This Policy is to be read in conjunction with Operational Policies and Procedures No 7 - SCAS Attendance at Sudden Death in Adults (Appendix 8)
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1.0 INTRODUCTION

1.1 This resuscitation policy fully supports the recommendations for clinical practice and training in cardiopulmonary resuscitation published by the Resuscitation Council (UK) (2016) and has been constructed to promote compliance with the NHSLA Risk Management Standards (NHSLA, 2013/14 Standard 5 Criterion 6) and the AACE/JRCALC Guidelines 2016.

1.2 Patients in cardio-pulmonary arrest are to be vigorously resuscitated whenever there is a chance of survival, however remote. Nevertheless, it is possible to identify patients in whom there is absolutely no chance of survival, and where resuscitation, or continued resuscitation, would be futile and distressing for relatives, friends and healthcare professionals.

1.3 This policy is in accordance with the AACE/JRCALC Clinical Practice Guidelines 2016, section 2 Resuscitation pages 39-81.

1.4 South Central Ambulance Service NHS Foundation Trust has contact with patients via several mediums, face to face, emergency and urgent care, patient transport services, telephone triage and advice via call centres, clinical support desk and 111 services. This policy is a corporate policy and acknowledges that NHS Pathways software advises and coaches basic life support once a cardiac arrest has been identified. This is a nationally controlled and monitored software system which the Trust ensures is up to date and has strict version control processes.

2.0 DUTIES

2.1 Accountability for the policy for the Resuscitation and Recognition of Life Extinct is ultimately with the Trusts Chief Executive; however this can be devolved within the Trust Board to the Executive Director of Patient Care & Service Transformation if appropriate.

2.2 Director of Finance

The Director of Finance has delegated responsibility for managing the development and implementation of procurement of equipment. Ensuring there are systems and processes for the ordering and delivering of equipment to departments.

2.3 Chief Operating Officer

The Chief Operating Officer has delegated responsibility for ensuring that all operational Staff and vehicles are fully trained and equipped and the operational risks associated with the provision of Emergency and Non Emergency Ambulance Service.

2.4 Executive Director of Patient Care & Service Transformation

The Executive Director of Patient Care & Service Transformation has Board level responsibility for the Resuscitation Policy within South Central Ambulance Service NHS Foundation Trust. The Executive Director of Patient Care & Service Transformation also chairs the Patient Safety Group.
2.5 **Assistant Director of Patient Care**

The Assistant Director of Patient care has senior management responsibility for reviewing, updating and forwarding to the relevant people and committees as amendments are made. The role also has a co-ordinating function between departments to ensure the smooth review, audit and dissemination of the policy.

2.6 **Assistant Director of Education**

Assistant Director of Education has responsibility for ensuring that all mandatory training is identified and provided as required and for ensuring all education and training is delivered to a high standard. He/she will be responsible for ensuring that appropriate records are maintained of all training, both internal and external undertaken or sponsored by the Trust.

The Assistant Director of Education has senior responsibility for reviewing the training need analysis and ensuring that all appropriate grades of staff receive training in resuscitation and provide reports to the Quality and Safety Committee on the number of staff trained in year.

2.7 **Education Manager/Facilitators and Community Responder Trainers**

The Education Managers/Facilitators and Community Responder Trainers are responsible for providing the resuscitation training to staff and volunteers, keeping their knowledge and skills in line with current recommendations and guidelines.

2.8 **Resuscitation Officer**

The Resuscitation Officer has delegated responsibility for providing mandatory train-the-trainer resuscitation education and ensuring the quality and high standards of education delivery and training are in-line with the standards of Resuscitation Council (UK), European Resuscitation Council and AACE/JRCLAC Guidelines.

2.9 **All Staff**

All staff have a responsibility to read and understand this policy and adhere to the Trust current resuscitation guidelines and training needs analysis.

2.10 **Quality and Safety Committee**

The Quality and Safety Committee will approve and monitor the implementation of the Resuscitation Policy. Record any rejection of relevant recommendations on the risk register, within the Trusts governance structure. The Quality and Safety Committee will monitor the financial implication of the policy ensuring that the Trust Board is aware of any significant risks or funding associated with the implementation of the policy.

2.11 **Clinical Review Group**

The Clinical Review group, which is chaired by the Medical Director, with all Medical Directors as membership which forms the Committee with responsibility for reviewing the Resuscitation policy and assessing the effectiveness of the Resuscitation Policy and co-ordinate the production of gap analysis and action plans for the Quality and Safety Committee to monitor should a policy review be needed. Any amendments to the policy will be forwarded to the Quality and Safety Committee for approval.

3.0 **TRAINING STRATEGY**

The strategy for resuscitation training shall embody the statements and guidelines published by the Resuscitation Council (UK), European Resuscitation Council and AACE/JRCLAC Guideline, incorporating the most recent updates to these guidelines.

This Trust will provide sufficient and appropriate resuscitation training for each of the main staff groups. Profession specific resuscitation training will be directed by their respective
functional role and the guidelines and directives issued by their professional bodies (e.g. The Health Care Professions Council (HCPC), General Medical Council (GMC) and Nursing & Midwifery Council (NMC)).

Resuscitation training will be provided as identified through the training needs analysis.

**Patient Facing Staff**

**3.1 Paramedics, Nurses and Specialist Practitioners**

Clinical qualified registered personnel (Paramedics, Nurses, and Specialist Practitioners) are qualified by registration to recognise life extinct.

**3.2 Technicians/Associate Ambulance Practitioners (AAP)**

Qualified Technicians, who have received resuscitation training, will receive further training in order that they are permitted to diagnose and VERIFY THE FACT OF DEATH (also known as “Diagnosing Death” or “Recognition of Life Extinct”) under certain conditions. Technicians and AAP’s can perform basic life support and manual defibrillation and assist in clinical staff in advanced life support.

**3.2 Emergency Care Assistants**

Emergency Care Assistants are trained in Basic Life Support and to use a defibrillator in advisory mode only. They are trained to assist clinical staff in advanced life support procedures such as Cannulation, airway management and medication administration.

**3.2 Community and Co Responders**

Community and Co Responders and volunteers who provide their time free to the Trust and are trained in basic life support, oxygen and AEDs and act as a first response for the organisation.

**3.3 Doctors**

Doctors work for SCAS both under paid contracts and voluntary honorary contracts. Basic Doctors are volunteers who respond to trauma and are called out by the Emergency Operations Centre to a set criterion. Doctors are also paid for admission avoidance shifts and for helicopter HEMS shifts. Their resuscitation training is provided by their employing NHS organisation.

**3.4 Patient Transport Services**

Patient Transport Services include Ambulance Care Assistants and Car Drivers will receive basic life support training as per the training needs analysis. Voluntary Car drivers will be offered basic life support training but this would be on a voluntary basis only.

**3.5 Emergency Operations Centre (CCC)**

All CCC staff will have a current qualification in NHS pathways telephone CPR and a current valid qualification in Basic Life Support.
Non Clinical Staff

3.6 Mechanics, Workshop Drivers and Supply Staff

These staff groups drive Trust vehicles clearly identified as belonging to the ambulance service. Members of the public would expect staff working for the ambulance service to at least be able to assist any person with basic life support. Support staff (contractors) have training in a documented process to manage these situations, South Central Fleet Services staff are trained in basic life support.

3.7 Administration staff

All administration staff do not deal with patients so will not be trained in resuscitation.

4.0 MONITORING

4.1 The Policy will be monitored for its effectiveness by the Assistant Director of Patient Care through the following:

- Responsibilities of staff will be monitored through attendance at meetings, management of systems, development of reports and the appraisal process;
- Number and percentage of staff completing mandatory training in year;
- Production of reports showing trend analysis of reporting broken down into:
  - Patients attended in Cardiac Arrest
  - Patients with a Return Of Spontaneous Circulation (ROSC) at hospital
  - Grade of staff attending
  - Divisional comparisons
  - Trust performance

4.2 These will be conducted on a six monthly basis and reports provided to the Clinical Review Group and the Quality and Safety Committee.

5.0 POST RESUSCITATION CARE

5.1 The Trust will make provisions for safe continuity of care and where necessary, safe transfer following resuscitation of the patient. This may involve the following steps:

- 111 call center transfer to 999
- Front line staff referring to the ED
- PTS staff calling 999 for back up from Frontline staff
- Transfer of patient from hospital to specialist hospital
- Preparation of equipment, oxygen, drugs and monitoring systems;
- Full and complete hand-over of care;
- Transfer co-ordination with the assistance of CCC
- Referral to a specialist (Air Ambulance)
- Informing relatives

5.2 Patients who are resuscitated from their cardiac arrest of a presumed primary cardiac cause, although emphasis is generally given to the actual resuscitation attempt and achieving return of spontaneous circulation (ROSC), patients who reach this stage are invariably very unstable and prone to further deterioration.

5.3 Good quality care following ROSC can double the patient’s chances of survival and is a vital final link in the chain of survival. The quality of ambulance management of a resuscitated patient is therefore vital to improving their chances of survival.
5.4 The post-arrest patient

Resuscitated cardiac arrest patients may be unstable for several reasons. Invariably these patients have some degree of impaired myocardial contractility due to a myocardial infarct that may have caused the original cardiac arrest, a subsequent period of ischaemia, and further injury from repeated defibrillation.

Neurological impairment may also result in an obstructed airway, a risk of aspiration and ineffective respiratory effort resulting potentially in hypoxia. Gastric distention from initial ventilation using a bag-valve-mask may also have caused gastric distention which further impairs ventilation and may also impair venous return.

5.5 Post-ROSC general management

- When possible, extricate and transfer a patient if tolerated in a supine position which helps achieve cardiovascular stability.
- Although 100% oxygen should be used in the resuscitation attempt, once ROSC is achieved, too much oxygen (hyperoxia) may actually harm the heart and other ischaemic tissues, including the brain. Titrate the oxygen flow to maintain oxygen saturations of 94-98% (as per AACE/JRCALC 2016). In the absence of heart failure and pulmonary oedema, patients may not need any supplemental oxygen to achieve this target oxygen saturation range.
- Perform a 12–lead ECG as soon as possible after obtaining ROSC. Patients with signs of ST elevation or LBBB, should be treated in a similar manner as those presenting with an acute MI and local protocols followed with regards to activation of the pPCI pathway.
- 1:4 patients without ST elevation or LBBB on post ROSC ECG will have a blocked coronary artery and may also benefit from emergency angiography/pPCI – thresholds should be low for discussing these cases with pPCI centre on a case by case basis, especially if there has been a proceeding history of chest pain prior to cardiac arrest.
- The pulse rate and rhythm and oxygen saturation should be closely monitored during transport to hospital. In patients who are shut down and poorly perfused, the pulse oximeter may fail to record and these patients may particularly benefit from early expert cardiac care in a pPCI centre.
- Blood pressure should be measured regularly; more often in unstable patients to detect any decline as soon as possible.
- Record the neurological status (AVPU/GCS and pupils). When examining the pupils, remember that both adrenaline and atropine cause pupillary dilation and dilated pupils (which may often appear fixed) are unreliable indicators of neurological outcome. It is essential to rule out hypoglycaemia in patients who remain unconscious after cardiac arrest. The neurological outcome in spontaneously breathing patients on arrival at hospital is often good with optimal specialist care.
5.6 Specific post-ROSC issues

- **Therapeutic hypothermia**
  Several hospital studies have shown that cooling patients who remain unconscious following ROSC reduces brain damage and increases their chances of survival. It had been thought that starting aggressive cooling in the pre-hospital setting using cold intravenous fluids may also help the patient. However, a recent study has shown that cold IV fluids may actually make the patient more unstable. It is therefore recommended to initiate simple first line passive skin cooling techniques (no blankets, no vehicle heating, windows open /air-conditioning on maximum etc) but NOT to actively cool the patient with cold IV fluid (See SCAS Clinical Memo 63 Nov 2011).

- **End-tidal CO\(_2\)**
  End-tidal CO\(_2\) can be monitored either using a paper device that changes colour (yellow) with CO\(_2\) or a more accurate electronic monitor (capnometer). The presence of CO\(_2\) confirms a cardiac output, blood flowing through the lungs and air going in and out of the lungs.
  
  Its use is mandatory when performing endotracheal intubation as the presence of end-tidal CO\(_2\) confirms correct placement of the tube in the trachea. CO\(_2\) may be absent for several reasons including:
  - Little or no cardiac output
  - Unrecognised oesophageal intubation
  - Poor quality chest compressions during CPR

  In any intubated patient, the absence of chest wall movement or CO\(_2\) (Easycap remaining purple) should be assumed to be due to unrecognised oesophageal intubation and the endotracheal tube must be removed immediately and replaced with either a BVM or iGel to achieve ventilation.

  When a patient is intubated, the CO\(_2\) level can be used as marker of cardiac output; the better the cardiac output, the higher the end-tidal CO\(_2\) brighter yellow the EasyCap paper will turn). During CPR, the end-tidal CO\(_2\) will increase rapidly once ROSC is achieved.

  End-tidal CO\(_2\) has also been used as a marker of futility in intubated patients. Very low levels during resuscitation are associated with poor outcome, but because the levels also depend on the quality of chest compressions, this is generally an unreliable marker in the pre-hospital setting.

  End-tidal CO\(_2\) measurements are of limited use with an i-gel in the presence of an air leak and give can give an artificially low ETCO2 reading.

- **Ventilation**
  Following ROSC, gentle ventilation is very important to maintain haemodynamic stability. If ventilation is too fast or too forceful, blood pressure will drop rapidly and the patient may re-arrest. It is therefore vital to ventilate the patient as gently as possible at no more than 8-10 breaths per minute. Use of a mechanical ventilator may reduce the risk of hyperventilation (hyperoxia and hypocarbia) for staff trained and experienced in their use and aid haemodynamic stability by improving venous return.

- **Blood glucose**
  Blood sugar is often unstable following a cardiac arrest. Measure the blood sugar and administer 10% glucose if indicated, according to JRCALC 2016 protocols. Be careful not to give excess glucose as it is bad for an ischaemic brain and heart following cardiac arrest.

- **Hypotension**
  Patients are often hypotensive following cardiac arrest. Make sure all reversible causes are corrected (e.g. tension pneumothorax). In adult patients who remain hypotensive (systolic BP < 80 mmHg) administer 250ml bolus of saline to achieve a systolic BP > 80
mmHg (using the same protocol for patients who are hypotensive from blood loss).

- **Treatment on scene**
  There is nothing to be gained by remaining on scene once ROSC has been achieved. Following ROSC, rapid hospital transport to the most appropriate hospital should be undertaken without delay. From 07:00 – 02:00, a doctor is usually available on one of the two air ambulances. Consider requesting medical backup from this resource early as additional intervention/critical care can be provided by this team which may help stabilise the patient and assist with onward transfer to an appropriate centre.

**References:**


**6.0 RESUSCITATION EQUIPMENT, REPLENISHMENT AND CLEANING**

6.1 All Trust vehicles frontline ambulances, Solo Response Vehicles and aircraft must be maintained in a state of readiness at all times. Vehicles should be checked by a qualified member of staff at least once every 24 hours and immediately following conclusion of a resuscitation event. The vehicles should be stocked in accordance with the standardised inventory according to organisation’s vehicle checklist.

6.2 Disposable items should be replenished at the earliest opportunity from the departmental storage areas in accordance with the organisation-wide policy. Non-disposable items should be de-contaminated / cleaned in accordance with both the manufacturers’ recommendations and the organisations infection control policy and re-instated to the vehicle as soon as is practical.

6.3 Pharmacy items must be replenished from departmental stock in accordance with the Medicines Management Policy. The defibrillator must be operationally checked in accordance with the Manufactures recommendations and the Trusts Medical Devices Policy.

