Freedom of Information Request: Our Reference CTHB_79_19

You asked:

I should be grateful if you would provide copies of all policies detailing the Health Board procedure for:

- **New admissions under the Mental Health Act;**

  We have no specific all-encompassing policy in place for new admissions under the Mental Health Act, they are more specific such as section 17 leave policy, consent to treatment policy etc. However, the attached is the patient's rights procedure which qualified nurses follow when a patient is first admitted onto the ward under the Mental Health Act (Attachment 1).

- **Heroin toxicity;**

  The Mental Health Directorate does not have a formal policy in place for this.

- **Morphine prescription;**

  Prescribing of Morphine complies with the Misuse of Drugs Acts as detailed in the British National Formulary (BNF) section on controlled drugs
  MedicinesComplete — Dashboard

- **Regularity and standard of patient observations;**

  Please find attached Policy for the Safe and Supportive Engagement and Observation Procedure in Mental Health Wards currently in place within the Mental Health Directorate (Attachment 2).

- **Emergency protocol for unresponsive patients.**

  Please find attached the Health Boards Resuscitation Policy (Attachment 3).

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Ref: MH17

Section 132 & 133
HOSPITAL MANAGERS PATIENT'S RIGHTS INFORMATION PROCEDURE

INITIATED BY:	Mental Health Act
APPROVED BY:	Clinical Governance Forum, Mental Health
DATE APPROVED:	19th February 2014
VERSION:	Version 2
OPERATIONAL DATE:	19th February 2014
DATE FOR REVIEW:	3 Years
DISTRIBUTION:	Executive Directors Directorate Managers Clinical Governance Mental Health Mental Health Act Monitoring Group Heads of Department: Mental Health

FREEDOM OF INFORMATION STATUS: Open

APPENDICES

1. PURPOSE

The purpose of this procedure is to ensure that the Hospital Managers, via delegated staff, provide certain information both orally and in writing to patients and, where applicable, to nearest relatives regarding which section of the Mental Health Act 1983 for the time being authorises his/her detention and the effects of that section. Under the Act the Hospital Managers have the authority to delegate this duty to the nursing team. This information includes:

- **Details of the relevant Section under Which they are detained**
- **The powers of that Section**
- **The patient's rights of appeal**
- **The right to free legal advice**
- **The right to an Independent Mental Health Act Advocate**

There is also a duty to ensure that patients understand the following provisions of the Act and how it applies to them:

- The ways they can be discharged from detention
- The role of the Nearest Relative
- The rule in respect to Consent to Treatment under the Mental Health Act
- How to appeal to Hospital Managers and the Mental Health Review Tribunal for Wales.
- The role of the Healthcare Inspectorate Wales
- How to access the Code of Practice

There is a statutory duty to ensure that such rights are given a soon as practicable after the detention. The staff giving the information should be as helpful as possible and if it appears that the patient does not understand the information they should try and explain it further at a later time and using appropriate aids if required.

2.INFORMATION TO BE GIVEN TO PATIENTS

(a) Consent to treatment

- The nature, purpose and likely effects of planned treatment;

- The right to withdraw consent to treatment at any time and of the need for consent to be given to any further treatment;

- How and when treatment can be given without their consent.

(b) Detention, renewal and discharge

- The Name of the patient's Responsible Clinician (RC);

- The existence of the Mental Health Act Code of Practice for Wales;

- The provisions of the Act under which patient is detained with reasons for detention;

- Patient will be informed in writing if the section is renewed at the end of the period of detention. (see Appendix E);

- The patient will have their rights read again on renewal of section (See Appendix 1);

- When the decision is made for the patient to be discharged from Section, a Section 23 discharge form will be completed and the patient and nearest relative (with patient's consent) will be informed in writing of this. (See Appendix F &G)

- The patient's rights of appeal to Hospital Managers and Mental Health Review Tribunal.

(**c) Information on applications to Mental Health Review Tribunals**

- Patient and nearest relatives rights to apply to Mental Health Review Tribunals;
- The role of the Tribunal;
- How to apply to a Tribunal;
- How to contact a suitably qualified Solicitor;
- The availability of Legal Aid;
- How to contact other organisations able to help them make an application to a Tribunal;

(d) Information on applications to the Hospital Managers

- Rights to apply to Hospital Managers
- The Role of the Hospital Managers
- How to contact other organisations able to help them make an application to the Hospital Managers

(**e**) **Information on Health Inspectorate Wales (HIW)**

- The role of HIW;
- When HIW is to visit the hospital;
- Of their right to meet HIW;
- Of their right to complain to HIW.

Additionally, all patients must be informed of their right to an Independent Mental Health Advocate (IMHA) and given the relevant IMHA leaflet.

Patients must also be informed of their right to request copies of their detention documents (see Appendix 1).

Supervised Community Treatment (SCT) patients have rights under Section 132 A to receive similar information. Cwm Taf Health Board's SCT Protocol deals with Section 132 A requirements in details.

(f) Relevant Patient Information Leaflets

This procedure applies to patients that are liable to be detained under the following sections of the Mental Health Act 1983. Patient leaflets are available as listed.

