for Palliative Care (2008)


15. ACKNOWLEDGEMENT
NHS - North West would like to thank South Central SHA and Tracey Courtnell (Senior Resuscitation Officer / Project Manager SCSHA uDNACPR) for sharing their experience, collaboration and allowing us to adapt their policy.

APPENDIX 1
### LILAC FORM STAYS WITH PERSON WHEREVER THEY ARE BEING CARED FOR.

**ADULT UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)**

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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Date of DNACPR decision:</th>
<th>Institution Name:</th>
</tr>
</thead>
<tbody>
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</table>

Date of birth: 
NHS or hospital number: 

#### 1. Reason for DNACPR decision: (select A, B or C) NB – DNACPR decisions should rarely be made without informing or consulting the patient or their family

- **A)** CPR is unlikely to be successful due to [ ]
  - This decision has been discussed with the person [ ]
  - The relevant other has been informed of the decision [ ]
  - Name of relevant other: 

- **B)** CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the person.
  - Person involved in discussions? [ ]
  - Person lacks mental capacity and has a legally appointed Welfare Attorney: Name: 
  - Person lacks mental capacity and does not have a legally appointed Welfare Attorney: This decision is made in accordance with the person’s best interest. This decision has been reached in consultation with those close to the patient including: Name(s): 
  - Specific Relationships (please state): 

- **C)** There is a valid advance decision to refuse CPR in the following circumstances. All circumstances [ ]
  - Specific Circumstances (please state): 
  - Attach a copy of the Advance Decision to Refuse Treatment (ADRT) to the back of the DNACPR form.

#### 2. Healthcare professional making this DNACPR decision:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
<th>GMC/NMC:</th>
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<tbody>
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Signature: 
Date: / / 
Time: :

If decision has been made by a delegated professional, the decision needs to be verified at the earliest opportunity:

<table>
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<tr>
<th>Name:</th>
<th>Position:</th>
<th>GMC/NMC:</th>
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</thead>
<tbody>
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</tbody>
</table>

Signature: 
Date: / / 
Time: :

#### 3. Review: NB – All DNACPR decisions are subject to ongoing monitoring

Review date if appropriate: / / 
Outcome of review: DNACPR to continue? [ ]

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
<th>GMC/NMC:</th>
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</thead>
<tbody>
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<td></td>
</tr>
</tbody>
</table>

Signature: 
Date: / / 
Time: :

#### 4. Who has been informed of this DNACPR decision?

- [ ] GP
- [ ] Care Provider (please state)
- [ ] Out of Hours
- [ ] Ambulance Warning Flag
- [ ] Other (please state)

#### 5. Other important information:

For example, ambulance crew instructions on transfer, Callings of treatment, Preferred place of care/death, Tissue or Organ donation.

---

The DNACPR form is located:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Post code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of birth: / / 
NHS or hospital number: 

---

Important: this form MUST be printed on Lilac paper
**ADULT UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)**

Consider using this form (as part of Advance Care Planning (ACP)), you would not be surprised if the patient were to die in the next year. This is NOT an Advance Decision to Refuse Treatment (ADRT). www.adrt.nhs.uk

**Explanation Notes** This form should be completed legibly in black ball point ink

- The person’s full name, NHS or Hospital number, date of birth, date of writing the decision and institution name should be completed and written clearly. Address may change due to person's deterioration e.g. into a nursing home. If all other information is correct the form remains valid even with incorrect address.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and "CANCELLED" written clearly between them, signed and dated by the healthcare staff. It is the responsibility of the healthcare staff cancelling the DNACPR decision to communicate this to all parties informed of the original decision (see section 4. on form).
- Electronic form must be printed and signed on lilac paper and copies kept for audit purposes and notes.
- Triple copy forms, keep together until person is discharged/dies or decision is cancelled. Lilac with the person, 1st white copy for audit and 2nd white copy retain in the notes.