**7.0 MANUAL HANDLING**

7.1 In situations where the collapsed patient is on the floor, in a chair or in a restricted / confined space the organisational guidelines for the movement of the patient, Refer to the Health & Safety Policy (section A) Minimum Lifting Policy, must be followed to minimise the risks of manual handling related injuries to both staff and the patient. Please also refer to the Resuscitation Council (UK) statement which can be found at [http://www.resus.org.uk/pages/safehand.htm](http://www.resus.org.uk/pages/safehand.htm)

**8.0 CROSS INFECTION**

8.1 Whilst the risk of infection transmission from patient to rescuer during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. It is therefore advisable that direct mouth-to-mouth resuscitation be avoided in the following circumstances:

- All patients who are known to have or suspected of having an infectious disease;
- All undiagnosed patients where history cannot be obtained, i.e. from relative or carer;
- Other persons where the medical history is unknown.

8.2 All trained staff should have immediate access to airway devices to minimise the need for mouth-to-mouth ventilation. However, in situations where airway protective devices are not...
immediately available, start chest compressions whilst awaiting an airway device. If there are no contraindications consider giving mouth-to-mouth ventilations. More detailed and further advice can be found in the Trusts Infection Prevention, Control and Decontamination Policy CSPP 2.

9.0 Profoundly Hypothermic (<30° Centigrade) patients in Cardiac Arrest

9.1 The 2016 ACCE Clinical Practice (JRCALC) Guidelines gives further advice on the practical management for profoundly hypothermic patients (less than 30 degrees centigrade) who are found in cardiac arrest in whom it is clinically appropriate to attempt resuscitation. There are a number of considerations and changes in practice that are important for all SCAS clinicians to be aware of that are different to when attempting the resuscitation of patients with a normal core temperature.

9.2 Management

- Thresholds for aggressively attempting resuscitation should be low in patients found in unexpected cardiac arrest in cold environments unless there are features unequivocally associated with death i.e. rigor mortis, hypostasis and putrefaction, or associated injuries incompatible with survival.
- Thresholds for aggressively resuscitating small children and young adults following immersion in cold water should also be very low – there are reports of complete neurological recovery in patients completely immersed up to 90 minutes in icy water (patients are not dead until they are ‘warm and dead’)
- It may only be possible to establish the futility of further efforts at resuscitation following admission to an Emergency Department when arterial blood gas analysis can guide the appropriateness or otherwise at further efforts at resuscitation (i.e. severe hyperkalaemia and metabolic acidosis suggest warm asphyxia and the futility of further resuscitation).
- In severely hypothermic patients with a core temperature of less than 30 degrees C repeated defibrillation is unlikely to be successful and repeat shocks are damaging to the myocardium (a maximum of 3 DC shocks recommended)
- **Repeat doses of adrenaline** in severely hypothermic patients with a core temperature less than 30 degrees C is also potentially toxic to the heart and to the brain – do not administer adrenaline (or amiodarone) to patients in cardiac arrest with a core temperature less than < 30 degrees C
- In patients with moderate hypothermia (30-35 degrees C) current RC (UK) guidelines recommend doubling the adrenaline dosing interval (1 mg every 6-10 minutes).
- The SCAS tympanic thermometers have a Displayed Temperature Range = 20 – 42.2 degrees C, an Operating Ambient Temperature Range = 10 – 40 degrees C, with an accuracy of up to 0.5 degrees C in the 20-35 temperature range.
- Consider transporting all such patients directly to the nearest Emergency Department with access to on-site cardiopulmonary bypass for active central rewarming (John Radcliffe Hospital Oxford, University Hospital Southampton). Obtain decision support if required from the JR/UHS Emergency Department via their priority line.
- Consider the use of a mechanical chest compression device (e.g. LUCAS2) to support on-scene and in-transit CPR if available, and requesting early Pre-hospital Emergency Medicine support via Air Ambulance / ECRU.
- Decision support is also available from the SCAS Medical Directors and the on call duty Medical Incident Adviser.
10.0 ANAPHYLAXIS

10.1 The management of suspected anaphylaxis / anaphylactoid reactions should be conducted in accordance with the AACE/JRCALC Guidelines 2016 section 3 pages 155 and 200 Medical emergencies further advice can be sought from the Resuscitation Council (UK) Guidelines for the management of anaphylaxis.

10.2 Ambulance crews should carefully check their medicine doses and administration routes in their pocket books prior to administration. These are time pressure situations where mistakes can occur unless robust checking procedures are in place.

11.0 DEFIBRILLATION

11.1 Defibrillators must only be operated by persons specifically trained in their use. The operation of defibrillators by all Trust staff and contracted services is subject to their compliance with the protocols within the Trusts training. For ECAs the defibrillators will be used in fully automated mode, but for suitably trained clinicians they should be used in manual mode.

11.2 Shockable rhythms in children are relatively rare and are usually due to congenital heart disease, tricyclic overdose, raised potassium levels or hypothermia. Defibrillation is a time-critical intervention, with mortality increasing approximately 10% for each minute’s delay in defibrillation. Basic life support only slows the demise of the patient; defibrillation is a potential cure. The longer defibrillation is delayed, the less likely it is to be successful.

11.3 In all cases, where a patient appears to be in fine ventricular fibrillation (VF), defibrillation should be delivered at the earliest opportunity.

11.4 Optimal defibrillation in children involves delivery of a proportionately smaller shock to that used in adults. In order to achieve this, defibrillators are available with smaller self-adhesive pads for use with children that reduce the electrical discharge from the defibrillator. Ideally, these paediatric pads should be used in children < 8 years age, and adult pads in older patients.

11.5 However, if paediatric pads are not available and a child/infant (of any age) is in a shockable rhythm, defibrillation must still be undertaken immediately; to delay the shock risks a fatal outcome for the child.

Action

- When paediatric self-adhesive pads are not available, adult self-adhesive pads must be used as an alternative and defibrillation should never be delayed.
- Ensure that the pair of self-adhesive pads do not touch each other; in small children, a front- back pad position may be necessary. Once the adult pads are in place, defibrillate the child as per usual procedure, following the defibrillator instructions when appropriate.
References:


12.0 PROCUREMENT

12.1 All resuscitation equipment purchasing is subject to the organisation’s standardisation strategy; therefore all resuscitation equipment purchased must be sanctioned by the Director of Finance or designated / delegated person prior to ordering.

13.0 RECOGNITION OF LIFE EXTINCT (ROLE) AND DO NOT ATTEMPT RESUSCITATION (DNAR) GUIDELINES

13.1 DEFINITION

13.1.1 SCAS personnel can only verify the “Fact of Death”. They cannot “Certify” the cause of death. Certification must be undertaken by a Doctor.

13.1.2 There are a number of circumstances whereby SCAS personnel may be required to consider establishing the Fact of Death. These are:
   - Death in a Private residence concurrent with existing medical treatment – colloquially an “Expected Death”
   - Death in a Private residence – an “Unexpected Death”
   - Death in a Public Place (i.e. not a Private residence) – an “Unexpected Death”
   - Death in an Ambulance
   - Death in a Major Incident situation

13.1.3 Any of these may also include “Death in Suspicious Circumstances” whereby it is likely that the Police, on behalf of HM Coroner, will be required to conduct an investigation into the circumstances of the death, to determine if a crime has been committed.

13.1.4 GPs are no longer obliged to attend a scene to confirm a death has occurred.

13.1.5 This policy applies to all age groups of patient

13.2 IMMEDIATE ACTIONS (See Appendix A)

13.2.1 Following arrival, and the recognition of a pulseless and apnoeic patient (in the presence of a patent airway), resuscitation should be commenced whilst the facts of the collapse are ascertained unless the conditions unequivocally associated with death are present (see 13.3.1.5) or a valid advance directive/DNACPR is visible to the ambulance staff. In all other cases resuscitation must be commenced and the facts pertaining to the cardiac arrest must be established. CCC call takers will commence telephone CPR instructions (unless the caller refuses) until a valid DNACPR/ADRT is visible and a healthcare professional has established that no reversible causes are present.

13.2.2 In the event of a paediatric cardiac arrest, resuscitation must be commenced immediately and continued to hospital. Transport to Hospital should be carried out at the earliest opportunity. The only circumstances in which resuscitation is not indicated are:
   - Massive cranial and cerebral destruction
- Hemicorporectomy or similar massive injury
- Decomposition / Putrefaction
- Incineration
- Where there is a valid DNR in place.

Unless Hypostasis and Rigor Mortis are in an advanced stage resuscitation should be attempted.

- Do not be deterred in your resuscitation attempts, even if a non-medically trained individual has determined that the resuscitation attempts are futile. The child should be immediately reassessed and resuscitation attempts commenced where appropriate.

- ALL children must be taken to the nearest emergency department with onsite paediatric support, not the mortuary, irrespective of whether active resuscitation is being carried out. The only exception is where there is a Valid DNR or Advanced Care Plan (ACP) in place, or where a crime scene has already been declared. In these extreme and very rare circumstances the child may be left “at scene” if all attempts to transport to Hospital have been exhausted first. The CCC must be informed immediately.

These actions will ensure that the child, the family and all staff concerned receive the best possible support.

- Further information can be found in AACE/JRCALC ‘Dealing with the Death of a Child (including SUDI).

- Some children have Advanced Care Plans which give specific information, such as not starting cardiac compressions, but allowing ventilatory support. You should respect the requests in these medical documents.

- See the Child Death flow chart in Appendix 4

13.2.3 In the following conditions resuscitation can be discontinued:

- The presence of an up to date formal DNACPR/ACP (Do not attempt Cardiopulmonary Resuscitation) order or an Advanced Decision to Refuse Treatment (ADRT) that states the wish of the patient not to undergo attempted resuscitation.
- When the patients death is expected due to terminal illness.
- Efforts would be futile if ALL the following exist together (see 13.3.1):
  - 15 minutes since the onset of collapse
  - No bystander CPR prior to the arrival of the ambulance
  - The absence of any exclusion factors (require reference)
  - Asystole for >30 seconds on the ECG monitor screen
  - Submersion (not immersion) of adults for longer than one hour, children longer than 1.5 hours (see 13.3.1.7).
13.3 CRITERIA FOR ESTABLISHING RECOGNITION OF LIFE EXTINCT

13.3.1 To establish the Fact of Death:

The following must be present:

1. There is a history of the patient having been unconscious without signs of life or respiratory effort for the previous 15 minutes and without any prior bystander or responder CPR.

2. Clinical examination reveals the absence of palpable central pulses (carotid/femoral), and the absence of any respiratory effort.

3. Fixed dilated pupils.

4. Asystole rhythm on ECG monitor screen > 30 seconds.

5. When the “conditions unequivocally associated with death” are present:
   - Rigor-mortis (note: generalised over body and not to be confused with Cadaveric Spasm)
   - Hypostasis (pooling of blood by gravity)
   - Injury which is obviously not compatible with life:
     - Decapitation
     - Decerebration (including massive cranial / cerebral destruction)
     - Incineration
     - Hemicorporectomy (or similar massive injury)
     - Decomposition / Putrification
     - Foetal Maceration

Alternatively:

6. If the patient does not respond despite full ALS intervention and remains asystolic despite >20 minutes of resuscitation then resuscitation may be discontinued.

7. This does not apply to patients who have suffered cold immersion injury, hypothermia, drowning or who are pregnant. These patients must continue to be resuscitated and removed to definitive care. However, patients who have categorically been submersed (as opposed to immersed) for 1 hour (adult) and 1.5 hours (child) may be considered life expired. If in doubt – resuscitate. (see AACE/JRCALC Guidelines, Resuscitation, section 2 for further information).

8. Cessation of resuscitation for patients in Pulseless Electrical Activity

   It can be extremely difficult to differentiate between pulseless electrical activity (PEA) and an organised cardiac rhythm with a low perfusion output. These cases will therefore be transported to hospital with full resuscitation as there is a serious risk that a patient could be left at the scene but actually still have a cardiac output. This risk is even more pronounced when a patient is cold.

13.4 Adult DNACPR / Advanced Decision to Refuse Treatment (ADRT)

13.4.1 All SCAS personnel may discontinue/withhold resuscitation attempt if:
1. A formal ‘Do Not Attempt Cardiopulmonary Resuscitation’ order (DNACPR) is in place, on the DNACPR/RESPECT form (may be Lilac but can be photocopied or printed on white paper or have a red lined box border) or a DNACPR notice which has the correct patient details, is completed and signed by a health care professional involved in the patient’s care and is in date:

The form will stay with the person, and will be located in the following places:

- Hospitals, nursing homes, hospices – in the front of person’s notes
- In the home – The tear off slip should be completed and placed in the ‘message in the bottle’ in the person’s refrigerator. The location of the DNACPR form needs to be clearly stated.
- If a “message in a bottle” is not available, a system needs to be put in place to ensure effective communication of the DNACPR form’s location to all relevant parties including South Central Ambulance Service. Special notes can then be attached to the patient’s notes so that ambulance staff are able to view the documents and receive an alert before attending. http://www.lionsmd105.org/Community/MIAB/where_bottle.htm
- GP surgeries – In the notes either paper or electronic ‘ALERTs’ should be set up on electronic notes, usually in the ‘reminder section.’

Ambulance transfer (Section 5 Lilac form) – To be completed if discussion has taken place as to where the person wishes to be taken should they deteriorate during the transfer (cannot be a public place). Section c) is the name and telephone number of the preferred destination and Next Of Kin (NOK). Section e) can be completed by a healthcare professional.

If this section is not completed, the person can be transferred and if they deteriorate they will be taken to the nearest Emergency Department. If the patient dies on route to hospital with a valid DNACPR then every effort must be taken to make sure that the next of kin are informed. Generally this will be done by the care facility from where the patient was transported from, but may be done by the crew, or by the police. Patients must not be left at the mortuary without informing relatives, next of kin or carers.

Patient Transport Services –

- DNACPR / End of Life Care Packages / ADRT to be recorded by either the Discharge Lounge or the Dispatchers on the Patients Journey record. To be recorded: the date the DNACPR / End of Life Care Packages / ADRT was signed and Dr’s name.
- The operational staff attending need to confirm the DNACPR / End of Life Care Packages / ADRT is still current preferably via the lilac form, however the old style form or Dr’s Letter (if in date) can be accepted.
- Before the patient is conveyed from the location of ‘pick-up’, the crew must inform the Dispatchers or Discharge Lounge they are ‘going mobile’. The crew then needs to confirm when they have completed the patient journey.
- It is perfectly acceptable for an escort / family member to accompany the patient during the journey. We do not need a formal written confirmation of this.

The reason the escort / family member may wish to travel with the patient may be that the patient may not survive for the journey itself or long after.

- End of Life Care Package patients must travel singularly on a double manned ambulance. (Many of these patients are likely to be going home or to a hospice for palliation or to die)
Non ambulance transfer between departments, other healthcare settings and home should be informed and abide by the DNACPR decision.

All SCAS personnel may discontinue/withhold resuscitation attempts if:

1. An Advance Decision to Refuse Treatment (ADRT) has been accepted by healthcare professionals to signify a DNACPR and documented on the lilac form.

2. Patients may have a "living will" or "advance directive" although it is not legally necessary for the refusal of treatment to be made in writing or formally witnessed. This specifies how they would like to be treated in the case of future incapacity. Case law is now clear that an advance refusal of treatment that is valid, and applicable, to subsequent circumstances in which the patient lacks capacity, is legally binding. An advance refusal is valid if made voluntarily by an appropriately informed person with capacity to make such a decision. Personnel should respect the wishes stated in any such a document.

3. If a patient has a DNACPR in place and does not wish their relatives or carers to be made aware of it, their decision must be respected. In the event of the person dying and the need to withhold CPR occurs, the existence of the DNACPR should be explained to the relatives or carers. To inform the relatives or carers of its existence prior to death would go against the patient's Human Rights.

4. A DNACPR decision does not include immediately reversible life-threatening clinical emergencies such as choking, suicide or anaphylaxis. Appropriate emergency interventions, including CPR should be attempted in these case.