Leaflet	
1	Section 2
2	Section 3
3	Section 4
4	Section 5(2)
5	Section 5(4)
6	Section 7 Guardianship Order
7	Section 17 A SCT
8	Section 17 E Recall from Supervised Community Treatment
9	Section 20 Renewal of detention
10	Section 35 Remand to Hospital for assessment
11	Section 36 Remand to Hospital for Treatment
12	Section 37 Hospital by Court Order
13	Section 37 Guardianship by Court Order
14	Section 37& 41 Admission to Hospital by a Crown Court Order
15	Section 37 &41 Recall from CD
16	Section 38 Interim Hospital Order
17	Section 45A Hospital and Limitation Directions
18	Section 47 Transfer to Hospital of a person serving a sentence of imprisonment without restrictions
19	Section 47 &49 Transfer to Hospital of a person serving a sentence of imprisonment with restrictions
20	Section 48 &49 Transfer to Hospital of an un-sentenced prisoner from a remand prison or remand centre with or without restrictions
21	Admission of patients removed by Police under a Court Warrant
22	Admission of mentally disordered persons found in a public place
23	Patients admitted to Hospital from the Courts
23	Your Nearest Relative under the Mental Health Act 1983

3. NEAREST RELATIVE

The Mental Health Act Administrators must take reasonable steps (unless the patient request otherwise) to ensure that Nearest Relative receive the same information as given to patient. Unless the Nearest relative has exercised their powers of discharge under the Mental Health Act, they must be informed of the patient impending discharge. This should be given at least seven days prior to the discharge if practicable. The Mental Health Act Administrators must therefore be notified of this information by the Nursing Team as soon as possible.

4. VICTIMS RIGHTS

Information relating to discharge or transfer of patients detained under Part 3 of the Mental Health Act may be shared with people with a valid interest. This may include victims and the families of victims as described in the Domestic Violence, Crime and Victims Act 2004 (as amended by the MHA 2007) In other circumstances, professionals should encourage (but cannot require) mentally disordered offender patients to agree to share information that will enable victims and victims families to be informed about their progress.

5. PROCEDURE

Nursing, Responsible Clinician & Mental Health Act Administration Roles

The patient's Key Nurse will, as soon as practicable, give the patient information on his/her rights under the Mental Health Act 1983.

- The Patient's Key Nurse must record that verbal and written information has been given to the patient. This information must be recorded on the electronic Record and Form 132 (See Appendix 1). Written information must be given in the form of the appropriate rights leaflet (See Chart above).

- If the patient seems unable to understand the information, further attempts to read the rights must be made at regular intervals.

- Form 132 must be signed by the Key Nurse and the patient (See Appendix 1). If patient is unable or refusing to sign the form, it must be recorded by the Nurse on the Section 132 Form.

- If the patient indicates that he/she wishes to request a copy of their detention documents, the Responsible Clinician (RC) must be informed and must complete Form 2. This form will then be passed to the Mental Health Act Administrator (MHAA), who will carry out the Responsible

Clinician's instructions with regard to withholding information and release of the papers and will file the form in the patient's detention folder and input it on the electronic records.

- On completion Form 132 must be forwarded to the Mental Health Act Administrator who will copy it and file in the detention folder and input it on the electronic record.

- The Mental Health Act Administrator must write to the patient's nearest relative enclosing a copy of the right leaflet (unless the patient objects). Under Section 133 of the Mental Health Act 1983, particular attention should be paid to ensuring that the nearest relative understands their rights and responsibilities in relation to the patient's discharge from detention (See Appendix B,C,D &E).

6. ACCESSING AN INTERPRETER

Where a patient has the need for an interpreter to understand his rights, it should be fully documented in the notes. The procedure to access an interpreter can be found on SharePoint under "useful staff information". Patients must have access to written information leaflets in their own language choice. The Mental Health Act Administrator can assist with this process.

7. REFERENCE

The leading legislative and NHS requirements in respect of this procedure and procedure will be defined in:

- Mental Health Act 1983 Section 132 and Section 133;

- Code of Practice, Chapter 22;

- Human Rights Act 1999

- Domestic Violence, Crime and Victims Act 2004

8 .REVIEW AND MONITORING ARRANGEMENTS

The use of this procedure will be subject to regular review by the Mental Health Act Administrators who will report to the Mental Health Act Monitoring Group and will inform the Directorate Manager of any non-compliance issues.

This procedure will be reviewed at three yearly intervals.

9. AUDIT ARRANGEMENTS

This procedure will be reviewed three years after completion and will be subject to review at intervals. The effectiveness of this procedure will be monitored by the Mental Health Act Office on behalf of the Directorate.

10. MANAGERIAL RESPONSABILITIES

Ward Managers will be responsible for ensuring all their Registered Nurses are fully conversant with this procedure.

11. RETENTION AND ARCHIVE

This procedure will be available via the Health Board's SharePoint /Intranet. The Directorate will retain all previous versions of this procedure for future reference. This procedure will be version controlled.

12. NON-CONFORMANCE

Conformance with this procedure will be monitored on a regular basis; non-conformance may be subject to an investigation and subsequent scrutiny by Health Inspectorate Wales.

13. EQUALITY IMPACT ASSESSMENT STATEMENT

Following assessment, this procedure is not felt to be discriminatory or detrimental in any way with regard to the following equality strands; Gender; Race; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human Rights.

EXPLANATION OF RIGHTS

e patient should be informed of:

- The provision of the Act under which they are detained or on and the reason for their detention together with the name of their Responsible Clinician.
- The right to apply to the Mental Health Review Tribunal and the right to free legal representation.
- The right to apply for a Hospital Managers Review of detention and the Managers powers of discharge.
- Consent to treatment issues, including their right to withdraw their consent to treatment and the circumstances when treatment can be given without consent.
- The right to be involved in their treatment and care plan.
- The role of the Health Inspectorate Wales.
- The existence of the Code of Practice to the Act.
- The powers of the Responsible Clinician and nearest relative in relation to discharge.
- The right to request an Independent Mental Health Advocate and copies of detention papers

S NAME	WARD
TATUS	HOSPITAL NO
e patient request copies of their detention :s? *(if yes, request the RC to complete Form 2)*	**YES NO** *(circle appropriate answer)*

EASE INDICATE REASONS	

attempts to inform patient of their rights. N.B. An must be obtained for any patient who does not speak a first language.