**Compulsory sections of the form: Top section, Section 1 and Section 2**

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Reason for DNACPR decision</td>
</tr>
<tr>
<td>1.A</td>
<td>CPR is unlikely to be successful</td>
</tr>
<tr>
<td>1.B</td>
<td>CPR may be successful, but may be followed by a length and quality of life which would not be of overall benefit to the person</td>
</tr>
<tr>
<td>1.C</td>
<td>DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent</td>
</tr>
<tr>
<td>2.</td>
<td>Person making this DNACPR decision/ Verification</td>
</tr>
<tr>
<td>3.</td>
<td>Review</td>
</tr>
<tr>
<td>4.</td>
<td>Who has been informed of this DNACPR decision</td>
</tr>
<tr>
<td>5.</td>
<td>Other Important Information</td>
</tr>
</tbody>
</table>

**1. Reason for DNACPR decision**

Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the person's best interest's. Be as specific as possible. Patients have a right, under Article 8 of the European Convention on Human Rights, to be consulted/ informed about DNACPR decisions – the presumption lies in favour of patient involvement in these decisions. Record the details of discussion or the reason for not discussing in the person's notes.

**1.A CPR is unlikely to be successful**

State clearly what was discussed and agreed. If this decision was not discussed with the person state the reason why this was inappropriate. Patients have a right, under Article 8 of the European Convention on Human Rights, to be consulted/ informed about DNACPR decisions – the presumption lies in favour of patient involvement in these decisions. If the person does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the person would decide if able to do so. If there is no one appropriate to consult and the person has been assessed as lacking capacity then an instruction to an Independent Mental Capacity Advocate (IMCA) should be considered. If the person has made a Lasting Power of Attorney (LPA), appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the person if this power is included in the original Lasting Power of Attorney. You need to check this by reading the LPA. If the person has capacity ensure that discussion with others does not breach confidentiality. State the names and relationships of relatives / relevant others with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

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

Summary of communication with person...

**1.C DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent.**

Check for the validity and applicability of the Advance Decision to Refuse Treatment (ADRT). Is the ADRT – 1. Specific to CPR? 2. In writing, signed and witnessed? 3. Contains the statement ‘even if life is at risk’? 4. Has the person been consistent with their ADRT? If the answer to all the above is ‘Yes’ the ADRT is valid and applicable. If the ADRT contains specific circumstances when CPR would not be appropriate write these on the form. Attach a copy of the ADRT to the person’s DNACPR form.

**2. Person making this DNACPR decision/ Verification**

State names and positions. In general this should be the most senior healthcare professional immediately available. If the decision is made by a delegated professional it must be verified by the most senior healthcare professional responsible for the person’s care at the earliest opportunity. If the person making the decision is the most senior person, verification is not required.

**3. Review**

All decisions should be regularly re-assessed at appropriate intervals: such as if (patients condition changes) regardless of whether a review date has been specified. This decision will be regarded as "ONGOING" unless:

i. a definite review date is specified
ii. there are changes in the person’s condition
iii. their expressed wishes change

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?**

Please ensure that all health and social care staff who have been informed are aware of their responsibility to document the decision in their own records, as the original stays with the person. It is the responsibility of health and social care staff to ensure those who have been informed of the decision are informed if the patient dies, or the form is cancelled.

**5. Other Important Information**

This information needs to be very clear and precise. For example, in transferring include name, address and telephone number of destination and next of kin. Ceilings of treatment include where ACP is kept. Preferred place of care should be noted.

**Tear off slip**

Complete details and place in “message in a bottle” if available with location clearly stated. For example, ‘in the nursing notes in the top drawer of the sideboard in the dining room.’
Appendix 2
This leaflet explains:

What cardiopulmonary resuscitation (CPR) is

How you will know whether it is relevant to you

How decisions about it are made

This is a general information leaflet for everyone over 18 (if you are under 18 there is a separate leaflet) but it may also be useful to your relatives, friends, carers and others who are important to you. This leaflet may not answer all your questions about CPR, but it should help you to think about the issue and the choices available. If you have any other questions, please talk to one of the healthcare professionals (doctors, nurses and others) caring for you.

A DNACPR decision is about cardiopulmonary resuscitation only and does not affect other treatment.
What is CPR?
Cardiopulmonary arrest means that a person’s heart and breathing stop. When this happens it is sometimes possible to restart their heart and breathing with an emergency treatment called CPR.