13.5 Child and Young Person Advanced Care Plan (ACP) on Lilac Paper

13.5.1 Any person below 16 years of age is classified as a child and cannot make decisions on their own. The child’s parents or legal guardian(s) are responsible for making decisions in the best interest of the child.

13.5.2 Any person of 16 or 17 years of age is classified as a “young person” and therefore may have a view in the decision making in respects of their health and well-being. However the Mental Capacity Act (MCA) does not apply to young persons, so legally they cannot make a decision themselves.

13.5.3 Any person over the age of 18 years old is deemed an adult and an Advanced Care Plan (ACP) should not be initiated after their 18th birthday, although an existing plan may stay in place until replaced by a DNACPR.

13.5.4 The child and young person Advanced Care Plan (ACP) is a formal document which is designed to communicate the health care wishes of children and young people who have chronic and life-limiting conditions. The ACP is designed to be used in all environments that a child may find themselves in, including hospitals, hospices, schools, care facilities and home, and will be used by the ambulance service. The ACP can be used as a resuscitation plan or as an end of life care plan. It remains valid when the child’s parents or legal guardian(s) cannot be contacted.

13.5.5 The fact of an ACP being in place will be communicated to the Clinical Coordination Centre when the call is received and will be printed and made available to the ambulance crew on arrival. The ACP should be checked for the validity of any decision and that it is signed and in date.
13.5.6 All children are for attempted resuscitation unless there is a valid DNACPR decision in place or unless ROLE criteria is fulfilled (section 13.2.2). If there is any doubt about the validity of a DNACPR decision then resuscitation should be initiated.

13.5.7 A DNACPR decision does not include immediately remediable life threatening clinical emergencies such as choking, suicide or anaphylaxis. Appropriate emergency interventions, including CPR should be attempted.

13.5.8 If a parent or legal guardian is present at the time of his or her child’s collapse, and they wish to deviate from the previously agreed ACP, then their wishes should be respected provided they are thought to be in the best interests of the child.

13.6 PROCEDURE FOLLOWING VERIFICATION OF THE FACT OF DEATH

13.6.1 Patients in cardio-pulmonary arrest are to be vigorously resuscitated whenever there is any chance of survival. Nevertheless, it is possible to identify patients in whom there is absolutely no chance of survival and where resuscitation, or continued resuscitation, would be futile and distressing for relatives, friends and healthcare professionals.

This policy is in accordance with the AACE/JRCALC Clinical Practice Guidelines section 2 Resuscitation (Recognition of Life Extinct).

All SCAS personnel may discontinue/withhold resuscitation attempts if any of the following is in place:-

- Advance Care Plan (ACP)
- Advance Decision to Refuse Treatment (ADRT)
- Do Not Attempt Cardiopulmonary (DNACPR) is in place (normally on lilac paper).
- There must be a statement of some sort that the ADRT/DNARCPR stands “even if life is at risk” this must be in writing, signed, and witnessed and within the review date.

A DNACPR decision does not include immediately reversible life-threatening clinical emergencies such as choking, attempted suicide or anaphylaxis, when appropriate emergency interventions, including CPR should be attempted.

Crew will obtain patient information from

- Patient care notes
- “Message in the bottle” in the person’s refrigerator.
- Electronic Alert placed on the CCC computer aided dispatch database.

**Suspicious circumstances or reason to suspect neglect, or mistreatment**

Police to be informed via CCC, safeguarding referral made and crew remains with the deceased until Police arrive

13.6.2 **Patient in a Private residence – Expected Death**

1. Where the death is expected, or the patient has been seen by his/her GP within the last 14 days, the GP (or OOH, the GP’s representative) should be informed. This can be achieved by contacting:

- the GP Surgery (in hours)
• the Out of Hours Call Centre. The OOH service will contact the Surgery and inform the GP on the next working day
• CCC

2. If there are any suspicious circumstances or reason to suspect neglect or mistreatment then the Police should be informed as per (OPP No7 – SCAS Attendance at Sudden Death in Adults) and a safeguarding referral made as per the CSPP 1 Safeguarding Policy.

3. Relatives can make arrangements with local Funeral Directors of their choice or the on duty funeral Directors out of hours to have the body removed.

4. If the patient has been seen by a Doctor in the last 14 days and that Doctor knows the cause of death, s/he can issue the Death Certificate. There is no requirement for the GP to visit, but they (the GP) may do so for humanitarian/social reasons. The OoH GP service is unlikely to be in a position to issue a Death Certificate.

5. The documentation process is completed.

6. Ambulance personnel are under no obligation to remain if relatives are present and may leave the scene once documentation is completed. However under the holistic patient-care principal, SCAS personnel may decide to remain until they are satisfied that friends and / or relatives in attendance can care for the next of kin, especially where elderly infirm relatives or parents of young children are involved. Relatives should be given every possible support when dealing with this traumatic event.

Summary:

• Inform GP of death via surgery telephone or OOH representative
• Suggest relatives/carer could inform other family members for support.
• Suggest relatives/carer could contact Funeral Directors for further advice to conform to faith/beliefs and to have the deceased taken to a chapel of rest.
• If relatives/carer do not have preferred Funeral Director, CCC to ask Police to provide “on call” Funeral Director for location, clearly define expected death no requirement for Police to attend, deceased information (Ambulance incident number, name, age/date of birth, address, GP details state DNACPR or ACP in situ patient detail with GP)
• Provide “What to do when someone dies leaflet”
• If there are concerns that cannot be reconciled within this process, discuss the situation with Clinical Support Desk. The decision-making process is then recorded for the Coroner.

After the documentation process is fully completed and a copy of the CAS 101 and ROLE form ePR or paper is left with the responsible person, ambulance personnel are under no obligation to remain with the relative/carer.

13.6.3 Patient in a Private residence – Unexpected Death

1. Where the death is unexpected and of apparent Natural Causes, contact the patient’s GP (procedure as above), and the police, MUST be informed, as per (OPP No7 – SCAS Attendance at Sudden Death in Adults) via CCC.

The following information will be required:

• Name and contact number of the attending crew
• Time, Address and location of the deceased within the address
2. The documentation process is completed CAS 101 and ROLE form ePR or paper and copies left at scene with the responsible person.

3. Ambulance personnel are under no obligation to remain if relatives are present and may leave the scene once documentation is completed. However, under the holistic patient-care principal, SCAS personnel may decide to remain until they are satisfied that friends and/or relatives in attendance can care for the next of kin, especially where elderly infirm relatives or parents of young children are involved. Relatives should be given every possible support when dealing with this traumatic event.

4. More than one body at a location is immediately “suspicious circumstances” and the Police must be informed by the CCC.

Summary:

**Inform GP of death via surgery telephone or OOH representative**

If GP is able to support cause of death:-

- Suggest relatives/carer could inform other family members for support.
- Suggest relatives/carer could contact Funeral Directors for further advice to conform to faith/beliefs and to have the deceased taken to a chapel of rest.
- Should there be any concerns that cannot be reconciled within this process, discuss the situation with Clinical Support Desk. (Decision making process is then recorded for the Coroner)
- If relatives/carer do not have preferred Funeral Director, the Ambulance Service CCC will ask the Police to provide an “on call” Funeral Director for your location, they will be required to provide the Ambulance incident number, name, age/date of birth, address, GP details and will clearly state the situation to the Police who are acting in the capacity of the Coroner’s Officer.
- Provide “What to do when someone dies leaflet”
- The documentation process should be fully completed CAS 101 and ROLE form ePR or paper and copies left at scene with the responsible person. No obligation for crew to remain, however if no relative/carer present, the attending crew must remain with deceased until Police arrive.

If GP is unavailable or is not able to support cause of death:-

- Suggest relatives/carer could inform other family members for support.
- Should there be any concerns that cannot be reconciled within this process, discuss the situation with Clinical Support Desk. (Decision making process is then recorded for the Coroner)
- Police to be informed via CCC as they may wish to dispatch Forensic Medical Examiner. Deceased information (Ambulance incident number, name, age/date of birth, address, GP details, state the situation and further clinical information with
The documentation process should be fully completed CAS 101 and ROLE form ePR or paper and copies left at scene with the responsible person and relatives advised that Police/Coroner’s Officer will or will not be attending. There is no obligation for the ambulance crew to remain, however if no relative/carer present, the attending crew must remain with deceased until Police arrive.

- Provide “What to do when someone dies leaflet”

13.6.4 **Patient in a Public Place (hereby defined as any place other than a patient’s private residence) – Unexpected Death**

1. Under most circumstances, establishing the Fact of Death in a public place is not an option. All patients should be resuscitated and removed to hospital, with resuscitation continuing until the ED personnel decide to cease efforts. The exceptions to this are (see also 13.3):

   - Where “ROLE” criteria apply
   - Where suspicious circumstances surrounding the death or the need to conduct an investigation exists. These may include, for example, industrial accidents, as well as possible criminal activity. *(However it must be stressed that the Preservation of Life, including attempted resuscitation and removal where appropriate, comes before scene preservation)*
   - Where timely removal of the patient is not possible and following completion of full ALS protocols, or where full ALS is not possible due to a patient being trapped with ROLE criteria (i.e. in a serious road traffic incident)

2. In **any** circumstance of a possible death in a Public place (verified or otherwise), the Police **MUST** be informed, as per (OPP No7 – SCAS Attendance at Sudden Death in Adults) via CCC.

### Summary:

- Suspicious circumstances or reason to suspect neglect, or mistreatment. Police to be informed via CCC, safeguarding referral made and crew remains with the deceased until Police arrive.
- Police to be informed via CCC as they may wish to dispatch Forensic Medical Examiner. Where possible the deceased’ information should be supplied (i.e. Ambulance incident number, name, age/date of birth, address, GP details)
- Should there be any concerns that cannot be reconciled within this process discuss the situation with Clinical Support Desk. (Decision making process is then recorded for the Coroner)

The documentation process should be fully completed; relatives advised that Police/Coroner’s Officer will or will not be attending. Attending crew must remain with deceased until Police arrive.

13.6.5 This process will ensure that the needs of the patient, their relatives/carers, GP’s and Police/Coroners are all met by SCAS. These situations are dealt with by SCAS staff regularly and there have been in comparison very few concerns, but the ones that have been received need to be acted upon to ensure that we are able to improve the service we provide.
13.7 **VERIFICATION OF THE FACT OF DEATH FOLLOWING RESUSCITATIVE EFFORT**

13.7.1 Ambulance personnel will always ensure the dignity of the deceased patient is maintained.

13.7.2 To aid in any subsequent investigation (and to reduce the possibility of body fluid spillage) a Patient who has been aggressively resuscitated with ALS techniques should NOT have the ET/LMA, cannulae and defibrillator pads and electrode pads removed. Where relatives are present, Ambulance personnel should explain that medical equipment used on the patient must remain in situ.

SCAS has a standardised post resuscitation procedure for all unexpected adult deaths in the community, where attempts have been made to resuscitate the patient and, the death has been confirmed at the scene.

This mirrors existing procedures in the Emergency Departments following unsuccessful attempted resuscitation in hospital, and has been introduced after consultation with Coroners within the South Central region. It has also been discussed at the SCAS Clinical Review Group.

- All intravenous lines, oral and nasal airways, laryngeal mask airways and endotracheal tubes should be left in place following any attempt at cardiopulmonary resuscitation in patients who have died unexpectedly to facilitate investigation of that death by the coroner and to protect SCAS clinical staff.

- These devices must NOT be removed by SCAS clinical personnel in the event of unsuccessful resuscitation attempt prior to transfer to the mortuary.

13.7.3 Where possible patients should be positioned to allow on-scene relatives to view the body should they request this. The patient will normally be placed in a “neutral straight line” position, either in bed, or where necessary on the floor, utilising pillows and blankets. Patients should not be carried upstairs even if this is requested by relatives.

13.7.4 **Patient in an Ambulance**

1. **Whilst this will not usually be undertaken**, where a patient has undergone full ALS protocols but is unresponsive (as in 13.3 above), the Fact of Death may be verified en route to ED. The **only** justifiable reason for taking this action is:
   - The patient will not survive further resuscitation attempts
   - The continued journey to ED will be protracted (time/distance) in excess of 20 minutes remaining
   - There is an increased risk to the crew and members of the public by continuing to convey under emergency indications (heavy traffic, adverse weather conditions etc).

3. As technicians / AAPs, ECAs and PTS crews are unable to perform full ALS level resuscitation, crews should make a decision as to whether to wait for paramedic / nurse back-up, or perform BLS to hospital. If a crew feels that the quickest option is to go to hospital then BLS should be continued until arrival at hospital.

4. In general, once a decision has been made to start resuscitation, efforts will not normally be terminated in the ambulance unless the criteria in section 1 (above) apply.

5. Where this occurs, CCC must be informed. CCC must inform the Police (to inform the Coroner) and the ED staff Resuscitation Team. If resuscitation is ceased in the ambulance on route to hospital, the place of death is the address of the receiving hospital.
6. Ambulance personnel who take this course of action will be required to comply with the provisions in 13.8.5 below.

7. Should a patient deteriorate and go into cardiac arrest while being conveyed on a Patient Transport vehicle (or on an E&U vehicle) with a non-emergency crew the crew should immediately call for a frontline crew.

The non-qualified staff members should render immediate basic first aid and ensure a patent airway and commence BLS if appropriate. If the patient has a valid DNACPR in place the crew should follow the above procedure but withhold CPR and await the arrival of the frontline crew. The frontline crew will then take responsibility for the patient and transport to the most appropriate receiving unit or the mortuary in line with section 13.8.5 of this policy.

13.8 PATIENTS WHERE DEATH IS VERIFIED IN A PUBLIC PLACE – REMOVAL OF BODIES

13.8.1 When the Coroner needs to be involved, the Police or Coroner’s Officer must see the body at the place where the Fact of Death is established. The Police may elect to dispatch a Police Forensic Medical Examiner.

13.8.2 Therefore, as far as practically possible, the body must not be moved or removed from scene.

13.8.3 CCC must be kept fully informed of the situation at all times and appropriate notes made on the patient report form.

13.8.4 However, there are circumstances which may dictate a need for the body to be moved, primarily the removal of a body from the public gaze.

13.8.5 If not on scene, the Police must be informed of the situation and their advice sought.

In such circumstances, and subject to Police approval, SCAS personnel may convey the body to the nearest Mortuary via the Emergency Department. CCC must be made aware of the details of the patient as far as is known and the destination. This must be passed to the Police. The Attendant will travel in the patient compartment with the patient, as with any other transfer.

13.9 ACCEPTANCE PROCEDURE FOR BODIES AT HOSPITALS

It is beyond the scope of this document to outline individual hospital trust guidelines on the admittance of bodies to the mortuary. All SCAS personnel must adhere to local guidelines and practice relevant to the trust. The following is a generic guide only.

13.9.1 When Relatives are NOT accompanying patient or following Ambulance to hospital:

1. The Ambulance Crew will inform CCC of the situation. CCC must inform Police (to inform the Coroner) and ED that a body is inbound. During the Mortuary quiet hours ED will arrange for the mortuary to be opened and staffed, via internal hospital procedures.

2. The Doctor’s attendance in the Ambulance is no longer required, nor is the Doctor’s signature on the Disposal form. The Driver will ensure that the Patient is booked on to ED computer system (PAS) under:
   - name if known (and confirmed at scene by relative)
   - “unknown male/female – believed to be ***” - if identity not confirmed
   - “unknown male/female” if identity unknown

3. The Ambulance crew will then remove the Patient to the mortuary. SCAS personnel will assist the mortuary staff with removal of the body from the Ambulance trolley cot only.
4. Ambulance crew and mortuary staff will complete relevant documentation as appropriate.