	Time	**Outcome/Problem encountered**	**Signature of Person giving Rights**

SFUL ATTEMPT MADE BY	
	TIME
APPEARS TO HAVE UNDERSTANDING OF	YES NO
GIVEN RIGHTS LEAFLET NOS	

patient object to their nearest relative being informed of ntion? Yes □ No □

Patient:

_____

ETED FORM 132 MUST ACCOMPANY ALL ON DOCUMENTATION AND SHOULD BE WARDED TO THE MENTAL HEALTH ACT ISTRATOR AT THE ROYAL GLAMORGAN HOSPITAL.

FORM 2

Appendix A-Patient's Rights under Section 132 (2 pages)

Form 2

ISSUING DETENTION DOCUMENTS TO A PATIENT
Record of Consultation with Patient and decision-making

Patient Name: _____DOB: _____

Section: _____Commenced/Renewed: _____

Ward: _____

1. Does the patient wish to have a copy of their detention documents?
Yes *(proceed with below questions)* / No *(no further action needed)*
2. Does the patient have the capacity to receive their detention documents?
Yes *(complete go to Q3)* / No *(go to Q2a below)*

2a. What evidence is there to support a lack of capacity for the patient to make this decision? Have all practical steps been taken to assist the patient in this matter? Is it in the patient's best interests to receive their detention documents if s/he wishes this, despite lacking capacity to decide?

_____
_____
_____
_____

3. Is it necessary to withhold the documents in part or in full because receipt of them would adversely affect the health or wellbeing of the patient or others?
Yes / No

3a. Issuing the detention documents would cause: *(*tick as appropriate)*
Harm to the patient ☐ harm to another person ☐ Other ☐ *Please specify.*
_____
_____
_____

3c. If the detention documents should be released in part, can you specify which information should be withheld?

_____
_____
This completed form should be passed to the Mental Health Act administrator, who will proceed with issuing the papers, subject to the decisions specified on the form. The MHAA will also routinely delete any assessors' personal information, e.g home addresses.

Signed _____
Responsible Clinician

Date _____ Time _____

Appendix B- Section 2 letter to Nearest Relative

Dear Mr _____

I understand that you are the nearest relative of ……. I am writing to inform you that …… was admitted to …….. Hospital and detained under Section 2 of the Mental Health Act 1983 on ……. for a period of up to 28 days.

I am sure that this news may be upsetting and I am keen to give you all the information needed to explain why …… is being kept in hospital in this way. I am therefore enclosing a copy of a leaflet that has been given to ……..

If you have any questions that you wish to ask, suggestions you wish to make concerning …… treatment, or complaints, I suggest that in the first instance, you talk to the Responsible Clinician, who is Dr ……..

To do this, it will be best for you to make an appointment. The Ward Manager, where …… is currently an inpatient, will assist you with this.

As the nearest relative of ……, you can propose that …….. should be discharged by writing to the Hospital Managers giving them 72 hours notice of your intentions.

If the Responsible Clinician thinks that …….. would be a danger to ……. or others, …… can prevent this process from happening. The Hospital Managers will then review ……. detention in hospital and decide whether the legal powers should remain. You will be informed in advance of this happening.

As I mentioned earlier, you will see that …….. can also apply to the Tribunal for …….. discharge. If …….. does, you will be informed of this and you will be able to attend or write to the Tribunal to tell them what you think.

If you are not satisfied with what you are told, you can also ask Health Inspectorate Wales (HIW) to help you. HIW is totally independent of the hospital and is concerned with the welfare of all patients who are detained under the provisions of the Act. You can write to them direct without contacting the hospital first. Their address is contained in the enclosed leaflet. You can even do this after …….. has left hospital.

I can assure you that as soon as ……. is to be discharged you will be informed of this unless you prefer not to know or …… asks that you should not be told. If ……. asks for you not to be told, we will normally respect …… wishes. The exception to this is if, by not having this information, you or other members of your family will be put at risk of harm.

I can also assure you that the hospital will arrange any follow up treatment or help that is necessary for the care of ……... If at some other time you feel that …….. needs to be admitted to hospital, we will ask a social worker to look into this matter. If they feel that a hospital admission is not the best way to deal with what is happening you will be given a written explanation.

I know that this is a lot of information to take in at what is often a distressing time, but I hope that this letter and the leaflets are helpful. If you wish to discuss any aspect of ……. detention in hospital, the team looking after ……. is often the best place to start. Alternatively you can contact the Mental Health Act Office on the number above.

Finally, I would like to offer my best wishes for …….. speedy recovery from ……illness.

Thank you

Yours Sincerely

_____

Mental Health Act Administrator

Enclosed leaflet
1, IMHA and 24

Appendix C- Section 3 letter to Nearest relative

Dear ----------

We understand that you are the nearest relative of ---------- . This letter is to inform you that ----------is being detained in hospital for an initial period of up to 6 months from ---------- under powers given by Section 3 of the Mental Health Act 1983.

We have a duty to give you certain information about _____being kept in hospital in this way. I am therefore, enclosing a leaflet that has been given to _____. If you have any questions that you wish to ask or complaints that you wish to make, I suggest you talk to his/her Responsible Clinician, who is _____, making an appointment first, or write to me at the above address. You can also ask Health Inspectorate Wales to help you if you are not satisfied with what you are told, or you can write to them directly without contacting the hospital first. You will find their address in the attached leaflet. You can do this even after _____ has left hospital.

You will notice from the attached leaflet that, as the nearest relative you can propose that _____ should be discharged, unless the Responsible Clinician thinks that he/she would be a danger to _____ or others. If you think _____ is ready to leave hospital, or should be here under legal powers, you should speak to the Responsible Clinician about it. If h/she does not think _____ is well enough for the legal powers to be withdrawn, but you still want this done so that _____can become a voluntary patient or leave hospital, you should write to me asking for your _____ to be discharged. You will be told this and you will be able to apply to a Mental Health Review Tribunal if you want to, but you must do this within 28 days of receiving this information.