CPR might include:
- repeatedly pushing down very firmly on the chest using electric shocks to try to restart the heart
- ‘mouth-to-mouth’ breathing; and
- inflating the lungs through a mask over the nose and mouth or tube inserted into the windpipe.

Is CPR tried on everybody whose heart and breathing stop?
In an emergency, yes, if it is felt there is a chance it will work. For example, if a person has a serious injury or suffers a heart attack and the heart and breathing stop suddenly. The priority is to try to save the person’s life.

However, if people are already very seriously ill and near the end of their life, there may be no benefit in trying to revive them. This is particularly true when people have other things wrong with them.

Where a person has expressed his / her wishes not to have CPR this must be in writing in order to be legally binding. The information in this leaflet has been written to help you to decide whether or not you want to make this decision. It is important to remember that your relatives, friends or carers cannot make the decision for you.

Do people get back to normal after CPR?
Each person is different. A few people will make a full recovery; some recover but have health problems. Unfortunately, most attempts at CPR do not restart the heart and breathing despite the best efforts of all concerned. It depends on why their heart and breathing stopped and the person’s general health. It also depends on how quickly their heart and breathing can be restarted. People who are revived are often still very unwell and need more treatment, usually in a coronary care or intensive care unit. Some people never get back to the level of physical or mental health they enjoyed before the cardiopulmonary arrest. Some have brain damage or go into a coma. People with many medical problems are less likely to make a full recovery. The techniques used to start the heart and breathing sometimes cause side effects, for example, bruising, fractured ribs and punctured lungs.

Am I likely to have a cardiopulmonary arrest?
This depends on your medical condition. The health professionals caring for you are the best people to discuss the likelihood of you having a cardiopulmonary arrest. People with the same symptoms do not necessarily have the same disease and people respond to illnesses differently. It is normal for health professionals and patients to plan what will happen in case of a cardiopulmonary arrest.

Somebody from the health care team caring for you, will talk to you about:
- your illness;
- what you can expect to happen; and
- what can be done to help you.

What is the chance of CPR reviving me if I have a cardiopulmonary arrest?
The chance of CPR reviving you will depend on:
- why your heart and breathing have stopped
- any illnesses or medical problems you have (or have had in the past)
- the overall condition of your health.

When CPR is attempted in hospital it is successful in restarting the heart and breathing in about 4 out of 10 patients. On average, 2 out of 10 patients survive long enough to leave hospital. The figures are much lower for people with serious underlying conditions or for those not in hospitals. Everybody is different and the healthcare team will explain what CPR may do for you.

Does it matter how old I am or that I have a disability?
No. What is important is, your current state of health, your current wishes, and the likelihood of the healthcare team being able to achieve what you want. Your age alone does not affect the decision, nor does the fact that you have a disability.

Will I be asked whether I want to discuss CPR?
Yes, the healthcare professional in charge of your care will discuss with you whether CPR should be attempted if your heart and breathing stop. The healthcare team looking after you will look at all the medical issues, including whether CPR is likely to be able to restart your heart and breathing if they stop, and for how long. It is beneficial to attempt resuscitation if it might prolong your life in a way that you can enjoy.

Sometimes, however, restarting a person’s heart and breathing leaves them with a severe disability or prolongs suffering. Prolonging life in these circumstances is not always beneficial. Your wishes are very important in deciding whether resuscitation may benefit you, and the healthcare team will want to know what you think. If you want, your close friends and family can be involved in these discussions.

Legally, your family and friends are not allowed to decide or consent on your behalf, so you should inform your family and friends of your wishes. For more information on The Mental Capacity Act please refer to: www.dca.gov.uk/legal-policy/mental-capacity/publications.htm If you have appointed a person with Personal Welfare Attorney (PWA) then they may be able to consent on your behalf in certain situations if you lack capacity.

If it is decided that CPR won’t be attempted, what then?
The healthcare team will continue to give you the best possible care. The healthcare professional in charge of your care will make sure that you, the healthcare team, and the friends and family that you want involved in the decision know and understand the decision. There will be a note in your health records that you are ‘not for cardiopulmonary resuscitation’. This is called a ‘do not attempt cardiopulmonary resuscitation’ decision or DNACPR decision.
What if I don’t want to discuss CPR?