5. Further involvement with relatives is undertaken by hospital staff / Police.

13.9.2 When Relatives ARE accompanying patient or following Ambulance to hospital:

1. The Ambulance Crew will inform CCC of the situation. CCC must inform Police (to inform the Coroner) and ED that a body is inbound with relatives accompanying / following the deceased.

2. The Patient will be unloaded from Ambulance and removed to ED Cubicle in the normal way.

3. The Patient will be booked on to ED computer system (PAS) in the normal way.

4. Where death is verified in an Ambulance en route to hospital, and relatives are following, the Ambulance crew will remain at the ED and, together with the ED staff, will inform the relatives of their decision to terminate resuscitation.

13.10 THE MAJOR INCIDENT SITUATION

The procedures for dealing with deceased patients in a major incident will be outlined in the major incident plan produced by the Emergency Planning Officers of SCAS and their divisional leads; the following is only a guide.

13.10.1 The priority of the Major Incident situation is to “do the most for the most”. During the Triage Sieve process it is vital that rapid assessment takes place. This does not allow enough time for full assessment as described above and is contained to opening airway and establishing respiratory effort. Absence of respiratory effort, at that stage, is sufficient to Verify the Fact of Death, along with any of the “Not Compatible With Life” criteria.

13.10.2 Appropriately trained SCAS personnel can verify the Fact of Death. A Doctor will confirm this and a record made of the time and name of the Doctor certifying on the Triage Card and Patient Report Form, if applicable. This would normally take place at one of three locations:

- Site
- Casualty Clearing Station
- Receiving Hospital

13.10.3 Other than to gain access to the live or injured to effect rescue, deceased casualties or remains should not be moved without the authority of the Police. This will assist the investigation that will undoubtedly take place and avoid possible disturbance or destruction of Forensic Evidence.

13.10.4 Any movement of the deceased must be undertaken with care, to assist in subsequent Forensic investigations, and be carried out in a sympathetic and respectful manner. Bodies should not be covered with blankets or sheets, which could contaminate the body or immediate scene in Forensic Evidence terms, without (where possible), the approval of a Scenes of Crime Officer (SoCO) or other Police Officer.

13.10.5 As soon as practical, the Police will establish a Body Holding Area to which deceased casualties or remains will be taken. This will only occur upon authorisation by the Police and under their supervision, prior to removal to a Temporary Mortuary.

13.10.6 Body Recovery may not take place until all live casualties have been removed, or e.g. until daylight hours, which will assist the gathering of Forensic Evidence. SCAS personnel will not normally be involved in this process, which will be carried out by specialist Police units with, where required, the assistance of the Fire Service.

13.10.7 Patients found to be dead on arrival at the Receiving Hospital will be dealt with in the normal
manner and then transferred to the Temporary Mortuary, when established, by the Police in conjunction with the local authorities.

13.10.8 Where many fatalities are exposed to public view, SCAS will assist the Police in transporting bodies to Temporary Mortuaries if resources allow, thereby avoiding the arrival of many mortuary / hearse vehicles at the scene of the incident and assisting in continuity. (Note: Transportation of the deceased must however, be viewed as a low priority and will only be undertaken when the evacuation of live casualties has been achieved.)

13.11 BODIES IN PUBLIC PLACES (particularly transportation accidents etc)

13.11.1 Bodies in public places are likely to be treated as a crime scene until proven otherwise and therefore are not generally the responsibility of the Ambulance Service. The Police have arrangements with (usually) local undertaking firms to remove from the scene. However, in exceptional circumstances, e.g. to assist the rapid removal of a body from the public gaze, SCAS personnel may be required to transport a body to the mortuary. In these cases, a Police Officer MUST travel in the Ambulance with the body, for continuity of evidence purposes, on behalf of the Coroner. Failure to do so may require the Ambulance crew being summoned at a later date to formally identify the body as that which they conveyed.

13.11.2 In general, all fatalities on the railway line will be treated as suspicious until evidence suggests otherwise, which means that the area will be treated as a crime scene. The British Transport Police will attend the incident, even though the County police service may be the first on scene.

13.11.3 SCAS personnel will treat bodies on the line in accordance with current SCAS clinical protocols regarding establishing the fact of death (bearing in mind the possible mechanism of injury and likelihood of resulting “Not Compatible with Life” circumstances) in conjunction with the Police Incident Officer and Rail Incident Officer, if present.

13.11.4 It is not an Ambulance Service function to collect or remove bodies or body parts from the railway. Network Rail has especially approved contractors for this purpose.

13.12 INFORMING NEXT OF KIN OF A DEATH

13.12.1 This is not a function of the Ambulance Service where tracing or contacting of relatives is required. This should be carried out either by the GP, Hospital, Police and / or Coroner’s Officer.

13.12.2 However, in the case of a death occurring in a Private residence, with relatives in attendance whilst resuscitation or other treatments are being performed, Ambulance personnel must keep them informed of the situation.

13.12.3 Where the Fact of Death has been established on scene, relatives present should be informed of what has happened, and what will happen next (see Appendix 3). When informing relatives, SCAS personnel should be sympathetic, but use plain language, to ensure that there is no misunderstanding of the situation.

13.12.4 Where death is verified in an Ambulance en route to hospital, and relatives are following, the Ambulance crew will remain at the ED and, together with the ED staff, will inform the relatives of their decision to terminate resuscitation

13.12.5 When providing handover information (written or verbal) to receiving agencies, Ambulance staff must ensure that there is clear understanding that arrangements for informing the next-of-kin are to be made by that agency.

13.13 DOCUMENTATION

13.13.1 CCC must be kept fully informed of the situation at all times and appropriate notes made on the relevant reporting forms.
13.13.2 Relatives, if present, must be given a copy of the Trusts leaflet “What to do when someone has died” and given every assistance when dealing with this traumatic event.

13.13.3 The SCAS patient report forms or Electronic Patient Report form (ePR) must be completed by the person verifying the Fact of Death and distributed as appropriate, which would require printing of the ePR on scene with Police officer signature:

- Patient Report Form (CAS101) or ePR complete with ECG strips (if available).
- The medical model should be completed on the continuation sheet (CAS 102) or as part of the ePR report.
- Recognition of Life Extinct form (CAS64), or the relevant sections of the ePR

13.13.4 Where copy forms are not required by agencies, these should be attached, with the top copy, to the Patient Report Form.

13.13.5 Where printing facilities on defibrillators are not available (e.g. Officers’ shock-boxes), the Recognition of Life Extinct may still be established, without the printout of the ECG, but this fact must be recorded on the Patient Report Form.

13.13.6 Where more than one body is at a location, Police assistance must be sought. It is vital that documentation is completed for each patient individually and can be identified uniquely for that patient. Agreement should be reached with the Police, on behalf of the Coroner, regarding the method of scene identification to be used (e.g. Body A, B etc or Male 1, Female 1 etc). Such identifiers must appear on each portion of the Ambulance Documentation.

13.13.7 The documentation will be audited at least six monthly to monitor compliance with this policy. Audits will be presented to the Clinical Review Group and the Clinical Quality and Safety Committee. Any actions required will be implemented at Operational level by the Area Managers.

13.13.8 When SCAS staff re-attend a patient in Cardiac Arrest which has been reviewed by SCAS 999 or 111 service within the previous 24hrs, a datix incident report should be submitted. The circumstances of the Cardiac Arrest will be reviewed on a case by case basis by senior clinical SCAS management.

13.14 AMBULANCE PERSONNEL SUPPORT MECHANISMS

13.14.1 Where required, and particularly in the case of incidents involving injuries “Not Compatible With Life” or death of paediatrics/children, SCAS personnel should be offered support via the Trust’s arrangements for defusing/debriefing. This will be arranged by CCC and/or the Duty Officer.

REMINDEERS - IF IN ANY DOUBT...

R  RESUSCITATE on scene, RESUSCITATE in Ambulance, RESUSCITATE into ED

O  Only declare in Ambulance if you are sure nothing else can be done and you are +20 mins from ED

L  Let CCC know what’s happening, so that Police / Coroner/ ED can be informed

E  Ensure that Relatives are cared for
SEQUENCE OF CLINICAL EVENTS
(Reference section 3.1 for staff competencies)

Cardio-pulmonary arrest

Pulseless/ Apnoeic with open airway

Start basic life support

ATTACH DEFIBRILLATOR

Yes

No

Evidence of CPR in past 15 minutes?

Any suspicion of: Drowning Hypothermia Poisoning and Overdose

Pregnancy?

No

Asystole > 30 seconds?

Yes

Cease resuscitation

Appendix B

No

Asystole despite 20 mins ALS

Transfer ED

Pregnancy is an indication for rapid transfer to ED to deliver the infant, by emergency caesarean section, in order to resuscitate the infant.
ACTIONS TO ESTABLISH FACT OF DEATH
(Reference section 3.1 for staff competencies)

Ambulance personnel believe Fact of Death can be established

Any suspicious circumstances?

Yes

Public Place?

Yes

Continue Resuscitation
Consider moving patient to ambulance whilst continuing resuscitation and then assessing criteria for ROLE
Notify CCC to inform Police
Remain on scene.

No

Home or place of Normal Residence?

Yes

Pt Seen by GP in 14 days?

Verifying Fact of Death
Offer Condolences
Notify CCC to inform GP/OOH
Complete Documentation
Leave Leaflet with Relatives

No

Are Relatives Present?

Yes

Pt NOT Seen by GP in 14 days? Or unknown

Verify Fact of Death
Offer Condolences
Notify CCC to inform GP/OOH AND Police
Complete Documentation
Leave Leaflet with Relatives
Remain if Required

No

Verify Fact of Death
Seek Contact Details
(Check Fridge – Message in a Bottle Scheme)
Notify CCC to inform Police
Follow OPP 7 Attendance at Sudden Deaths

No

Verify Fact of Death
Preserve scene
Notify CCC to inform GP/OOH AND Police
Advise of a suspicious death
Remain on scene
Complete Documentation

No

Verify Fact of Death
Preserve scene
Notify CCC to inform GP/OOH AND Police
Advise of a suspicious death
Remain on scene
Complete Documentation
When Someone Dies – What Happens Next  
(Reference section 3.1 for staff competencies)

Please accept our sincere condolences at the loss of the person you care for. The death of someone you care for is a devastating experience and can bring about stronger emotions than most people have ever felt before. You will want to ensure that the individual’s beliefs and faith is fully considered and acted upon.

The role of the ambulance crew – Expected Death

The ambulance crew will recognise and document the fact of death.

The crew will:-

- Inform GP of death via surgery telephone or OOH representative.
- Suggest relatives/carer could inform other family members for support.
- Suggest relatives/carer could contact Funeral Directors for further advice to conform to faith/beliefs and to have the deceased taken to a chapel of rest.
- If relatives/carer do not have preferred Funeral Director, the Ambulance Service Emergency Operations Centre will ask the Police to provide an “on call” Funeral Director for your location, they will be required to provide the Ambulance incident number, name, age/date of birth, address, GP details and will clearly state the situation to the Police. Acting in the capacity of the Coroner’s Officer the Police may wish to attend.

When the crew have fully documented the situation and are assured that the relative/carer is able to progress the situation by informing relatives and instructing a Funeral Director, they will leave.

Should you need further assistance please contact the GP via the surgery number.

The role of the ambulance crew – Unexpected Death

The ambulance crew will recognise and document the fact of death.

The crew will undertake to inform GP of death via surgery telephone or OOH representative.

If GP is able to support cause of death the crew will:-

- Suggest relatives/carer could inform other family members for support.
- Suggest relatives/carer could contact Funeral Directors for further advice to conform to faith/beliefs and to have the deceased taken to a chapel of rest.
- If relatives/carer do not have preferred Funeral Director, the Ambulance Service Emergency Operations Centre will ask the Police to provide an “on call” Funeral Director for your location, they will be required to provide the Ambulance incident number, name, age/date of birth, address, GP details of the deceased and will clearly state the situation to the Police. Acting in the capacity of the Coroner’s Officer the Police may wish to attend.

When the crew have fully documented the situation and are assured that the relative/carer is able to progress the situation by informing relatives and instructing a Funeral Director, they will leave.

If GP is unavailable or is not able to support cause of death the crew will:-
• Suggest relatives/carer could inform other family members for support.
• The Ambulance Service Emergency Operations Centre will inform the Police as they may wish to dispatch Forensic Medical Examiner. They will be required to provide the Ambulance incident number, name, age/date of birth, address, GP details of the deceased and state the situation and further clinical information with GP or OOH representative
• Advise relatives/carer that Police/Coroner’s Officer will be attending.

When the crew have fully documented the situation, there is no obligation for them to remain on scene. However, if no relative/carer present, the attending crew will remain on scene until Police/Coroner’s Officer arrives.

Should you need further assistance please contact the GP via the surgery number.

**Funeral Director**

You will find the funeral director invaluable during the early stages of your bereavement and there is a list of them in the yellow pages or in your local paper. Reputable directors are committed to the highest professional standards and will explain clearly all options available and will provide a clear estimate of possible charges. In circumstances of hardship it may be possible to apply for a funeral payment towards the expenses of a simple ceremony. Once you have appointed a funeral director you will find that they can advise on faith, beliefs and the details of registering the death.

**Support agencies**

There are many organisations that may be able to provide you with help and support.

**CRUSE**
National number 0844 477 9400
[www.crusebereavementcare.org.uk](http://www.crusebereavementcare.org.uk)

**SAMARITANS**
National number 08457 90 90 90
[www.samaritans.org](http://www.samaritans.org)

**CITIZENS ADVICE BUREAU**
[www.citizensadvice.org.uk](http://www.citizensadvice.org.uk)
Or you can phone your local branch. A complete list can be found in the *Useful Telephone Numbers* section of your local telephone directory.

**SOUTH CENTRAL AMBULANCE SERVICE PATIENT EXPERIENCE TEAM**
The Patient Experience Team is on hand to offer you guidance and advice on any matter relating to the service we provide. The team will work on your behalf to provide answers and understanding should you have a need to discuss any aspect of our care or treatment to you or a close relative or friend.

If you think we can help you in any way, please contact us:

Telephone: 0300 123 9280

or email [patientexperience@scas.nhs.uk](mailto:patientexperience@scas.nhs.uk)
Collaborative Procedure between South Central Ambulance Service, Hampshire Police and Thames Valley Police

**Conditions Unequivocally Associated with Death in children less than 18 years** –
1. Massive cranial and cerebral destruction
2. Hemicorporectomy
3. Massive truncal injury incompatible with life including decapitation
4. Decomposition / Putrefaction
5. Incineration

Hypostasis and Rigor Mortis are not to be considered in children these should all be conveyed.

**Child Death Detective Inspector** - A Detective Inspector that is trained in the management of child death incidents to ensure the multi-agency investigation is commenced and evidence gathered to ascertain the full facts of the child's death.
SCSHA Do Not Attempt Cardiopulmonary Resuscitation Policy
Unified
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy
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1 Introduction

The chance of survival following Cardiopulmonary Resuscitation (CPR) in adults is between 5-20% depending on the circumstances. Although CPR can be attempted on any person, there comes a time for some people when it is not in their best interests 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.

2 Policy Statement

The South of England (Central) Strategic Health Authority (SofE(C) SHA) 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
   • An Advance Decision to Refuse Treatment (ADRT) prohibits CPR.

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 an ADRT to ensure the verbal refusal is adhered to.

2.2 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.

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

2.4 When CPR might restart the heart and breathing of the individual, advanced discussion will take place with that individual if this is possible (or with other appropriate individuals for people without capacity); although people have a right to refuse to have these discussions.

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

2.6 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 could include carers and relatives if appropriate.

2.7 The DNACPR decision-making process is measured, monitored and evaluated to ensure a robust governance framework.

2.8 Training at a local/regional level will be available to enable staff to meet the requirements of this policy.

2.9 This policy has been reviewed by the local Trust Legal Services Department to ensure it provides a robust framework underpinned by relevant national documents.