The enclosed leaflet tells you more about the Tribunal. If you need help with your Tribunal application, a Solicitor, Citizens Advice Bureau or Social Worker can help you. You may be able to have free legal advice to enable you to prepare a case and be represented before the Tribunal at little or no cost to yourself, if you are qualified by a simple means test. You will see that _____ can apply to the Tribunal for discharge. If he does so, you will be able to attend or write to the Tribunal to tell them what you think.

It may help you to know that we shall tell you as soon as _____is to be discharged unless you prefer not to have this information or _____ asks that you should not have it. The hospital will try to arrange any follow up treatment or help that is necessary and if at some other time you feel _____ needs to be admitted to hospital, your _____local authority now has a duty to ask a social worker to look into the matter. If they feels admission is not the best plan they will write to you and tell you why.

Thank you

Yours Sincerely

_____

Mental Health Act Administrator

Enclosed leaflet 2 and 24

Appendix D-Section 4 letter to nearest relative

Dear----------

We understand that you are the nearest relative of _____

S/he has been detained from _____for up to 72 hours to give some time to decide how best to help her/him. This has been done under powers given by Section 4 of the Mental Health Act 1983.

We have a duty to give you certain information about your _____being kept in hospital in this way. I am therefore, enclosing a leaflet that has been given to your_____ . If you have any questions that you wish to ask or complaints that you wish to make, I suggest you talk to her/his hospital doctor, making an appointment first, or write to me at the above address.

You can ask Health Inspectorate Wales to help you if you are not satisfied with what you are told, or you can write to them direct without contacting the hospital first. You will find their address in the attached leaflet. You can do this even after your _____has left hospital.

Thank you

Yours Sincerely

_____

Mental Health Act Administrator

Enclosed Leaflet 3 and 24

Appendix E- Letter to patient re: Renewal of Detention

Dear

RE: Renewal of Section 3 of the Mental Health Act 1983

I have received a Section 20 renewal of authority for detention from your Responsible Clinician, Dr……. This means that your detention under Section 3 of the Mental Health Act 1983 has now been extended for up to a further ---------- months as from ……..

As the Hospital Managers are obliged to consider all renewals of detention, this hearing will be arranged in the near future and I will contact you with the details.

It is also necessary that Consent to Treatment or a Second Opinion is required for medication in accordance with Section 58 (a) or (b) of the Mental Health Act 1983 from …….

If for any reason you wish to withdraw your consent then a Second Opinion Doctor will be requested by the Health Inspectorate Wales. The Doctor will examine you and discuss with two other professional members of staff whether the treatment plan proposed should be followed.

If you require further assistance in this matter, please do not hesitate to contact me on the number above.

Yours sincerely

Mental Health Act Administrator

Appendix F- Letter to patient: discharge from Section

Dear …….,

RE: DETENTION UNDER THE MENTAL HEALTH ACT

Your Clinician Dr ……. Has decided that you are no longer subject to Section ……. Of the Mental Health Act 1983 and has discharged you from the provisions and powers of the Act.

It has been agreed that you can remain in hospital as an informal patient.

Thank you

Yours Sincerely

_____

Mental Health Act Administrator

Appendix G- Letter to nearest relative: discharge from Section

Dear ……..,

I wish to inform you that [name of patient] has been discharged from detention under Section …… of the Mental Health Act 1983.

[name of patient] will now remain in hospital as an Informal patient.

Thank you

Yours Sincerely

_____

Mental Health Act Administrator

Equality Impact Assessment

Approved 12th January 2011 as part of the Policy for the Management, Identification and Authorisation of Policies and Procedures – Operational 1 January 2011

All Public Sector bodies have a legal duty to undertake an equality impact assessment (EqIA) as a requirement of the equality legislation.

EqIA's provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

The process itself ensures that individual staff, managers and teams think carefully about, and record, the likely impact of their work on staff, patients and other members of the community.

The need for collection of evidence to support decisions and for consultation mean the most effective and efficient EqIA is conducted as an integral part of policy development, with the EqIA commenced at the outset.

The documentation consider the effects that decisions, policies or services have on people on the basis of their gender, race, disability, sexual orientation, religion or belief, age, Welsh Language and human rights. Assessing impact across a broad range of equality dimensions (not just those required by law), helps organisations to embed equality and human rights and assist them in the delivery of their services.

Policies will not be approved by the Board/Sub Committee of the Board without a completed EqIA Report.

For further information or advice, contact the Diversity, Equality & Standards Manager on 01443 744800.

Form 1: Preparation

Part A must be completed at the beginning of a Policy/function/strategy development or review, and for every such occurrence. (Refer to the Step-by-Step Guide for additional information).

1 – Preparation	
Title of Policy - what are you equality impact assessing?	Section 132 and Section 133 Hospital Managers patient's rights information procedure
Policy Aims and Brief Description - what are its aims? Give a brief description of the Policy (The What, Why and How?)	Guidance to ensure compliance with Mental Health Act Code of Practice in respect to information given to patients under Section 132 and Section 133 of the Mental Health Act 1983
Who Owns/Defines the Policy? - who is responsible for the Policy/work?	Mental Health Act Monitoring Group Mental Health Clinical Governance Heads of Department Mental Health
Who is Involved in undertaking this EqIA? - who are the key contributors and what are their roles in the process?	Mental Health Act Monitoring Group Mental Health Department
Other Policies - Describe where this Policy/work fits in a wider context. Is it related to any other policies/activities that could be included in this EqIA?	This procedure is in line with the Mental Health Act Code of Practice for Wales
Stakeholders - Who is involved with or affected by, this Policy?	Mental Health Act Monitoring Group Clinical Governance Mental Health Heads of Department: Mental Health
What might help/hinder the success of the policy? These could be internal or external factors.	There is a requirement for understanding and commitment to this procedure to ensure compliance with the Mental Health Act 1983. There is a need to monitor compliance which will be undertaken by the Mental Health Act Monitoring Group.