You don’t have to talk about CPR if you don’t want to, or you can put discussion off if you feel you are being asked to decide too much too quickly. Your family, close friends, carers or those who you feel know you best might be able to help you make a decision you are comfortable with. Otherwise, the doctor in charge of your care will decide whether or not CPR should be attempted, taking account of things you have said.

What if a decision hasn’t been made and I have a cardiopulmonary arrest?

The doctor in charge of your care will make a decision about what is right for you. Your family and friends are not allowed to decide for you, unless you have appointed them as a personal welfare attorney and provided them with appropriate authority. Nevertheless, it can be helpful for the healthcare team to talk to them about your wishes. If there are people you do (or do not) want to be consulted you should let your care team know.

I know that I don’t want anyone to try to resuscitate me. How can I make sure they don’t?

If you don’t want CPR, you can refuse it and the healthcare team must follow your wishes. To ensure your wishes are legally binding, you can make an Advanced Decision to Refuse Treatment (ADRT) (also known as a living will). An ADRT is a statement made by a mentally competent person aged over 18 years which defines in advance their refusal of specific medical treatment should he/she become mentally or physically incapable of making his/her wishes known.

What if I change my mind?

You can change your mind at any time, and talk to any of the healthcare team caring for you.

If you feel you have not had the chance to have a proper discussion with your care team, or you are not happy with the discussions you have had you can follow the formal complaints procedure. Please do not hesitate to keep asking questions until you understand all you wish to know.

Who else can I talk to about this?

If you need to talk about this with someone outside of your family, friends or carers, to help you decide what you want, you may find it helpful to contact any of the following:

- Counsellors
- Independent Advocacy Services
- Patient Advice and Liaison Service (PALS)
- Patient Support services
- Spiritual carers, such as a chaplain.

Please insert local contact details in box

An ADRT can be either a written document or a verbal statement. However, if you wish the ADRT to refer to life-sustaining treatment then this must be in writing. You may revoke the decision at any time, either in writing or orally. However it is important that you let the healthcare team and people close to you know of any revocation.

If the ADRT refuses life-sustaining treatment, such as CPR it must:

- Be in writing (it can be written by someone else on your behalf and recorded in your healthcare notes)
- Be signed by you and witnessed (the witness must also sign the document to prove this); and
- State clearly that the decision applies ‘even if life is at risk’.

If you have an ADRT, you must make sure that the healthcare team knows about it and puts a copy of it in your records. You should also let people close to you know so they can tell the healthcare team what you want if they are asked.

What if I want CPR to be attempted, but my doctor says it won’t work?

Although nobody can insist on having treatment that will not work, no doctor would refuse your wish for CPR if there was any real possibility of it being successful. If there is doubt whether CPR might work for you, the healthcare team will arrange a second medical opinion if you would like one. If CPR might restart your heart and breathing, but is likely to leave you severely ill or disabled, your opinion where appropriate about whether these chances are worth taking is very important.
## Unified Do not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy Audit Tool