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 applies to all of the multidisciplinary health, social and tertiary care teams involved in patient care across the range of settings within the SofE(C) SHA.

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). 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 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 www.southofengland.nhs.uk/end-of-life-care for Mental Capacity Act in DNACPR decision making)

5.4 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 who lack capacity will not be able to demonstrate one of the following:

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

5.5 Advance Decision to Refuse Treatment (ADRT). A decision by an individual to refuse a particular treatment in certain circumstances. A valid and applicable ADRT is legally binding.

5.6 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) refers to not making 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.

5.7 Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA). The Mental Capacity Act (2005) allows people aged 18 years or over, who have capacity, to make a LPA by appointing a PWA who can make decisions regarding health and wellbeing on their behalf once capacity is lost.
5.8 Independent Mental Capacity Advocate (IMCA). An IMCA supports and represents a person who lacks capacity to make a specific decision at a specific time and who has no family or friends who are appropriate to represent them. They must be consulted when a decision about either serious medical treatment or a long term move is being made.

5.9 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.

5.10 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.

5.11 South of England (Central) (SoE(C)) Strategic Health Authority (SHA) South Central SHA has merged with South West and South East SHA to form NHS South of England. This policy covers the Central region only.

6 Legislation and Guidance

Legislation

6.1.1 Under the Mental Capacity Act (2005), health and social care staff are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made.

6.1.2 The following sections 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:

Coroners, post-mortems and inquests: Directgov - Government, citizens and rights
http://www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713

6.1.4 SoE(C) SHA policy requires the completion of an Equality Impact Assessment (EIA), an example of which can be found in Appendix 3. Each organisation will need to carry out an EIA.

Guidance

6.2. The Resuscitation Council (UK):

- Recommended standards for recording "Do not attempt resuscitation" (DNAR) decisions (2009)
- Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (October 2007, updated November 2007). Decisions Relating to Cardiopulmonary Resuscitation
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/ General Practitioner (or Doctor who has been delegated the responsibility by their employer) / Registered nurse who has achieved the required competency. Registered nurses must complete the recognised competency training (designed by SoFE(C) SHA) and be indemnified by their organisation. [http://www.southofengland.nhs.uk/what-we-do/end-of-life-care/central-area-documents/](http://www.southofengland.nhs.uk/what-we-do/end-of-life-care/central-area-documents/)

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 the SoFE(C) SHA 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.

7.5 Chief Executives of provider organisations are responsible for:
   - compliance, both clinical and legal with the regional policy and procedure
   - ensuring the policy is agreed and monitored by the organisation’s governance process

7.6 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 at the SoFE(C)SHA
   - DNACPR forms, leaflets and policy are available as required.

7.7.1 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. Acute trusts must ensure that a DNACPR decision is verified by a professional with overall responsibility at the earliest opportunity
   - ensure the decision is documented (See 8.6)
   - involve the individual, following best practice guidelines when making a decision, (See 8.5) and, if appropriate, involve relevant others in the discussion
   - communicate the decision to other health and social care providers
   - review the decision if necessary.

7.7.2 A registered nurse making DNACPR decisions must:
   - be competent to make the decision
   - document the decision (See 8.6.1)
   - involve the individual, following best practice guidelines when making a decision, (See 8.5) and, if appropriate, involve relevant others in the discussion
• communicate the decision to other health and social care providers
• review the decision if necessary.

7.8 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.
• ambulance service staff (including private providers) must adhere to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guidelines.

7.9 Commissioners and Commissioned Services must:
• ensure that services commissioned implement and adhere to the policy and procedure as per local contracts
• ensure that pharmacists, dentists and others in similar health and social care occupations are aware of this policy
• ensure DNACPR education and training is available
• ensure audit of Trusts 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
• a suitably empowered LPA is present at the point of the arrest, this individual will then make the decision regarding commencement of CPR
• there is clear evidence of a recent verbal refusal of CPR as this needs to be considered when making a best interests decision.

8.3.1 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.

8.3.2 In the event of registered health care staff finding a person with no signs of life and clear clinical signs of prolonged death, and with no DNACPR decision or an ADRT to refuse CPR, they must rapidly assess the case to establish whether it is appropriate to commence CPR (Some organisations may define other health care staff within this section). Consideration of the following will help to form a decision, based on their professional judgement which can be justified and later documented:
• what is the likely expected outcome of undertaking CPR?
• is the undertaking of CPR contravening the Human Rights Act (1998) where the practice could be inhuman and degrading?
• Is there recent evidence of a clearly maintained verbal refusal of CPR? This needs to be carefully considered when making a best interests decision on behalf of the patient
• provided the registered health care staff has demonstrated a rationale for their decision-making, the employing organisation will support the member of staff if this decision is challenged.

8.4. The decision-making framework is illustrated on page 10. When considering making a DNACPR decision for an individual it is important to consider the following:
• is Cardiac Arrest (CA) a clear possibility for this individual? If not, it may not be necessary to go any further
• if CA 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, a LPA will make the decision. If a LPA has not been appointed a best interests decision will be made.
• if the person has an irreversible condition where death is the likely outcome, they should be allowed to die a natural death and it may not be appropriate in these circumstances to discuss a DNACPR decision with the individual.

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, then a discussion with relatives/ carers should only take place with the person’s permission.
• 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

Documenting and communicating the decision

8.6.1 Once the decision has been made, it must be recorded on the SofE(C) SHA approved DNACPR form (See Appendix 1) and written in the person’s notes. 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 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, nursing homes, in-patient Specialist Palliative Care setting 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 the appropriate Read Code) and the third white copy is retained for audit purposes. The tear-off slip on the lilac form should 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 form’s location to all relevant parties including the ambulance service
http://www.lionsmd105.org/Community/MIAB/where_bottle

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 SofE(C) SHA 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 SofE(C) SHA 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.

8.6.2 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 and is not contrary to their interests.

8.6.3 It is the health care staff’s responsibility to ensure communication of the form. 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.

Discharge/ Transfer process

8.7.1 Prior to discharge, the person, or relevant other if the person lacks capacity, MUST be informed of the 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.

If such discussion is likely to cause undue distress then it is usually impossible to place a DNACPR form in the person’s home until further discussions have taken place.

8.7.2 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.
• 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. 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.

8.7.3 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 Cross Boundaries: If a patient is discharged from an institution that does not use the SofE(C) SHA 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 SofE(C) SHA DNACPR form. Therefore, a patient who lives on the SofE(C) SHA borders may have 2 forms, depending on where they go in the region. Whenever a patient comes back into the SofE(C) SHA 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 in the circumstances of this person?

YES → Is there a realistic chance that CPR could be successful?

YES → Does the person lack capacity?

YES → Are the potential risks and burdens of CPR considered to be greater than the likely benefit of CPR?

YES → CPR should be attempted unless the individual has capacity and states that they would not want CPR attempted.

NO → Does the person lack capacity?

YES → Do they have a valid and applicable ADRT, if so this must be respected. If an attorney, deputy or guardian has been appointed they should be consulted.

NO → Are the potential risks and burdens of CPR considered to be greater than the likely benefit of CPR?

YES → When there is only a very small chance of success and there are questions as to whether the burdens outweigh the benefits of attempting CPR, the involvement of the individual (or if the person lacks mental capacity those close to him / her) in making the decision is crucial. When the individual has mental capacity their own view should guide the decision making.

NO → If there is no reason to believe that the individual is likely to have a cardiac or respiratory arrest it is not necessary to initiate discussion with them (or those close to person who lacks capacity) about CPR. If, however, the individual wishes to discuss CPR this should be respected.

When a DNACPR decision is made on these clear clinical grounds, it is not appropriate to ask the person’s wishes about CPR, but careful consideration should be given as to whether to inform them of the DNACPR decision. Where the individual lacks capacity and has a Lasting Power of Attorney (LPA), Court Appointed Deputy or guardian, this person must be consulted about the DNACPR decision and the reasons for it as part of the ongoing discussions about the individual’s care. If a second opinion is requested, this should be respected, whenever possible.

Adapted from: Decisions relating to cardiopulmonary resuscitation. A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. October 2007.
9 Review

9.1 This decision will be regarded as ‘indefinite’ 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.

If a review date is specified then the health care staff with overall responsibility (or a
delegated representative) must contact all relevant ongoing care givers to inform them of
the need for a review. This contact must initially be by phone/ in person and then followed
up with a discharge letter to ensure that the details of the review are clear to all concerned.
Informal reviews can take place at any time.

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.

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
www.southofengland.nhs.uk/end-of-life-care for Mental Capacity Act in DNACPR decision
making)

10.2 Individuals may try to insist on CPR being undertaken even if the clinical evidence suggests
that it will not provide any overall benefit. Furthermore, an individual can refuse to hold a
DNACPR form in their possession. An appropriate sensitive discussion with the person
should aim to secure their understanding and acceptance of the DNACPR decision and in
some circumstances a second opinion may be sought to aid these discussions.

10.3 Individuals do not have a right to demand that doctors carry out treatment against their
clinical judgement. Where the clinical decision is seriously challenged and agreement
cannot be reached, legal advice may be indicated. This should very rarely be necessary

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 CA 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 CA, 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.

**13 Audit**

13.1 The SoFE(C) SHA 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 (See Appendix 4 Audit Tool).

13.3 Frequency.

- compliance with the policy will be audited annually using the DNACPR Audit Tool (See Appendix 4)
- 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)

NHS South Central SHA (2011) Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) How it relates to the Mental Capacity Act (MCA) 2005

Resuscitation Council UK (2007) Decisions relating to cardiopulmonary resuscitation; a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. RC (UK) [http://www.resus.org.uk/pages/dnar.pdf] [Accessed 03-06-2009]

Appendix 1

This form will be in triplicate format or printed on lilac paper
# Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Consider using this form (as part of Advance Care Planning (ACP)), if you would not be surprised if the patient were to die in the next year. For more information on ACP please contact the toolkit at: [http://www.southofengland.nhs.uk/wp-content/uploads/2012/04/ACP-toolkit-v5.pdf](http://www.southofengland.nhs.uk/wp-content/uploads/2012/04/ACP-toolkit-v5.pdf)

This is **not** an Advance Decision to Refuse Treatment (ADRT). [www.adrt.nhs.uk](http://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 "CANCELED" 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.

- Triplicate 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>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Reason for DNACPR decision</strong></td>
</tr>
<tr>
<td>1.A</td>
<td>CPR is unlikely to be successful</td>
</tr>
<tr>
<td></td>
<td>Summary of the main clinical problems and reasons why CPR would be inappropriate, unnecessary or not in the person’s best interests. As specific as possible. In this situation discussion with person / relevant other is not compulsory, although it is considered best practice to inform the person of the decision, if the person is discharged home they need to know about the decision. Record the details of discussion or the reason for not discussing in the person's notes.</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></td>
<td>Summary of communication with person... State clearly what was discussed and agreed. If this decision was not discussed with the person state the reason why this was inappropriate.</td>
</tr>
<tr>
<td></td>
<td>If the person does not have capacity their relatives or friends must be consulted and may be 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 than an instruction to an Independent Mental Capacity Advocate (IMCA) must 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 the 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.</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></td>
<td>Check for the validity and applicability of the Advance Decision to Refuse Treatment (ADRT), is the ADRT valid? 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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>2.</td>
<td>Person making this DNACPR decision/Verification</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>3.</td>
<td>Review</td>
</tr>
<tr>
<td></td>
<td>A fixed review date is not recommended. This decision will be regarded as “INDEFINITE” unless:</td>
</tr>
<tr>
<td></td>
<td>i) a definite review date is specified</td>
</tr>
<tr>
<td></td>
<td>ii) there are changes in the person’s condition</td>
</tr>
<tr>
<td></td>
<td>iii) the person wishes change</td>
</tr>
<tr>
<td></td>
<td>Reviewer needs to complete all details on the form and document the outcome in the notes.</td>
</tr>
<tr>
<td>4.</td>
<td>Who has been informed of this DNACPR decision?</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>5.</td>
<td>Other important information</td>
</tr>
<tr>
<td></td>
<td>This information needs to be very clear and precise. For example, if transferring include name, address and telephone number of destination and next of kin. Only spill over details include where ACP is kept. Preferred place of care should be noted.</td>
</tr>
<tr>
<td></td>
<td>Tear off slip</td>
</tr>
<tr>
<td></td>
<td>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 bedside in the dining room.”</td>
</tr>
</tbody>
</table>

---

* For further information regarding Section C, ordering new DNACPR forms, for the policy or for the electronic form access: [http://www.southofengland.nhs.uk/what-we-do/end-of-life-care/central-area-documents](http://www.southofengland.nhs.uk/what-we-do/end-of-life-care/central-area-documents)
Appendix 2  Patient information leaflet – For full leaflet go to www.southofengland.nhs.uk/what-we-do/end-of-life-care
Appendix 3

Equality Impact Assessment (EIA) Evidence Form - Example

South of England (Central) Strategic Health Authority strives to design and implement policies and measures that meet the diverse needs of our service population ensuring that none are placed at a disadvantage over others. This form is designed to help you to consider the needs and assess the positive, adverse or neutral impact of a protocol, proposal or service on all groups within our local communities, and to record the evidence that you have done so. Any proposal or policy submitted to the Board must have undergone EIA.

This form will be used as evidence of the assessment you have undertaken. It will need to be made available to the Board and Equality and Diversity Steering Group.

Policy / Proposal / Service Title
Do Not Attempt Cardiopulmonary Resuscitation Adult Policy

Name of EIA Lead Tracey Courtnell

Others involved in assessment

Date EIA commenced 6th August 2012

---

EIA Completed and Approved

Signature (Lead Director):

Name (print):

Job Title:

Date:

ONCE COMPLETED, PLEASE SUBMIT TO EQUALITY AND DIVERSITY LE AD EVIDENCE AND PUBLICATION.

Unified DNACPR Main Document Version 2 Final
August 2012
### Unified Do not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy Audit Tool

**Appendix 4**

**Unified DNACPR Main Document Version 2 Final August 2012**

**100% compliance required for shaded area**

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

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

This document was written by the Child and Young Person’s South Central Advance Care Plan Working Group for a launch date of 18th March 2010. This group is a subgroup of the NHS SC eolc (National Health Service South Central end of life care) programme board. Details of this group can be found on the South Central Strategic Health Authority (SCSHA) website. This policy is valid until its review. The policy will be reviewed initially at 1 year and then at three yearly intervals thereafter.

This policy is supported by a package which consists of:
- An Advance Care Plan proforma (Appendix 1)
- A Guide to using the Child and Young Person’s Advance Care Plan SCSHA www.southcentral.nhs.uk (eolc) webpage
- An information leaflet for parents and carers about Advance Care Plans (Appendix 2)
- An information leaflet for young people about Advance Care Plans (Appendix 2).

A Child and Young Person’s Advance Care Plan (ACP) is designed to communicate the health-care wishes of children or young people who have chronic and life-limiting conditions (a different ACP is used in adults). It sets out an agreed plan of care to be followed when a child or young person’s condition deteriorates. It provides a framework for both discussing and documenting the agreed wishes of a child or young person and his or her parents, when the child or young person develops potentially life-threatening complications of his or her condition. It is designed for use in all environments that the child encounters: home, hospital, school, hospice, respite care, and for use by the ambulance service. This ACP can be used as a resuscitation plan or as an end-of-life care plan. It remains valid when parent(s) or next of kin cannot be contacted.

2 Definitions

2.1 A Child and Young Person’s Advance Care Plan (ACP) is a document that records the advance wishes of a child or young person and/or those with parental responsibility for them. A different ACP can be used in adults. An ACP will include whether the child’s resuscitation status has been discussed, and the outcome of that discussion.