Form Two – Information Gathering

Is the policy relevant to the public duties relating to each equality strand. Tick as appropriate.							
	Race	Disability	Gender	Sexual Orientatio	Age	Religion Belief	Welsh Language
Is the policy relevant to "eliminating discrimination and eliminating harassment?"	√	√	√	√	√	√	√
Is the policy relevant to "promoting equality of opportunity?"	√	√	√	√	√	√	√
Is the policy relevant to "promoting good relationships and positive attitudes?"	√	√	√	√	√	√	√
Is the policy relevant to "encouragement of participation in public life?"	x	x	x	x	x	x	x
In relation to disability, is the policy relevant to "take account of difference, even if it involves treating some individuals more favourably?		√					

The Human Rights Act contains 15 rights, all of which NHS organisation have a duty to act compatibly with and to respect, protect and fulfil. The 7 rights that are particularly relevant to healthcare are listed below. For a fuller explanation of these rights and other rights in the Human Rights Act please refer to Appendix A: The Legislative Framework. Consider the relevance of your Policy to these Human Rights and list any available information to suggest the Policy may interfere with, or restrict the enjoyment of these rights.
The right to life **N/A**
The right not be tortured or treated in an inhuman or degrading way **N/A**
The right to liberty **N/A**
The right to a fair trial **N/A**
The right to respect for private and family life, home and correspondence **N/A**
The right to freedom of thought, conscience and religion **N/A**
The right not be discriminated against in relation to any of the rights contained in the Human Rights Act **N/A**

Equality Strand	Evidence Gathered
Race	Applies equally to all groups covered by Equality Legislation
Disability	Applies equally to all groups covered by Equality Legislation
Gender	Applies equally to all groups covered by Equality Legislation
Sexual Orientation	Applies equally to all groups covered by Equality Legislation
Age	Applies equally to all groups covered by Equality Legislation
Religion or Belief	Applies equally to all groups covered by Equality Legislation
Welsh Language	Applies equally to all groups covered by Equality Legislation

Form 3: Assessment of Relevance and Priority

Equality Strand	Evidence: Existing evidence to suggest some groups affected. Gathered from Step 2. (See Scoring Chart A)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C)
Race	**1**	**1**	**1 (P)**
Disability	**1**	**1**	**1 (P)**
Gender	**1**	**1**	**1 (P)**
Sexual Orientation	**1**	**1**	**1 (P)**
Age	**1**	**1**	**1 (P)**
Religion or Belief	**1**	**1**	**1 (P)**
Welsh Language	**1**	**1**	**1 (P)**
Human Rights	**1**	**1**	**1 (P)**

Scoring Chart A: Evidence Available

3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact

-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact Decision

-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

FORM 4: (Part A) Outcome Report

Policy Title:	Section 132 and Section 133 Hospital Managers Patient's RIGHTS Information Procedure
Organisation:	Cwm Taf University Health Board
Name: **Title:** **Department:**	Clinical Governance Forum: Mental Health Directorate Mental Health Act Monitoring Group
Summary of Assessment:	This procedure is not found to be discriminatory. This procedure has been devised based on the requirements of the Mental Health Act Code of Practice for Wales
Decision to Proceed to Part B Equality Impact Assessment:	No There is no evidence to suggest that this procedure is discriminatory and/or contravenes the Human Rights Act or Equality Legislation.

Action Plan

You are advised to use the template below to detail any actions that are planned following the completion of Part A or Part B of the EqIA Toolkit. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual adverse impact, as well as any arrangements to collect data or undertake further research.

	Action(s) proposed or taken	**Reasons for action(s)**	**Who will benefit?**	**Who is responsible for this action(s)?**	**Timescale**
What **changes** have been made as a result of the EqIA?	None Not found to be discriminatory	N/A	N/A	N/A	N/A
Where a Policy may have differential impact on certain groups, state what arrangements are in place or are proposed to **mitigate** these impacts?	None	N/A	N/A	N/A	N/A

Justification: For when a policy may have adverse impact on certain groups, but there is good reason not to mitigate.	N/A	N/A	N/A	N/A	N/A
Describe any **mitigating actions** taken?	N/A	N/A	N/A	N/A	N/A
Provide details of any actions planned or taken to **promote equality**.	This Procedure will be brought to the attention of staff by the Mental Health Act Monitoring Group, Clinical Governance Mental Health	To promote and ensure equality. Staff involved in the process undertake on-going relevant training	All staff	Heads of Department Mental Health, Clinical Governance Forum, Mental Health Act Monitoring Group.	N/A

Date:	19/02/2014
Monitoring Arrangements:	Mental Health Act Monitoring Group Mental Health Clinical governance
Review Date:	19/02/2017
Signature of all Parties:	Pamela Connor

Appendix A - Training Impact Assessment

If training requirements are identified a policy training impact assessment is to be completed and forwarded to the Workforce and Organisational Development Directorate

1. Will training be required as a result of the policy?

Yes	Proceed to question 2
No	If no, please state how this policy will be communicated within the LHB

2. Please complete the following information relating to training

Course/ policy title	Section 132 and Section 133 Hospital Managers Patient's rights information procedure
Course type	Mental Health Act
Reference to KSF/NMC Dimensions	Communication Information processing Quality
Target Audience (refers to scope of policy)	Staff working across health
Course / policy training objectives	To familiarise staff with contents of the procedure in order to comply with requirements of the Mental Health Act 1983.
Course / policy training content	Information to be given to patients Staff Responsibilities Nearest relative rights Forms to be used Rights of victims Equality/Diversity needs
Duration of course / programme	To be agreed
Name of trainer (or policy lead)	To be agreed
Approximate cost of providing training	To be agreed
Please embed lesson plan, link to e-learning, presentation or other relevant learning material	Not currently available