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not recorded</th>
<th>Comments (for e.g. no address, illegible, what’s missing? If no, why? etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DNACPR Form</strong></td>
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</tr>
<tr>
<td>1. Are there clear patient details?</td>
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<td>2. Is the date of DNACPR decision completed?</td>
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<td>3. What reason for DNACPR decision has been completed</td>
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<td>1a</td>
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<td>1b</td>
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<td>1c</td>
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<td>4. Has more than 1 reason been ticked?</td>
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<td>5. If section 1a has been ticked, is there <strong>CLEAR</strong> and <strong>APPROPRIATE</strong> information regarding why the decision has been made?</td>
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<td>6. Has the person been informed of the decision?</td>
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<td>7. If the person has not been informed has a relevant other?</td>
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<td>8. Who has made the decision?</td>
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<tr>
<td>GP</td>
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<tr>
<td>Accredited Nurse</td>
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<tr>
<td>Other</td>
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<tr>
<td>9. Is the record clearly dated, timed and signed correctly?</td>
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<td>10. Has the decision been verified (Acute Trusts Only) if appropriate?</td>
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<td>11. Have the following sections been completed?</td>
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<tr>
<td>Section 3 - Review</td>
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<tr>
<td>Section 4 - Who has been informed</td>
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<tr>
<td>Section 5 – Other important information</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not recorded</th>
<th>Comments (If no or not recorded, why?)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Person’s Notes</strong></td>
<td></td>
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</tr>
<tr>
<td>1. Was the form initiated in your organisation?</td>
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</tr>
<tr>
<td>2. Is the decision documented in the person’s notes?</td>
<td></td>
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<tr>
<td>3. Are the notes clearly dated, timed and signed correctly?</td>
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<tr>
<td>4a. Is there evidence of discussion?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4b. Who was it discussed with?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Person</td>
<td></td>
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</tr>
<tr>
<td>Relevant other</td>
<td></td>
<td></td>
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<tr>
<td>4c. If there is no evidence of discussion, is there evidence of why decision was not discussed with the person?</td>
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<tr>
<td>5. Is there evidence since the DNACPR decision has been made, that CPR has been carried out?</td>
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<tr>
<td>6. Is there evidence of a mental capacity assessment?</td>
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</tr>
</tbody>
</table>
Appendix 4
MENTAL CAPACITY ACT 2005 GUIDANCE

Mental Capacity Act (MCA) 2005 (Amended 2007)
The MCA came into operation in 2007. It serves 2 functions:

1. To provide a statutory framework which empowers and protects people who may lack capacity to make certain decisions for themselves

2. To provide a framework for people who wish to plan ahead for a time when they may lack capacity

Clinicians are expected to be familiar with and adhere to the MCA's principles, understand how it works in practice and apply this where applicable when making DNACPR decisions. Staff working with people lacking capacity should be familiar with the MCA’s Code of Practice and follow its guidance. Details of where copies of the MCA and its code, along with other useful information, can be found are located at the end of this Appendix.

Principles

The MCA is underpinned by five key principles set out in Section 1:

1. 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. Assumptions should not be made that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

2. People must be supported as much as possible to make a decision before anyone concludes that they cannot make their own decision. This means that you should make every effort to encourage and support the person to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

3. People with capacity have the right to make what others might regard as an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.

4. Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

5. Anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms. Professionals making decisions on behalf of those who lack capacity on a best interests basis should always try to choose the option that interferes the least with the individual's day-to-day life. However, sometimes a level of restraint may be required in the person's best interests.

Capacity

Capacity is time and decision specific. In accordance with the first principle of the MCA, everyone over the age of 16 is presumed to have capacity unless it is found otherwise. The MCA lays down a framework that must be followed when services are working with people who may, permanently or temporarily, lack the capacity to make all, or some, decisions about their treatment and care themselves.

Assessing Mental Capacity

The Two-stage Test (the diagnostic test)
Consider the following questions when assessing whether an individual has the capacity to make a decision:
1. Does the person have an impairment of mind or brain, or is there some sort of disturbance affecting
   the way their mind and brain works, either on a temporary or a permanent basis?

2. If so, does that impairment or disturbance mean that the person is unable to make the decision in
   question at the time it needs to be made (see functional test below)

**The Four-step functional test (the functional test)**

According to the MCA, a person is unable to make their own decision if they cannot do one or more of
the following:

(i) Understand the information relevant to the decision, including what will happen if they do or do not
    make the decision;

(ii) Retain that information;

(iii) Use or weigh that information up in making their decision; and

(iv) Communicate their decision by any means, including talking or making sounds, movements
    (however slight e.g. squeezing another’s hand, blinking can be sufficient), signs (e.g. drawing
    pictures) or any other means (principle 2 is particularly relevant here)?

All details of a person’s Mental Capacity Assessment must be documented in the person’s notes. This
information should be shared with all relevant health and social care staff involved in the person’s care
(including IMCAs).