2.2 Cardiopulmonary Arrest is the cessation of breathing and loss of cardiac output.

2.3 Cardiopulmonary Resuscitation (CPR): Interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs.

2.4 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) refers to not making efforts to restart breathing and/or the heart following a cardiopulmonary arrest.

2.5 Valid DNACPR: A DNACPR is only valid if it is signed and dated.

2.6 Local Lead Clinician for Advance Care Planning: Acts as the primary link between members of his or her organisation and the SCSHA Child and Young Person’s ACP Working Party.

2.7 ACP Co-ordinator: is responsible for ensuring that all ACPs in his or her area are appropriately completed, regularly reviewed and that all relevant parties have the most recent copy of the ACP. This role can be undertaken by a senior clinician, an advanced nurse practitioner or consultant nurse.

2.8 Child Death Overview Panel (CDOP): This group monitors and reviews the deaths of all children, and a rapid response team is activated to initiate a review within a designated time frame each time a death occurs.

2.9 Adult: A person aged 18 years or over
Young Person: A person aged 16 or 17.
Anyone under this age is regarded as a child.

For the purposes of this document when the word child is used it can be read as child/young person.
3 Policy Statement

The SCSHA Child and Young Person’s Advance Care Plan policy will ensure that:

3.1 All children are presumed to be “For attempted CPR” unless a valid DNACPR decision has been made.

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

3.3 Standardised documentation for the Child and Young Person’s Advance Care Plan will be used. (See appendix 1).

3.4 The existence of an ACP for a child will be communicated to all affected members of the child’s multidisciplinary team and to all relevant settings.

3.5 The Child and Young Person’s Advance Care Planning process is measured, monitored and evaluated to ensure a robust governance framework.

3.6 Training will be available to enable staff to meet the requirements of this policy.

4 Purpose

4.1 This policy will provide guidance for staff responsible for providing or organising health care for children within the South Central region.

5 Scope

5.1 This policy applies to all the multidisciplinary healthcare team involved in children’s care across the range of care settings within SCSHA.

5.2 This policy is appropriate for all children up to 18 years of age. Once initiated the Child and Young Person’s ACP may be extended beyond the 18th birthday, with discretion, for young adults within the special education or hospice environment.

6 Legislation and Guidance

Legislation www.opsi.gov.uk/acts

6.1.1 Under the Children Act (1989 & 2004) clinicians are expected to understand how the Act works in practice. The key consideration is to make decisions consistent with the best interests of the child.

6.1.2 Adoption and Children Act 2002: Clinicians are expected to understand who has parental responsibility to consent to treatment in a child.

6.1.3 Mental Capacity Act 2005. Particularly pertaining to 16 and 17 year olds (see point 7.2).

6.1.4 Working Together to Safeguard Children 2006 as this pertains to responsibilities to report child deaths to the Child Death Overview Panel (CDOP) and the role of the local Rapid Response Team.

6.1.5 The following sections 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).

6.1.6 Coroners Act 1988: Clinicians are expected to know the circumstances when a death must be discussed with the District Coroner.

6.1.7 Equality Impact Assessment (See Appendix 4)

Guidance

6.2.1 European Resuscitation Guidelines. www.resus.org.uk/siteindx.htm

6.2.2 Advanced Paediatric Life Support Group Guidelines. www.alsg.org/en/?q=enlapls


6.2.4 Resuscitation Council (UK) Recommended standards for recording “Do not attempt resuscitation” (DNAR) decisions (2009). www.resus.org.uk/siteindx.htm

6.2.5 Decisions relating to Cardiopulmonary Resuscitation, A Joint Statement from the British Medical Association(BMA), the Resuscitation Council (UK), and the Royal College of Nursing. (October 2007, updated November 2007). www.bma.org.uk/ethics/cardiopulmonary_resuscitation/CPRDecisions07.jsp


6.2.7 General Medical Council (2007) 0-18 years: guidance for all doctors. www.gmc-uk.org/publications/standards_guidance_for_doctors.asp#0-18

6.2.8 DNAR decisions in the Perioperative Period; Association of Anaesthetists of Great Britain and Ireland May 2009 www.aagbi.org/publications/guidelines/docs/dnar-09.pdf

6.2.9 Withholding and withdrawing life-prolonging medical treatment 3rd Ed BMA 2007 www.bma.org.uk/ethics/end_life_issues/Withholdingwithdrawing.jsp
7 Ethical and legal background

(Mr Robert Wheeler Consultant Neonatal & Paediatric Surgeon, Specialist Adviser in Clinical Law (2009)).

7.1 18 year olds and older (terminology for this age group is adult)

7.1.1 The legal definition of an adult is anyone of 18 years or over. Anyone of 18 years of age or above can make his or her own decisions about consenting to, or refusing treatment. He or she can also make a legally binding ‘Advance Decision’ about these issues. An ACP should not be used for this purpose.

7.1.2 In the majority of circumstances the Child and Young Person’s Advance Care Plan for the child should not be initiated after the 18th birthday and the adult form should be used. However if the form is already being used it may be better for the individual and their family to continue with the Child and Young Person’s Advance Care Plan beyond the 18th birthday. There may also be occasions where it is appropriate to use this form for adults still under paediatric services or within the hospice environment.

7.1.3 The MCA provides a test for capacity. A person lacks capacity if they have an impairment or disturbance that affects the way their mind or brain works and the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made. This two-stage test should therefore be used if a clinician has cause to believe that the person lacks capacity. A person is deemed to be ‘unable to make a decision’ if they cannot:

- understand information relating to the decision that has to be made
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision.

7.1.4 If an adult is found to lack capacity then the decision is made on best interests. The only person who determines best interests (i.e. decides what the best interests of the person are) is the decision maker. The decision maker is usually the clinician in charge, otherwise the Court of Protection, its deputy, or someone with Lasting Power of Attorney. Everyone else including parents or Independent Mental Capacity Advocates, are not legally able to determine best interests; they merely support the decision maker by, amongst other means, providing the information to allow the decision to be made.

7.1.5 The SCSHA adult DNACPR document and the MCA provide clarification on decision making in adults.

7.2 16 and 17 year olds (terminology for this age group is young person)

7.2.1 Although applicable to young people in many respects, the MCA does not permit 16 & 17 year olds to make arrangements to enable them, once incapacitated, to refuse life saving treatment. Thus there is no provision for them to appoint Lasting Powers of Attorney, or to make an Advance Decision to Refuse Treatment (ADRT).

7.2.2 There is a presumption that 16 and 17 year olds have the capacity to make decisions for themselves. Young people of this age can consent to treatment and may be able to refuse treatment in some circumstances. Legal advice may be required in this situation.

7.2.3 If a 16/17 year old is thought to lack capacity for a decision and has a parent with them who can be consulted, they fall outside of the remit of the MCA 2005, since they are not unbefriended. The parents have a right to provide consent under the normal arrangements under the Children Act.

7.2.4 For 16/17 year olds the main effect of the MCA is to consolidate into Parliamentary law (statute) the common law that has for many years accumulated, with respect to how 16 & 17 year olds who lack capacity, have decisions made about them. The MCA runs ‘parallel’ with the Children Act 1989 (CA), and the two statutes are drawn up in such a way as to co-exist, rather than provide contradictory advice. There will be times when it is not clear whether a clinical problem should be approached via the CA, and thus through the Family Courts, or the MCA, and thus the Court of Protection. Sometimes the distinction may be rather fine.

7.3 For persons under 16 years of age

7.3.1 For these children the MCA can only provide decisions, through the Court of Protection (a body that the MCA creates) about property and finance relating to children in certain circumstances. However it has no role in resuscitation decisions.

- those with ‘parental responsibility’ for the child make decisions on the child’s behalf (CA).
  This ‘parental responsibility’ bestows on parents the responsibility of making decisions for, and acting in the best interests of the child, until he or she is old enough to make their own decisions
- parents hand over the responsibility for making decisions to their child when a child is old enough to make his or her own decisions affecting their care, and ultimately their life. As a child develops and matures so will his or her understanding of their illness or disability. They will come to understand their condition, the reasons for their treatment, and the consequences of not having that treatment. This maturity or competence has been referred to as ‘Gillick’ competence. The child who understands the nature of his or her illness and the likely outcomes of treatment options should be involved where possible in the decision-making process.

7.3.2 The child’s family and health care team must decide whether the child is competent to make his or her own decisions relating to resuscitation, and to what degree they will be involved in the discussions. Over the last decade the Courts have been consulted several times regarding children who have made ‘competent’ decisions that were at odds with the wishes of their health care professionals and/or those with parental responsibility for them. The current position in the Common law is that a ‘child’ under 18 can consent to treatment, but if they refuse treatment then those with parental responsibility for them can override that decision, but it would be wise to seek legal advice case by case in such circumstances.

7.3.3 The Consultant in charge of the child’s care has final responsibility for resuscitation decisions. There is no legal obligation on the doctor to provide any medical treatment if it is not in the best interests of the patient.
8 Roles and Responsibilities

8.1 Chief Executive of South Central Strategic Health Authority is responsible for:
- ensuring that this policy adheres to statutory requirements and professional guidance
- supporting unified policy development and the implementation within other organisations
- ensuring that the policy is monitored and reviewed
- review of policy.

8.2 National Health Service (NHS) Commissioners must ensure that commissioned services implement and adhere to the policy and procedure and provide funding to ensure staff training.

8.3 Chief Executives of all provider organisations must ensure that provider services:
- implement and adhere to the policy and procedure
- procure and/or provide legal support when required
- resource/enable funding of an ACP Co-ordinator or identify the inclusion of this role into the job plan of an existing post
- resource/enable training for staff.

8.4 Directors or Managers who are responsible for the delivery of care must ensure that the policy is implemented and that:
- staff are aware of the policy and how to access it
- staff understand the importance of issues regarding DNACPR/ACPs
- staff are trained and updated in managing DNACPR/ACPs
- sufficient supporting materials are available for staff and for families
- the policy is audited and the audit details fed back to nominated Director at the SCSHA.

8.5 Local Lead Clinician for ACPs liaising with the SCSHA Child and Young Person’s Advance Care Plan Working Group and are responsible for:
- disseminating information about the ACP package to all SCSHA staff in their area who are affected by it
- feeding back queries about the contents and application of the package to the Working Party on behalf of the staff in their domain
- acting as a resource and support for clinicians.

8.6 Senior clinicians take ultimate responsibility for the completion of an ACP for a child in their care. They will ensure that:
- all ‘interested parties’ are involved in the initial discussions about the possibility of an ACP for a particular child
- information about all possible treatment options for the child, and their implications, are available to the group while discussing Advance Care Planning
- the group discuss whether it would be appropriate to raise the issue of DNACPR with the child and his or her family
- decisions are appropriately documented, disseminated and reviewed.

8.7 ACP Co-ordinator is responsible for ensuring that all ACPs in their area are appropriately completed, regularly reviewed and that all relevant parties have the most recent copy of the ACP.

8.8 Clinical staff delivering care must:
- adhere to the policy and procedure
- notify line manager of any training needs
- check the validity of any decision – that it is in date and signed
- notify other services of the DNACPR / ACP on the transfer of a child
- participate in the audit process
- be aware of local procedures for storing and accessing ACP information.

8.9 Commissioners and commissioned services, for example pharmacists and dentistry, should be aware of this policy and consider its implications when commissioning or providing services.

8.10 The Ambulance service will:
- adhere to the policy and procedure
- ensure they are aware of the existence of a DNACPR/ACP via the individual / relatives or the health care professional requesting assistance
- check the validity of any decision – that it is in date and signed
- participate in the audit process
- be aware of local procedures for storing and accessing ACP information.

8.11 Hospices will adhere to the policy and procedure, and will ensure that:
- information regarding a DNACPR/Child and Young Person’s Advance Care Plan is included in pre-admission documentation
- all DNACPR/Advance Care Plans are effectively cascaded to staff
- individual staff will:
  - notify line manager of any training needs
  - ensure they are aware of the existence of any DNACPR/ACPs
  - check the validity of any decision— that it is in date and signed
  - participate in the audit process
  - be aware of local procedures for storing and accessing ACP information.

8.12 Schools have a responsibility to ensure that:
- the ACP is available and followed
- in an acute event, an ambulance is called and the presence of the ACP highlighted to ambulance staff (follow protocol including giving home postcode)
- parents immediately contacted by phone.
9 Process

The guide to using the Child and Young Person’s Advance Care Plan (www.southcentral.nhs.uk under eolc webpage) should be used when initiating an ACP. It provides guidance on the overall process as well as page-by-page instruction on completing the documentation.

10 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

10.1 A child with a valid DNACPR decision in place should not have any attempt made to resuscitate them in the event of a life threatening change in his or her clinical condition (excluding rapidly reversible causes such as choking or anaphylaxis, or causes specific to the individual child specified in the Advance Care Plan).

10.2 In hospital a clinical emergency (crash) call will not usually be made and no active interventions will be made to assist the child’s failing respiratory or circulatory function including compressions and ventilation.

10.3 If an ambulance is called then Ambulance Control must be told about the existence of an ACP.

10.4 If the death is anticipated, the GP should be called.

10.5 A DNACPR decision does not mean withdrawal of care. Every attempt will continue to be made to make the child as comfortable as possible, and to fulfil his or her and the families’ wishes.

10.6 All children are for attempted resuscitation unless there is a valid DNACPR decision in place. If there is any doubt about the validity of a DNACPR decision then resuscitation should be initiated.

10.7 A valid DNACPR decision:

- reflects the agreed wishes of the child (where appropriate), those with parental responsibility for the child, and the health care professionals caring for the child
- is clearly recorded in the DNACPR section of the ACP
- falls within the time period specified on the form.

10.8 The ACP will only apply to situations described within the care plan and only when it is current, dated and signed by the child’s parent or legal guardian (see section 7 on ethical and legal background). If the young person has capacity for the decision, his or her signature may also appear on the form, although this is optional.

10.9 The Child and Young Person’s ACP should not usually be used for the first time in an adult of 18 years or over. There may be some young adults in which this form was initiated before their 18th birthday. If the young adult is deemed competent and has signed the form, it will remain valid, and a parental signature is no longer required.

10.10 In all circumstances not covered by the ACP it must be assumed that the child should have full resuscitation measures in the event of deterioration or collapse. Clinicians retain the right to not resuscitate or to stop resuscitation if they believe it is futile.

10.11 A valid ACP should be followed even when the parent or legal guardian is NOT present at the time of the child’s acute deterioration or collapse.

10.12 If a parent or legal guardian is present at the time of his or her child’s collapse, and they wish to deviate from the previously agreed ACP, then their wishes should be respected provided they are thought to be in the best interests of the child.

Note: For further guidance on how to complete the Child and Young Person’s Advance Care Plan, please see Staff Guidance leaflet. www.southcentral.nhs.uk (eolc webpage)

11 Review

The ACP should be reviewed regularly, and in good time to ensure there is always a current valid plan. The local ACP co-ordinator is responsible for distributing the latest version of the ACP.

12 Situations where there is lack of agreement

Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice must be sought.

13 Cancellation of a DNACPR Decision

In rare circumstances a decision may be made to cancel or revoke the Advance Care Plan or DNACPR decision. In this situation the plan should be crossed through with 2 diagonal lines in black ball-point ink and the word ‘CANCELLED’ written clearly between them, dated and signed by the senior clinician, and the reasons clearly documented. It is the responsibility of the ACP Co-ordinator to inform all parties and to organise and urgent review so that a new ACP can be completed.

14 Exclusions from and suspension of DNACPR Decision

14.1 A DNACPR decision does not include immediately remediable and acutely life-threatening clinical emergencies such as choking or anaphylaxis. Appropriate emergency interventions, including CPR should be attempted.