Ref: MH32

Safe and Supportive Engagement and Observation Procedure in Mental Health Wards

INITIATED BY:	Mental Health Directorate
APPROVED BY:	Clinical Governance Forum: Mental Health
DATE APPROVED:	20th January 2016
VERSION:	2.0
OPERATIONAL DATE:	1st February 2016
DATE FOR REVIEW:	19th January 2019
DISTRIBUTION:	Executive Directors, Directorates, Clinical Governance Mental Health, Mental Health Act Monitoring Group, Heads of Department: Mental Health
FREEDOM OF INFORMATION	STATUS: OPEN

CONTENTS

1. Purpose

The purpose of this procedure is to set out the Mental Health Directorate Procedure on the safe and supportive engagement and observation of patients within the in-patient environment.

2. Procedure Statement

Nursing observation is a skilled activity which can be defined as "regarding the patient attentively while minimising the extent to which they feel that they are under surveillance" (SNMAC 1999).

Observation is not simply a custodial activity; it is an opportunity for the nurse to interact in a therapeutic way with the patient on a one to one basis. Encouraging communication, listening and conveying to the patient that they are valued and cared for, are important components of skilled nursing observation. "Effective nursing is predicated on engagement with the person." (Barker & Cutcliffe 1999 p.11).

This procedure recognises the need to maintain peoples' safety whilst in hospital. During an acute phase of their illness some patients are not able to protect themselves from harm, either from themselves or others. Alternatively some patients during an acute phase of their illness have difficulty controlling their actions / behaviours.

It also acknowledges that the use of safe and supportive engagement and observation is a helpful intervention when people are withdrawn, isolated, not engaging in care or have complex acute physical health care needs alongside their mental health needs.

3. Principles

This Procedure is based on the following key principles:

- Maintaining and promoting personal safety of all patients is a fundamental component of care provided to patients in a hospital setting.

- Safe and supportive engagement and observation can help minimise risk and all decisions should link to the information in the risk assessment document.

- Higher levels of engagement and observation should also be considered useful, where a patient is socially withdrawn on the ward as nursing engagement is key to carrying out effective supportive observations.

- It is recognised that whilst nursing patients in an acute phase of their illness, each patient will require a specific level of support and observation in order to minimise risks, maximise their engagement in treatment and to ensure theirs and others safety.

- Privacy and dignity of patients must be considered and maximised however this will always be balanced against the need to maintain safety.

- When a patient is undergoing close supervision by a Health Care Support Worker the registered nurse in charge of the clinical area will maintain responsibility for assessment of the patients needs, care planning and evaluation and the safety and well being of patient and staff member.

- Not all risk can be eliminated. Preventing a patient from falling is a particular challenge especially in hospital settings because patient safety has to be balanced against the right of patients to make their own decisions about the risks they are prepared to take and their dignity and privacy.

This procedure stipulates that all patients in hospital will need to be nursed under one of a range of four specific levels of supportive observation.

NB
As a matter of routine all patients will be checked:

- At the morning handover by a nurse from the on-coming and off-going shift,
- At 14.00 hrs by a designated nurse on duty,
- At the night handover by a nurse from the on-coming and off going shift

This will be recorded on the ward record of observation sheet (Appendix 1a & 1b)

All in-patients will be subject to general observation as described below. There is no expectation that a newly admitted patient will automatically have a level of engagement and observation over and above general observation. However, each patient's level of engagement and observation will be based on a consideration of their individual needs and risks.

All patients will have a documented and care planned level of engagement and supportive observation.

4. Scope

This procedure will apply to all Mental Health in-patient wards within the Mental Health Directorate.

5. Legislative and NHS Requirements

This Procedure recognises the guidance contained within:

- Department of Health Standing Nursing and Midwifery Advisory Committee (SNMAC) practice guidance, "Safe and Supportive Observation of Patient's at Risk" (July 1999)

- Avoidable Deaths' Five year report of the national confidential inquiry into suicide and homicide by people with mental illness (2006) University of Manchester
- "Safe Management of Mental Health In-Patients" CNO (2008) 01CMO(2008) 01.
- Nursing and Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives. London: NMC.
- National Institute for Health and Care Excellence (2015) Violence and aggression: short term management in mental health, health and community settings NICE guideline 28 May 2015

6. Procedure

6.1 There are four levels of safe and supportive observation:

<u>General observation - Level 1 safe and supportive engagement and observation</u>

This is the minimum acceptable level of engagement and observation for all in-patients. Staff should know the location of all patients, but not all patients need to be kept within eyesight. At least once a shift staff will set aside dedicated time to engage with the patient, discuss their care plan and check out how they are feeling, this must then be documented in the clinical records. During the night shift patients on general observation should be checked at a minimum of hourly intervals. This will be recorded on the ward observation check sheets. Within Psychiatric Intensive Care Unit (PICU) and the Enhanced Care Unit (ECU) the checks at night will be every 30 minutes. (Appendix 1a & 1b)

<u>Intermittent observation - Level 2 safe and supportive engagement and observation</u>

The patient's whereabouts must be checked every 15 minutes. The care plan should stipulate if the checks need to be carried out sensitively in order to cause as little intrusion as possible or, more explicitly in order to reassure the patient. However the 15 minute observations should be seen as an opportunity to engage the patient in therapeutic conversation regularly throughout the shift.