**Best Interests**

Where a person is unable to make a decision for themselves, and all reasonable efforts have been made
in an attempt to support them to make their own decision, any decision made on their behalf must be
made in accordance with their best interests. The MCA does not fully define ‘best interests’ but case law
has confirmed that best interests looks at both medical and non-medical factors. Every patient, and every
case, is different and must be decided on its own facts. Decision makers must look at welfare in the
widest sense, taking into account not just medical but social and psychological factors. In order to assist
in decision making, the MCA sets out a checklist of factors which must be considered.

**Best Interests Checklist**

- Is there a relevant substitute decision maker by virtue of a WPA or Court Appointed Deputy?
- Is there a valid and applicable ADRT to refuse treatment?
- Assess whether the person may gain capacity; if so, can the decision wait?
- Involve the person in the decision as much as possible.
- Explore the person’s past and present views, culture, religion and attitudes.
- Do not make assumptions based on a person’s age, appearance, condition or behaviour.
- If the decision relates to the provision or withdrawal of life-sustaining treatment, the decision must not
  be motivated by a desire to bring about the person’s death.
- Consult interested family and friends.
To satisfy best interest principles you must also include things such as whether or not the decision to be made, on the patient's behalf, is the least restrictive and evidence-based confirmation that all practicable steps have been taken to help make an informed decision but without success.

**Decision-maker responsibilities**

DNACPR decision-makers must:

- Involve the person.
- Have regard for the past and present wishes and feelings, especially written statements which may be in the form of an advance care plan (ACP).
- Consult with others who are involved in the care of the person e.g. carer, LPA.
- Not make assumptions based solely on the person's age, appearance, condition, disability or behaviour.
- Ensure a valid and applicable ADRT (see below for details) to refuse CPR is respected even if others think that this decision is not in the person's best interests.
- Respect any LPA and/or ADRT including end of life treatment.
- Seek the appointment of an IMCA were the person lacks capacity and there is no one to speak on their behalf other than a paid carer.
- Be kept under review.

**Decisions Reserved to the Court of Protection**

There are certain serious decisions are reserved to the Court of Protection and cannot be taken without recourse to the Court. This includes cases where there is a dispute about whether a particular treatment will be in a person's best interests.

It is essential that decision makers are familiar with sections 6.18 and 8.18 of the Code of Practice.

**Advance Decision to Refuse Treatment**

A DNACPR is a clinical decision made on best interests relevant to the disease of the person whereas an ADRT is the person's own decision.

The MCA creates statutory rules with clear safeguards so people can make an ADRT including end of life treatment if they should lack capacity in the future. Where a patient wishes to make an ADRT to refuse life-sustaining treatment, it must comply with the following legal requirements:

- It must be in writing
- It must be signed by the person (or in their presence if they are unable to do so themselves)
- It must be witnessed
- It must include a statement that it is to apply even if life is at risk

ADRTs which do not relate to refusal of life-sustaining treatment do not have to be in writing, although this is always preferable if possible. The ADRT does however need to be specific and clearly relate to the treatment in question. Where an ADRT is provided verbally, this should be recorded in detail in the patient's records and the accuracy confirmed with the patient.

A valid and applicable ADRT is classed as a contemporaneous decision and must be followed, unless the patient withdraws the decision (a withdrawal does not need to be in writing, even where it relates to an ADRT refusing life-sustaining treatment) or has indicated that they have changed their mind (eg, by acting inconsistently with its terms).
A DNACPR is not an ADRT; it is a legal document informing healthcare professionals of a medical direction. If the person has a valid and applicable ADRT refusing CPR a copy should be attached to the back of their DNACPR form.

The decision maker should make reasonable efforts to ascertain whether a patient who may be considered for a DNACPR decision has made either an ADRT or an advance decision to refuse end of life treatment.