14.2 A valid DNACPR decision may be temporarily suspended, for example around the time of specific interventions such as anaesthesia or surgery that have an associated increased risk of cardiopulmonary arrest. If such procedures are planned then the ACP should be reviewed and whatever decision is made should be documented and communicated accordingly. This documentation should clearly specify the beginning and end date of the suspension.
Audit

15.1 The SCSHA will measure, monitor and evaluate compliance with this policy through audit and data collection.

15.2 All organisations will have clear governance arrangements in place which indicate individuals and committees who are responsible for the governance of this policy at a local level and that can respond to the SCSHA request for audit purposes.

This includes:
- data collection
- ensuring that approved documentation is implemented
- managing risk
- sharing good practice
- monitoring of incident reports and complaints regarding the DNR process
- developing and ensuring that action plans are completed
- (see Appendix 3 audit tool).

15.3 Frequency and information
- compliance with the policy will be audited annually using the SCSHA Audit Tool (see Appendix 3)
- local leads will decide number of Advance Care Plans to be examined.

15.4 Information will be used for future planning, identification of training needs and for the policy review.
# Advance Care Plan: Management of cardio-respiratory arrest

Regardless of the patient's resuscitation status, the following immediately reversible causes should be treated: **choking, anaphylaxis, blocked tracheostomy tube, other (please state):**

## RESUSCITATION STATUS

- Resuscitation status has not been discussed – attempt full resuscitation
- Resuscitation status has been discussed and the following has been agreed:

  - Clearly delete actions not required
  - For full resuscitation
  - Attempt resuscitation with modifications below:
  - Do not attempt cardiopulmonary resuscitation DNACPR

### AIRWAY:

### BREATHING:

### CIRCULATION:

### DRUGS:

### OTHER:

### PICU/HDU:

## Ambulance directive: (eg transfer to home/ward/Emergency Department /hospice)

- In the event of sudden death
- 24 hour emergency number for doctor who knows the child:

## Name of person/people with parental responsibility (and address if different from above):

### Emergency contact number for person with parental responsibility: 

### Other emergency contact numbers: 

### Other key people (e.g. family and friends): 

### Name: 
#### Relationship: 
#### Tel: 

### Name: 
#### Relationship: 
#### Tel: 

## Primary diagnosis and background summary:

## Advance Care Plan for use in:

- Home
- School
- Hospital
- Hospice

Other, please state:

<table>
<thead>
<tr>
<th>Date Plan Initiated</th>
<th>Date Review is due</th>
<th>Date reviewed/amended</th>
<th>Name &amp; title of lead reviewer</th>
<th>Next review due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## Senior Clinician Signature: 

- Name: 
- GMC No: 

- Date Initiated: 
- Review Date (see page 1)
Advance Care Plan: Intercurrent illness/acute deterioration

Name: ____________________________ Date of Birth: ___ / ___ / ___

Main Diagnoses: ____________________________ Known Allergies: ____________________________

Signs/Symptoms to expect:

In the event of a likely reversible cause for acute life-threatening deterioration such as choking, tracheostomy blockage or anaphylaxis please intervene and treat actively. Please also treat the following possible problems actively e.g. bleeding (please state):

If a cardiac or respiratory arrest is not specifically anticipated, decisions about resuscitation would normally be made on a ‘best interests’ basis at the time of such an event. Unless a separate resuscitation section has been completed, the presumption would normally be for attempted resuscitation initially unless this seemed futile, unlikely to be successful, not in best interests, or otherwise directed.

**In the event of acute deterioration:** (Clearly delete all options NOT required. Add comments to clarify wishes):

- support transfer to preferred place of care if possible (specify):

- maintain comfort and symptom management, and support child / young person and family
- clear upper airway
- face mask oxygen if available
- bag and mask ventilation
- emergency transfer to hospital if doctor considers appropriate in the specific situation
- intravenous access or intraosseous access
- consider nasogastric feeding tube (insertion or removal)
- non-invasive ventilation
- intubation
- consider stopping feeds
- consider stopping fluids
- other; please state: ____________________________

**Management of seizures**

Description of usual seizure pattern / types: ____________________________

Rescue medication: (drug name, dose and route)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First line</td>
<td>after ________ mins</td>
</tr>
<tr>
<td>Second line</td>
<td>after further ________ mins</td>
</tr>
<tr>
<td>Third line</td>
<td>after further ________ mins</td>
</tr>
</tbody>
</table>

Call 999 for emergency transfer to hospital? [ ] Yes [ ] No
If yes, at what stage? ____________________________

Other instructions for seizures:

**Management of infection** (prompt, check for known allergies recorded p3)

Preferred antibiotic or regime for recurrent infections – drug dose, route, duration:

Intravenous antibiotics will normally require transfer to hospital for investigation and initiation of treatment.

Other instructions/comments regarding infection-related symptoms e.g. nebulisers, steroids.

**Instructions for emergency care in other specific circumstances**

(Document here regimes specific to this child/younl person, for example for management of metabolic disturbance etc).

**Additional Comments:**

[EXAMPLE]
Advance Care Plan: Wishes

Name: ___________________________ Date of Birth: ___/___/___

(please continue on p7- free text for communications and discussions if insufficient space for responses)

<table>
<thead>
<tr>
<th>WISHES DURING LIFE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Young Person’s wishes e.g. Place of care, symptom management, people to be involved (professional/non-professional), activities to be continued (spiritual and cultural).</td>
</tr>
<tr>
<td>Family wishes e.g. Where you want to be as a family, who you would like to be involved (e.g. medical, spiritual or cultural backgrounds).</td>
</tr>
<tr>
<td>Others wishes (e.g. school friends, siblings).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WISHES AROUND THE END OF LIFE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred place of care of child/young person.</td>
</tr>
<tr>
<td>Funeral preferences. Seek detailed information or further advice if needed.</td>
</tr>
<tr>
<td>Spiritual and cultural wishes.</td>
</tr>
<tr>
<td>Other child/young person &amp; family wishes, e.g. what happens to possessions?</td>
</tr>
<tr>
<td>Organ &amp; tissue donation.</td>
</tr>
</tbody>
</table>

This page discussed by: ___________________________

Child/Young Person / Parent / Carer

Professional (full name and job title): ___________________________ Date: ___/___/___

Advance Care Plan: Decision making

Name: ___________________________ Date of Birth: ___/___/___

Basis of discussion / decision-making? (Tick as appropriate)

- Wishes of child/young person with capacity
- Wishes of parent(s) for child on “best interests” basis
- Best interests basis (as in Mental Capacity Act 2005)
- Other (please state) ___________________________

Comments: ___________________________

Consider the following questions. For detailed responses use free text below

- what do you/the child/young person know about this condition, any recent changes, and anticipated prognosis?
- what do siblings understand about the condition and anticipated prognosis?
- what involvement is appropriate / possible for the child/young person in decision-making?
- to what extent has the child/young person been involved in decision-making in this area?
- what does the child/young person know about what decisions have been taken?
- have there been discussions about legal decisions and the Child Death Review process?
- has the Ambulance Service/ GP/ Out of Hours Service/ Coroner/ Child Death Overview Panel/Rapid Response team been informed that there is an Advance Care Plan written for this child/young person?
- have these wishes been discussed elsewhere? In order to enhance continuity of care please attach documentation arising from any such discussions.

Communications and discussions

This page discussed by: ___________________________

Child/Young Person / Parent / Carer

Professional (full name and job title): ___________________________ Date: ___/___/___
Advance Care Plan

Who has agreed and supports the plan?

Name: _______________________________  Date of Birth: __/__/___

Senior Clinician e.g. Paediatric Consultant – I support this care plan
Name: ___________________  Signature: _______________  GMC No: _______  Date: ___/___/___

Child / Young person – I have discussed and support this care plan (optional)
Name: _______________________________  Signature: __________________________  Date: ___/___/___

Parent/Guardian – We / I have discussed and support this care plan
Name: _______________________________  Signature: __________________________  Date: ___/___/___

Other e.g. CCN – I have discussed and support this care plan
Name: _______________________________  Signature: __________________________  Date: ___/___/___

Other e.g. GP – I have discussed and support this care plan
Name: _______________________________  Signature: __________________________  GMC No: _______  Date: ___/___/___

Other e.g. Hospice doctor – I have discussed and support this care plan
Name: _______________________________  Signature: __________________________  GMC No: _______  Date: ___/___/___

Other people informed: see circulation list.

Clinicians have a duty to act in a patient's best interests at all times.
If a parent or legal guardian is present at the time of their child's collapse, they may wish to deviate from the previously agreed Advance Care Plan and under these circumstances their wishes should be respected, provided they are thought to be in the best interests of the child/ young person. The child/ young person or parents/guardian can change their mind about any of the preferences on the care plan at any time.
Appendices

Appendix 2

Patient Leaflets;

Parent information Leaflet

What happens if...?: Planning ahead for the needs of children and young people with life-limiting or life-threatening conditions.

Intro: Sometimes families worry about what might happen if their child suddenly or unexpectedly becomes unwell. Talking through what might happen can help reduce some of these worries and concerns.

Who is this leaflet for?
This leaflet is for families who have a child or young person with a life-limiting condition. It provides information about an Advance Care Plan – what it is, how it is created and what it means for the child. There is a separate leaflet for young people to read.

What is an Advance Care Plan?
An Advance Care Plan is a document that sets out an agreed plan of care to be followed if/when your child’s condition deteriorates. It is very difficult to make rational and informed decisions during a crisis, so the benefit of an Advance Care Plan is that a plan of action can be made before the situation occurs.

How does it work?
Everyone who plays an important role in the life and health care of your child or a young person, and if appropriate your child/young person themselves, can be involved in the advance planning. The plan covers a variety of different circumstances including slow deterioration and sudden emergencies, but is specific to the needs of your individual child and your family.

A key feature of an Advance Care Plan is that it is shared with all professionals involved in the routine care of your child as well as those who might be called in an emergency. This means that everyone has clear information about the wishes and needs of your child and your family, so they can provide that care.

What does the process involve?
The first step in the process is deciding whether the time is right to make an Advance Care Plan, and you are likely to have questions about this. Your child’s health care team will try to answer your queries and concerns as realistically and sympathetically as possible. You may also want to talk through the issues with friends or family, or your religious advisor, or have any of these people with you when you next talk to your child’s doctors.

What happens when the plan is agreed?
Once an Advance Care plan is agreed it will be signed by you and a senior doctor or clinician who knows your child/young person. Copies of the Advance Care Plan are given to you and to each of the health care professionals who are routinely involved in your child’s care, as well as those who might be contacted in an emergency.

Advance Care Plans are reviewed regularly to ensure that the plan of care is still appropriate and that everyone remains in agreement. The team caring for your child will discuss with you how often these reviews will take place.

What if I want to change an aspect of the Advance Care Plan once it has been agreed?
If you want the Advance Care Plan to be reviewed you do not have to wait for the next review date. Just talk to one of your child’s care team, and the care plan can be reconsidered.

Where can I get further help or information?
Child Bereavement Charity www.childbereavement.org.uk
www.specialchild.co.uk is a book that has been reproduced on line; it is written by a mother who could not find the information that she needed when she needed it.

Through the contact a family scheme you can talk with other parents who are in a similar position: www.cafamily.org.uk, or telephone 0808 808 3555.
Each hospital has a Patient Advice and Liaison Service (PALS).

Local Contacts:
Young Person Information Leaflet

Advance Care Plans: Planning ahead for the needs of young people with life-limiting or life-threatening conditions.

Intro: Sometimes people with life-limiting conditions worry about what might happen if they suddenly or unexpectedly become unwell and families will often share these worries. Talking through what might happen can help reduce some of these worries and concerns.

Who is this leaflet for?
This leaflet is for young people who have a life-limiting condition. It provides information about an Advance Care Plan – what it is, how it is created and what it means for you.

What is an Advance Care Plan?
An Advance Care Plan is a document that sets out an agreed plan of care to be followed if/when your condition deteriorates. It is very difficult to make decisions during a crisis, so the benefit of an Advance Care Plan is that a plan of action can be made before this happens.

How does it work?
Everyone who plays an important role in your life and health care can be involved in the advance planning. The plan covers a variety of different circumstances, including a gradual decline in your condition and sudden emergencies, but is specific to your needs and, where appropriate, the needs of your family. A key feature of an Advance Care Plan is that it is shared with all professionals involved in your care as well as those who might be contacted in an emergency. This means that everyone has clear information about your wishes and needs so they can provide that care.

What does the process involve?
The first step in the process is deciding whether the time is right to make an Advance Care Plan, and you are likely to have questions about this. Your health care team will try to answer your questions and concerns as realistically and sympathetically as possible. You may also want to talk through the issues with friends or family, or your religious advisor, or have any of these people with you when you next talk to your doctors.

You may have very clear ideas and feelings about some aspects of care, whereas other aspects may be less clear to you. A member of your team can show you an Advance Care Plan and discuss the various options that might be suitable for you. We will work together with you at your pace to put together a plan which suits you best.

What happens when the plan is agreed?
Once an Advance Care Plan is agreed it will be signed by you and a senior doctor (or clinician) who knows you and if appropriate your parent/s. Copies of the Advance Care Plan are given to you and to each of the health care professionals who are regularly involved in your care, as well as those who might be contacted in an emergency.

Advance Care Plans are reviewed regularly to ensure that the plan of care is still right for you and that everyone remains in agreement. The team caring for you will discuss with you how often these reviews will take place.

What if I want to change an aspect of the Advance Care Plan once it has been agreed?
If you want the Advance Care Plan to be changed or re-looked at you do not have to wait for the next review date. Just talk to one of your care team, and the care plan can be looked at with you and altered if needed.

Where can I get further help or information?
ACT – The Association of Children with Life-threatening and Terminal Conditions and their families www.act.org.uk
Child Bereavement Charity www.childbereavement.org.uk
www.specialchild.co.uk is a book that has been reproduced on line; it is written by a mother who could not find the information that she needed when she needed it.

Through the contact a family scheme you can talk with other families or young people who are in a similar position: www.cafamily.org.uk, or telephone 0808 808 3555.

Each hospital has a Patient Advice and Liaison Service (PALS).

Local Contacts:
Appendix 3

Child and Young Person’s Advance Care Plan Audit

Service: ___________________________ Date: ___/___/_____

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Is there a Child and Young Person’s Advance Care Plan?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>2  Has the decision been recorded on approved documentation?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>3  Has the decision been made by an appropriate clinician?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>4  Is the record clearly dated and signed in full?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>5  Are there clear patient identifiers?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6  Are all fields of the record completed?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>7  Is there evidence that the best interests of the child has been considered?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>8  Is there evidence of discussions with the child and/or their family?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>9  Is there evidence that the multidisciplinary team are aware of the decision?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>10 Is there evidence that decisions are reviewed and documented?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>11 Is the Child and Young Person’s Advance Care Plan policy easily accessible to relevant staff?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>12 Is there evidence that copies of the ACP have been distributed to the individuals listed on the final page of the ACP</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 4

Equality Impact Assessment (EIA) - Evidence Form

South Central Strategic Health Authority strives to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. This form is designed to help you to consider the needs and assess the positive, adverse or neutral impact of your policy, protocol, proposal or service on all groups within our local communities, and to record the evidence that you have done so. Any proposal or policy submitted to the Board must have undergone EIA.

This form will be used as evidence of the assessment you have undertaken. It will need to be made available to the Board and Equality and Diversity Steering Group.

Policy/Proposal/Service Title: ___________________________

Child and Young Person’s Advance Care Plan Policy ___________________________

Name of EIA Lead: ___________________________

Others involved in assessment: ___________________________________________

Date EIA commenced: ___/___/_____

EIA Completed and Approved: ___________________________

Signature (Lead Director): ___________________________

Name (print): ___________________________

Job Title: ___________________________

Date: ___/___/_____

ONCE COMPLETED, PLEASE SUBMIT TO EQUALITY AND DIVERSITY LEAD FOR EVIDENCE AND PUBLICATION.
1. Personal details

Full name
NHS/CHI/Health and care number
Preferred name

Date of birth
Address
Date completed

2. Summary of relevant information for this plan (see also section 6)
Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below

Focus on symptom control as per guidance below

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended
Adult or child

CPR attempts NOT recommended
Adult or child

For modified CPR
Child only, as detailed above
5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan?  
Yes / No

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations?  
Yes / No / Unknown

If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

- **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in making this plan.