<u>Within eyesight observation - Level 3 safe and supportive engagement and observation</u>

The patient should be kept within eyesight at all times, by day and by night. If deemed necessary, any items that patients could use to harm themselves or others should be removed. Engagement and therapeutic conversation is an essential aspect of this level of observation.

<u>Within arm's length - Level 4 safe and supportive engagement and observation)</u>

This will involve nursing the patient within arm's length at all times. Issues of privacy and dignity and consideration of gender when allocating staff are a priority when implementing this level of intervention. This will include being with the patient in the toilet and the bathroom. On rare occasions more than one nurse may be necessary to maintain a safe level of intervention. It is implicit in this level of

engagement and observation that the nurse uses the time to actively engage the person in therapeutic conversation, assess their mental state, support them to participate in ward or other therapeutic activities or where appropriate diversional activities.

Selecting a level of safe and supportive observation

Signs that may indicate the need for higher levels of safe and supportive observation are:

- Withdrawn, socially isolated patients who are difficult to engage or who could be overlooked at busier times;
- History of previous suicide attempts, self harm or aggression towards others;
- Hallucinations, particularly voices suggesting harm to self or others;
- Paranoid ideas where the patient believes that other people pose a threat;
- Thoughts and ideas the patient has about harming themselves or others;
- Specific plans or intentions to harm themselves or others;
- Vulnerability due to mental state or poor judgement (i.e. disinhibited or manic phase, confusion), gender, age and other patients presentation;
- High levels of impulsivity
- High levels of hopelessness
- Significant levels of agitation
- Acute/complex physical health problems especially in older people
- A history of falls in patients with specific wandering behaviours, especially in older adults.
- End of life care

This list is not exhaustive and decisions will be made on the individual patients' circumstances.

NB A person who is under the age of 18 at the time of their admission will always be deemed vulnerable on adult in-patient wards. Therefore they will automatically be kept within eyesight as a minimum (Safe and Supportive observation level 3)

Undertaking Observations of Sleeping Patients

It is important to balance the risk of ensuring adequate observations with the need for sleep and rest. When undertaking the observation of sleeping patients the minimum standard is that visual contact of the patient is made and there are obvious signs of unrestricted breathing. Where there are shapes in beds or the view from observation windows is restricted the nurse undertaking the check will need to undertake any necessary steps to ensure they have clear sight of the individual. There are occasions where more thorough observations are required and these will need individual care plans.

6.2 Who is responsible for deciding the observation level required for each patient?

Decisions about observation should be made jointly by the medical and nursing staff with the patient being as involved as possible. When a patient is being admitted to a ward the decision about what level of supportive engagement and observation is required will be made by the nurse in charge of the ward in conjunction with the patient, medical team and admitting professional. The initial risk assessment must give consideration to:

- Past risk history including vulnerability and pre-admission known risk factors;
- Current mental health presentation, needs and risks;
- The patient and carers perspective;
- The ward environment at that time.

Observation levels do not have to remain static across a 24-hour period. They can be reduced or increased at specific times if there is considered to be a reduced or increased risk. For example, level 3 could be reduced to level 2 at night or level 2 could be reduced to general observations (level 1). The rationale for this and the specific details must be documented fully in the patient's care plan and must be agreed upon by medical and nursing staff. The time for increasing / reducing the level of supportive observation must be clearly stated in the care plan.

Where there is uncertainty about a patient's level of need or risk staff should be cautious until more information is available.

Where a consensus decision about the level of supportive engagement and observation is not achieved by all parties involved, the nurse in charge of the ward will be responsible for making the decision.

The nurse in charge is responsible for ensuring the patient is given a timely, full explanation about the level of supportive engagement and observation they will be nursed on and what this means for them.

The nurse in charge will also be responsible for notifying the family and / or carers and colleagues of the level of engagement and observation put in place.

6.3 How should decisions be recorded?

The doctor or nurse must record decisions regarding observation levels in the patient's notes. This entry will then be countersigned by any other party involved in the decision. This record should include:

- Patients current mental state;
- The current assessment of risk;
- The specific levels of observation to be implemented;
- Who was involved in making this decision;
- The timing of the next review (this will also be recorded on the care plan).

The Nurse in Charge should ensure the record of supportive observation form is in place for those patients on level 2 or above (Appendix 2). These will include the name of the patient and the reason for the observation level implemented, the nurse responsible for the period of observation and the time that they commence and conclude their period of observation.

A safe and supportive engagement and observation care plan will be devised collaboratively with the patient within 3 hours of admission. If this time frame cannot be achieved the reason should be documented and the care plan completed at the earliest opportunity. The care plan must be completed within 12 hours of admission. The care plan should make clear:

- The exact level of observation;
- Any specific issues of privacy, dignity, gender or cultural issues;
- Clear directions regarding the therapeutic approach that will best meet the needs of the patient at that time;
- Environmental dangers or vulnerable areas of the ward;
- Any changes to the level of supportive engagement and observation when the patient has visitors.

6.4 Procedure for allocating nursing staff to undertake levels of supportive observation

At the commencement of each shift the nurse in charge will allocate a member of staff to each patient on the ward.

Where there are patients on level 4, level 3 or level 2 engagement and supportive observations the nurse in charge will devise a rota for the shift. The rota will allocate staff to carry out the supportive observations for hour long periods.

The names of the allocated staff will be recorded on the record of supportive observation form (see appendix 2).

Prior to taking over a patient's care, the allocated nurse must be given information regarding the patient in particular specific risk information. They must also be aware of the layout of the ward and the emergency procedures in place.

In the case of Level 4 or 3 engagement and observations, the person next on the rota should take over from the person currently undertaking engagement and observation duties.

When completing their allotted period the nurse should not assume someone else has taken over from them. The handover of staff each hour must be explicit and whenever possible the handover between the two nurses should involve and take place in the presence of the patient. Staff should strive to involve the patient in the discussion, rather than discuss the patient in their presence.