There is sometimes confusion regarding Advance Care Planning (ACP), advance decisions and DNACPR. Some basic definitions are:

<table>
<thead>
<tr>
<th>Advance Care Planning</th>
<th>Advance Decisions to Refuse Treatment</th>
<th>DNACPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a process of discussion between an individual and their care providers irrespective of discipline. The difference between ACP and planning more generally is that the process of ACP is to make clear a person's wishes and will usually take place in the context of an anticipated deterioration in the individual’s condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others.</td>
<td>These must relate to a refusal of specific medical treatment and can specify circumstances. It will come into effect when the individual has lost capacity to give or refuse consent to treatment. Careful assessment of the validity and applicability of an advance decision is essential before it is used in clinical practice. Valid advance decisions, which are refusals of treatment, are legally binding.</td>
<td>A DNACPR decision applies to CPR only, other ceilings of treatment need to be discussed. A DNACPR is a method of communicating a medical instruction, a clinical decision made on best interests relevant to the disease of the person.</td>
</tr>
</tbody>
</table>
Equality and Human Rights Analysis

Title: Policy and Procedure for Resuscitation (including Do Not Attempt Cardiopulmonary Resuscitation)

Area covered: Trust wide

What are the intended outcomes of this work? Review 19:06:16

The policy ensures that any service user suffering cardiac or respiratory arrest, will receive appropriate care. It also contains a link to NHS North of England, North West Unified Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) Adult Policy.

Who will be affected?
Staff and Service Users.

Evidence

What evidence have you considered?
The standards for practice within Mersey Care NHS Foundation Trust have been drawn from, ‘Cardiopulmonary Resuscitation; Standards for Clinical Practice and Training’, (Resuscitation Council UK 2010) a joint statement from:
The Royal College of Anaesthetists
The Royal College of Physicians of London
The Intensive Care Society
The Resuscitation Council(UK)
DNACPR Unified Policy considers the following Legislation Advanced Decisions to Refuse Treatment, a guide for health and social care professionals(2009)
Coroners and Justice Act 2009
GMC (2010) Treatment and care towards the end of life: good practice in decision making guidance for doctors.
Human Rights Act (1998)
Mental Capacity Act(2005)
NHS End of Life Care Programme& National Council for Palliative Care (2008)
Royal College of Physicians(2009) Advanced Care Planning
Reviewed 19:05:2016
Calderstones procedures added in to the policy

Disability (including learning disability)
Any service user whose first language isn’t English an interpreter or other mediums as requested would be provided.
A service user who is deaf a person able to use BSL would be provided.
The policy can also be provided in large text.
As part of the trust’s mandatory training all staff must complete Equality, Diversity, & Human Rights training at the appropriate level commensurate with their job role.
If the service user lacks mental capacity to take part in the discussion and make any necessary decisions then
Relatives, others close to the service user or recognised carers would be consulted as per policy.

**Reviewed 19:05:2016**
Calderstones procedure added in to the policy.
This policy contains a link to the NSH North Of England; North West unified Do Not Attempt Cardiac monary Resuscitation Adult policy. To be assured of equitable process within the provision of CPR.

<table>
<thead>
<tr>
<th>Group</th>
<th>Policy Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>Policy SD07 applies to all staff and service users regardless of sex. Staff should always be mindful of maintaining equality wherever possible throughout any clinical procedure. <strong>Reviewed 19:05:2016</strong></td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>Policy SD07 applies to all staff and service users regardless of race. If an interpreter or other medium was requested this would be provided by the trust. <strong>Reviewed 19:05:2016</strong></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Policy SD07 relates to adults only. <strong>Reviewed 19:05:2016</strong></td>
</tr>
<tr>
<td></td>
<td>Calderstones procedure added in to the policy. This policy contains a link to the NSH North Of England; North West unified Do Not Attempt Cardiac monary Resuscitation Adult policy. To be assured of equitable processes within the provision of CPR.</td>
</tr>
<tr>
<td><strong>Gender reassignment (including transgender)</strong></td>
<td>Policy SD07 applies to all staff and service users regardless of gender reassignment (including transgender) <strong>Reviewed 19:05:2016</strong></td>
</tr>
<tr>
<td><strong>Sexual orientation</strong></td>
<td>Policy SD07 applies to all staff and service users regardless of sexual orientation. <strong>Reviewed 19:05 2016</strong></td>
</tr>
<tr>
<td><strong>Religion or belief</strong></td>
<td>This policy applies to all staff and service users regardless of religion or belief <strong>Reviewed 19:05:2016</strong></td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>Not Applicable <strong>Reviewed 19:05:2016</strong></td>
</tr>
<tr>
<td><strong>Carers</strong></td>
<td>Not Applicable <strong>Reviewed 19:05:2016</strong></td>
</tr>
<tr>
<td><strong>Other identified groups</strong></td>
<td>Not Applicable <strong>Reviewed 19:05:2016</strong></td>
</tr>
<tr>
<td><strong>Cross Cutting</strong></td>
<td>Policy SD07 applies to all staff and service users without discrimination. <strong>Reviewed 19:05:2016</strong></td>
</tr>
</tbody>
</table>