- **B** This person does not have the mental capacity to participate in making these recommendations. This plan has been made in accordance with capacity law, including, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

- **C** This person is less than 18 (UK except Scotland) / 16 (Scotland) years old and (please select 1 or 2, and also 3 as applicable or explain in section D below):
  - **1** They have sufficient maturity and understanding to participate in making this plan
  - **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
  - **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

- **D** If no other option has been selected, valid reasons must be stated here. Document full explanation in the clinical record.

Record date, names and roles of those involved in decision making, and where records of discussions can be found:

<table>
<thead>
<tr>
<th>Designation (grade/speciality)</th>
<th>Clinician name</th>
<th>GMC/NMC/HCPC Number</th>
<th>Signature</th>
<th>Date &amp; time</th>
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7. Clinicians’ signatures

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<tr>
<th>Role</th>
<th>Name</th>
<th>Telephone</th>
<th>Other details</th>
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<tbody>
<tr>
<td>Legal proxy/parent</td>
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<td>Family/friend/other</td>
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<td>GP</td>
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<tr>
<td>Lead Consultant</td>
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8. Emergency contacts

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<tr>
<th>Review date</th>
<th>Designation (grade/speciality)</th>
<th>Clinician name</th>
<th>GMC/NMC/HCPC number</th>
<th>Signature</th>
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OPP No 7 SCAS attendance at sudden Death in Adults
# SCAS Attendance at Sudden Deaths

(Adults >30 unless pre-existing condition)

Procedure No. 7

<table>
<thead>
<tr>
<th>DOCUMENT INFORMATION</th>
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<tr>
<td><strong>Directorate:</strong></td>
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<td>Operations</td>
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<tr>
<td><strong>Author:</strong></td>
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<td><strong>This document replaces:</strong></td>
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<tr>
<td>1. Outline</td>
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<td>2. Purpose of Procedure</td>
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<td>3. Implications</td>
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<td>4. Consultations</td>
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<td>5. Definitions</td>
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<td>6. Police Attendance at Reported Death</td>
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<td>7. Apparent Death by Natural Causes</td>
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<td>8. DNACPR</td>
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<td>9. Death in the Workplace</td>
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<td>10. SCAS Attendance at Obvious Death</td>
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<td>11. Appendix A – Police Attendance Flow Chart</td>
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<td>12. Appendix B – How to Contact the Police</td>
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<td>13. Appendix C – SCAS Attendance at Obvious Death</td>
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<td>14. Appendix C - Undertakers</td>
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<td>Date</td>
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1.0 Outline
The attendance and management of deaths in the community is a key role for the Police and Ambulance service and has a considerable demand for resources. Managing this demand against the needs for investigative assessment, support for the public and the need to provide information for HM Coroner is the key principle to this procedure.

2.0 Purpose of the Procedure
This procedure seeks to provide a proportionate response to deaths in the community, allowing the most appropriate resource to attend, assess and manage such incidents.

A large proportion of deaths in the community are as a result of natural causes, but may not have been expected. Generally the ambulance service attends these as a first response, pronouncing life extinct and obtaining background details from family and others present to make a clinical decision.

By providing a clear framework to identify what the Police and South Central Ambulance Service (SCAS) will attend, including support around risk and intelligence assessment from the Police.

This will allow SCAS to deal with the majority of natural deaths in the community from initial attendance to reporting to the deceased’s General Practitioner or the Out of Hours provider.

This in turn will allow the Police service to focus on unnatural deaths that may be suspicious or have a criminal nature.

3.0 Implications of the Policy
There are no significant implications in respect of Risk, Health and Safety, Equalities and Legal considerations. In specified circumstances it will remove the need for Police and SCAS attendance at certain types of sudden deaths. Staff must follow the Death of a Child procedure when dealing with deaths in the Under 18’s

4.0 Consultation
Consultation has been undertaken externally with Thames Valley and Hants Police and other services such as the Coroner(s) and Coroner’s officers within the SCAS footprint. This procedure has also been scrutinised by the relevant policy/procedure review groups.
5.0 Definitions
Deaths can be classified as the following:

Suspicious Deaths
Those deaths where another person suspects another person has, or may be involved in the death and criminal offences have, or may have been committed (eg. Murder, Manslaughter including neglect etc).
Violent or Unnatural Deaths.
Deaths that may have initially been treated as suspicious at the time of initial attendance, but have been seen to be not so, or where the mechanics of death involves trauma or accident (e.g. suicide, hanging, drowning, overdoses, neglect, Health & Safety issues etc.).

Natural Deaths
Where a doctor may issue a death certificate as the cause of death is natural or following post mortem, the death has been established as being due to natural causes.

The following terms are also important:

Certified Deaths
A doctor has certified the medical cause of death.

Confirmation of Death / Recognition of Life Extinct
Only Doctors can certify death. Ambulance Nurses, Paramedics, Technicians and AAPs (in set circumstances), undertake the recognition of life extinct but cannot record the medical cause of death.

6.0 Police Attendance at reported Death
The Police will attend reports of death that fall within the following categories:

- Homicide and all reported 'suspicous deaths', where criminality may be a factor
- All reported violent and unnatural deaths.
- Fatal accidents of all types (e.g. road traffic collision, industrial/workplace incidents)
- Suspected suicide or assisted suicide
- Death with suspected drug abuse a cause.
- Sudden & Unexpected Deaths in Infants & Children (SUDIC)
- Death of a person aged 30 (years) or younger, unless there is an obvious medical reason.
- Persons found dead after forced entry (either by Police Officers or others) into premises. This includes reports of 'Concern for Welfare' to Police, even if the death
appears to be from natural causes.

- Death in a public place
- Deaths in private premises where the next of kin, or responsible adult is in attendance, will not take responsibility for the deceased.
- Deaths on/in premises occupied by the Ministry of Defense.
- Where a person's identity is not known or suspected to be false.
- Deaths where the person is not registered with a GP.
- Where the reported death is at a care or nursing home and there are potentially suspicious circumstances.

Suspicious deaths involving suspected criminality. Ensure that the body is not disturbed and that the scene is kept intact to preserve evidence.

7.0 Apparent death by natural causes: - Private Residential Premises

The Police WILL NOT attend scenes of routine presumed natural deaths in a private residential premises for circumstances reported from Doctors, hospitals, families or responsible adults, which DO NOT fall into the above category. (See 6.0 Police attendance at reported death).

Reports of deaths from apparent natural causes to the Police will be shared with SCAS who will be the primary response and will attend the scene. If the deceased is inside private premises, a Paramedic/Nurse/Technician/AAP may confirm death following a strict protocol. A form ROLE (Recognition of Life Extinct) and patient report form will be left with the immediate next of kin or responsible adult.

SCAS will be responsible for informing the deceased’s GP of the death. This needs to be verbally in hours and via the Out of Hours providers during those times. The ePR record will automatically emailed to a secure email address at the GP practice and printed copies need to be left with the responsible adult/next of kin to the deceased.

For natural / expected deaths the GP is expected to certify the death and provide the Medical Certificate of Cause of Death (MCCD) to deceased’s relatives / person taking responsibility. If, however the death is reportable to the coroner for any other reason, then it is the responsibility of the GP to complete an electronic referral and submit to the coroner’s office at the earliest opportunity.

If the GP is unwilling/unable to issue a MCCD then it is acceptable to remove the deceased to a Chapel of Rest by Undertakers of the family/responsible persons choice without Police attendance. Although the GP may say they haven’t seen the patient during the last 14 days, if the death is seen to be natural it’s likely the Coroner will support the GP issuing the MCCD. If after the Coroners Officer speaks with the GP there is still an issue the Coroner would arrange to move the body for Post Mortem at that point.
SCAS will inform the Police that death has been confirmed in accordance with the SCAS protocol.

SCAS staff will provide Police with information from the scene regarding the apparent nature of the incident. This is to include but not exclusive to:-

- Name and contact number for the attending crew
- Time, address & location within the address the deceased person was found by the person who found the deceased
- Circumstances of Death – Based on the initial circumstances, what do you think has happened?
- Name, DOB & address of deceased person
- Person who called the ambulance - Name, DOB, address & relationship to deceased

And the following information to be provided by the attending crew to enable relevant intelligence checks to be completed and a decision on attendance to be made:

- Time, address & location within the address the deceased person was found by the person who found the deceased
- Circumstances of Death – Based on the initial circumstances, what do you think has happened?
- What was the position of the body when you arrived? Have you observed or been told anything that makes you suspicious about the circumstances? Are there any suspicious marks on the body? Where have you looked?
- Do you have any information about the general health of the deceased? Have SCAS had any prior calls relating to the deceased?
- Name, DOB & address of deceased person
- Who is in attendance
- Person who found the deceased - Name, DOB, address & relationship to deceased
- Person who called the ambulance if different - Name, DOB, address & relationship to deceased

Once an assessment of the incident has been made by Police and it is deemed that Police WILL NOT attend, the SCAS crew at the scene will inform the next of kin/family;

- To use the undertaker of their choice and they must contact them.
- A copy of the ePR/PCR (CAS 101) will be left with the person taking responsibility.
- To contact the patients GP/ OoHs to report the death and provide the GP with the Patient Report Form (CAS 101) or ePR record.

The Police WILL NOT attend presumed Death by natural causes in home circumstances merely to act in a counselling role or to assist in the removal of the body from the scene.
A flow chart of this process is provided in Appendix A. It is presumed within the flow chart that a responsible adult will take responsibility for dealing with the deceased. If this is not the case, then Police WILL attend the deceased location.

8.0 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Please refer to CSPP 3 Resuscitation Policy (ROLE) for full details on DNACPR and associated directives around the deceased patient. The below definitions have been taken directly from CSPP 3.

**Definition**

SCAS personnel can only verify the "Fact of Death". They cannot "Certify" the cause of death. This must be undertaken by a Doctor.

There are a number of circumstances whereby SCAS personnel may be required to consider establishing the Fact of Death. These are:

- **Death in a Private residence concurrent with existing medical treatment** - colloquially an "Expected Death"
- **Death in a Private residence** - an "Unexpected Death"
- **Death in a Public Place (i.e. not a Private residence)** - an unexpected Death
- **Death in an Ambulance**
- **Death in a Major Incident situation**

**SCAS policy CSPP 3 applies to all age groups of patient**

### Adult DNACPR | ADRT

All SCAS personnel may discontinue/withhold resuscitation attempt if:

A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order is in place, on the DNACPR form (usually Lilac but can be photocopied or printed on white paper) or a DNACPR notice which has the correct patient details, is completed and signed by a health professional involved in the patients care and is in date:

The form will stay with the person. It will be located in the following places:

- **Hospitals, nursing homes, hospices** - in the front of person's notes
- **In the home** - The tear off slip should be completed and placed in the 'message in the bottle" in the person's refrigerator. The location of the DNACPR form needs to be clearly stated. If the "message in a bottle" is not available, a system needs to be put in place to ensure effective communication of the DNACPR form's location to all relevant parties including South Central Ambulance Service
- **GP surgeries** - In the notes either paper or electronic an 'Alert" should be set up on electronic notes, usually in the 'reminder section.'
9.0 Deaths in the Work Place

Deaths in the workplace will include all instances where death in any workplace occurs. Whilst initially appearing to be accidental, such incidents should not be presumed to be so and the following action will be taken in order to prevent loss of evidence or information, should the incident subsequently justify investigation as possible manslaughter.

10.0 SCAS Non-Attendance at Obviously Deceased patients

Incidents that are reported to SCAS from Police or Transport Police control rooms, where significant traumatic injuries are likely to have occurred such as railways/motorways, SCAS will not be routinely required to attend where there are obvious un-survivable injuries.

The criteria for injuries not compatible with life are:
- Hypostasis (pooling of blood by gravity)
- Injury which is obviously not compatible with life:
- Decapitation
- Decerebration (including massive cranial / cerebral destruction)
- Incineration
- Hemicorpectomy (or similar massive injury)
- Decomposition / Putrification
Appendix A: – Flow Chart for Police Attendance at Deceased Patients

Deceased patient fits one of the Police attendance categories

First SCAS resource will provide sit rep to Police Control room stating nature of incident **

Apparent death by natural causes in private residence

Police non-attendance confirmed with Police Control room.

SCAS to inform GP of death and supply CAS101/ePR record/ROLE

Deceased patient to inform the next of kin/responsible adult of the next steps.

Police attendance agreed with Police Control room supervisor

Next of Kin/responsible adult to contact an Undertaker of their choice. If unwilling or unable then Police will attend.

SCAS staff to inform the next of kin/responsible adult of the next steps.

It is not the responsibility of SCAS resources to inform undertakers but should offer assistance to the vulnerable/elderly that have little family support.

Undertakers confirm they will attend – SCAS resource to clear incident
Appendix B: - Process for Informing Police

**SCAS staff will provide Police with information from the scene regarding the apparent nature of the incident. This is to include but not exclusive to the questions below. The answers to these will mean the relevant intelligence checks can be completed and a decision on attendance can be made:**

- Name and contact number for the attending crew. This needs to a SCAS number from your handheld radio and not a personal number. Should the Police require a number for future reference then provide either the number for Northern House 01869 36500 or Southern House 01962 898000.

- Time, address & location within the address the deceased person was found by the person who found the deceased

- Circumstances of Death – Based on the initial circumstances, what do you think has happened?

- What was the position of the body when you arrived? Have you observed or been told anything that makes you suspicious about the circumstances? Are there any suspicious marks on the body? Where have you looked?

- Do you have any information about the general health of the deceased? Have SCAS had any prior calls relating to the deceased? (EOC will be able to give you that information)

- Name, DOB & address of deceased person

- Who is in attendance

- Person who found the deceased - Name, DOB, address & relationship to deceased

- Person who called the ambulance if different - Name, DOB, address & relationship to deceased

- Person who called the ambulance - Name, DOB, address & relationship to deceased
Appendix C: - SCAS Non-Attendance at Obvious Death

SCAS receives call from Police Control to attend person with injuries that are not compatible with life

Does the patient fit any of the listed non-attendance criteria?
- Hypostasis (pooling of blood by gravity)
- Decapitation
- Decerebration (including massive cranial / cerebral destruction)
- Incineration
- Hemicorporectomy (or similar massive injury)
- Decomposition/Putrefaction

**Yes**
SCAS EOC to inform caller of non-attendance with patient with injuries not compatible with life

**No**
SCAS to attend as per normal response
APPENDIX D – How to Funeral Directors

If the family do not know of a local Funeral Director they can be directed to one of the following Trade Association web sites where they can search for a local Funeral Director:

National Association of Funeral Directors (NAFD) - [http://nafd.org.uk/](http://nafd.org.uk/)
Society of Allied and Independent Funeral Directors (SAIF) - [https://saif.org.uk/](https://saif.org.uk/)

These web-sites also contain other information which the family member may find useful.

**Paupers Funerals/Government Social Fund**- If the family do not believe they or the deceased have sufficient funds to pay for this service or a funeral, they may be entitled to help. This should not prevent them from contacting a Funeral Director and arranging for the body to be removed and transported to the Chapel of Rest as the issue of payment will be addressed at a later date.

**NAFD**
(+44) 0121 711 1343
09.00am and 5.00pm Monday to Friday.

**SAIF**
Office open hours: Monday to Friday 9am to 5pm
Tel: 0345 230 6777 or 01279 726 777
Fax: 01279 726 300
Email: [info@saif.org.uk](mailto:info@saif.org.uk)

SAIF Business Centre
3 Bullfields
Sawbridgeworth
Herts
CM21 9DB