Page 78 of 81
SD07 Resuscitation (including Do Not Attempt Cardiopulmonary Resuscitation) – Version 5, 2017
<table>
<thead>
<tr>
<th>Human Rights</th>
<th>Is there an impact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to life (Article 2)</td>
<td>At Review: 19:05:16. This policy ensures that the Trust responsibility in relation to article 2 is met. To include reference the Human Rights Act responsibilities and considerations in the principles</td>
</tr>
<tr>
<td>Right of freedom from inhuman and degrading treatment (Article 3)</td>
<td>At review: 19:05:2016. This policy ensure that the Trust responsibility in relation to article 3 is met. To include reference the Human Rights Act responsibilities and considerations in the principle.</td>
</tr>
<tr>
<td>Right to liberty (Article 5)</td>
<td>At review: 19:05:2016. This article is not engaged in this policy</td>
</tr>
<tr>
<td>Right to a fair trial (Article 6)</td>
<td>At review: 19:05:2016. This article is not engaged in this policy</td>
</tr>
<tr>
<td>Right to private and family life (Article 8)</td>
<td>At review: 19:05:2016. This article is not engaged in this policy</td>
</tr>
<tr>
<td>Right of freedom of religion or belief (Article 9)</td>
<td>At review: 19:05:2016. This article is not engaged in this policy</td>
</tr>
<tr>
<td>Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)</td>
<td>At review: 19:05:2016. This article is not engaged in this policy</td>
</tr>
<tr>
<td>Right freedom from discrimination (Article 14)</td>
<td>At review: 19:05:2016. This article is not engaged in this policy</td>
</tr>
</tbody>
</table>

**Engagement and Involvement** detail any engagement and involvement that was completed inputting this together.

No engagement.

**Summary of Analysis**

Eliminate discrimination, harassment and victimisation
This policy is implemented in line with the policy content irrespective of any protected characteristics.

**Advance equality of opportunity**
Staff will only implement the policy when required.

**Promote good relations between groups**
All relevant staff will have access to the appropriate training.

**What is the overall impact?**
*Dignity may be affected at time - in life threatening situations implementation of the policy will be in line with best practice guidelines.*

**Addressing the impact on equalities**
*There needs to be greater consideration re health inequalities and the impact of each individual development /change in relation to the protected characteristics and vulnerable groups
All efforts during any clinical intervention will be made to maintain dignity where ever possible for all individuals irrespective of protected characteristics.*

With particular reference to people who may be vulnerable to inequality within the resuscitation process for example people with learning disabilities.*

**Action planning for improvement**
Detail in the action plan below the challenges and opportunities you have identified

At Review included the specific reference to our responsibilities regarding the Human Right Act 1998*

**For the record**
Name of persons who carried out this assessment:
Janet Hussein- Ali
Rhian Pritchard
Reviewed by : Joanna Morgan, 19thMay 2016
Meryl Cuzak

Date assessment completed:
19:05:16

Name of responsible Director:
Ray Walker- Executive Director of Nursing and Secure Services

Date assessment was signed:
## Action plan template

<table>
<thead>
<tr>
<th>Category</th>
<th>Actions</th>
<th>Target date</th>
<th>Person responsible and their area of responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>Within the process of the bi annual DNACPR audit, make specific assurance and analysis regarding the protected characteristics. DNACPR audit completed 2015-2016</td>
<td>March 2016</td>
<td>J Morgan S Siddiqui</td>
</tr>
<tr>
<td>Human Right Act 1998</td>
<td>To include specific reference within the principles of the policy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>