It is recognised that this can be difficult; however it can help increase the patients' feelings of involvement in their care, their sense of autonomy and encourage the development of trust.

The person who has completed their allotted hour will then sign the record of supportive observation form to indicate that they have completed their period of engagement and observation.

In the case of intermittent observation (Level 2), at the end of a nurse's period of observation they are required to visually check the patient's whereabouts with the nurse taking over the observation.

It is important to note that the registered nurse in charge remains accountable for the decision to delegate observation to a Health Care Assistant. This involves ensuring the Health Care Assistant:

- knows the patient well prior to undertaking engagement and observation, this includes knowing the patients history, background and specific risk factors;
- Is familiar with the ward layout, emergency procedures, and potential risks in the environment;
- Understands their role in observation and has received appropriate training in carrying out observations for a patient at risk of harm to themselves or others.

Under no circumstances should the person undertaking the observation discontinue, if the handover has not been conducted as indicated in this procedure.

6.5 How often and by whom should observation levels be reviewed?

Throughout an admission a patient's needs and risks will be continuously reviewed. Any change in mental state or risk will trigger an evaluation of the patient's level of supportive observation.

A decision to change the level of supportive observation will be taken by the medical and nursing staff in conjunction with the patient whenever possible. This will be reviewed by the Consultant Psychiatrist or the nominated deputy, with the primary / named nurse (where possible) and / or nurse in charge of the ward.

In an emergency situation the nurse in charge can raise the level of observation without consultation. The Ward Manager/Deputy Ward Manager can decrease levels of observation from Intermittent (Level 2) to General Observation (Level 1). (See procedure for reducing observation levels below). The ward doctor and Consultant Psychiatrist should be informed of this action. Level 4 and 3 observation reductions can be initiated by the Ward Manager/Deputy Ward Manager but must be agreed with by the Consultant.

At each review of the observation level the timing of the next review must be documented. This should never exceed 72 hours. However if circumstances change, the time of the review can/should be brought forward.

If enhanced observation levels are continued for 1 week a full multi-disciplinary review must be convened.

The nurse in charge is responsible for ensuring the patient is given a full explanation about the reason for the change in the level of supportive engagement and observation they will be nursed on and what this means for them. If this is not possible the rationale for this must be documented. The nurse in charge will also be responsible for notifying the family and / or carers and colleagues of the change in the level of engagement and observation.

6.6 Patients on observations going off the ward

Some patients, who are on higher levels of engagement and observation, may find going off the ward with appropriate supervision therapeutic and this may form an important part of treatment and recovery. Decisions regarding patients leaving the wards accompanied must be made by the multi-disciplinary team. The rationale for this decision needs to be fully documented in the notes; this should include consideration of the benefit and risk.

Any decision to agree to a patient on Level 2 or 3 observation going off the ward needs to take into account both the potential benefit and the risk.

On rare occasions it may be appropriate that a patient on a Level 4 safe and supportive observation may leave the ward. This can only be agreed by the Ward Manager, their Deputy or the patient's own Consultant. The decision and rationale must be recorded in the notes by the professional making the decision.

Patients on a level 4, 3 or 2 safe and supportive observation should not leave the ward/unit unaccompanied.

If an informal patient under observation insists on leaving the ward without supervision and if the clinical team believes that the risk is considered too great for observation levels to be removed consideration of assessment under the Mental Heath Act should be triggered.

6.7 The role of other professionals

Where a Level 4 supportive observation is in place the nursing team must continue to provide this level of support during any interventions.

Where non ward staff i.e. a psychologist, occupational therapist or community staff are required to work with a patient on a Level 3 or 2 they will discuss the patient with the nurse in charge prior to undertaking any work.

Both parties will discuss and agree how the level of supportive observation will be managed during the time the work will take place. The three options that can be considered depending on the patient's circumstances and the practitioner's skills and experience include:

- Nursing staff handing over responsibility of the level of supportive observation to the visiting practitioner;
- Nursing staff continue to provide the level of supportive observation and where necessary sit in on the intervention;
- The intervention is deferred until a later date when the level of supportive observation has been reduced.

The same decision making process will be used whether the work is to take place on the ward or elsewhere on the hospital site.

6.8 The role of the family / carer in observations

On occasions it may be appropriate to reduce or suspend a level of observation during visits by families or carers. Any such decision will be agreed by the multidisciplinary team in conjunction with the patient and their family / carer. The care plan setting out how this will work will be written with the patient whenever possible and a copy given to all parties involved.

The care plan will clearly set out what should happen as the visit nears completion and the family member / carer intend to leave the ward.

Should a decision be made to allow the patient to go off the ward (see in paragraph 6.6) the family / carer will be able to accompany the patient. Again in some circumstances it may be appropriate to reduce a level of observation in order to give the person some privacy with their visitor. The procedure will be followed as above.

Only in exceptional circumstances will a person on Level 3 or Level 2 safe and supportive observation leave the ward with a family member / carer without a nurse present. The rationale for not having a nurse present must be clearly documented by the Ward Manager, their Deputy or the patient's own Consultant.

Patients on Level 4 will be nursed on the ward due to the complexities of managing this level ofobservation.

7. Training Implications

Training in observation techniques as set out in this procedure will be available to all staff required to participate in engagement and observations.

The respective Ward Manager will undertake this training and keep a record of training undertaken with their staff. Where a new member of staff or bank / agency nurse is asked to participate in safe and supportive engagement and observation it will be the responsibility of the nurse in charge to train them in the use of the

Procedure if this has not already been done. A record of this will be given to the Ward Manager.

8. Review, Monitoring and Audit Arrangements

The monitoring and review of this procedure will be subject to regular audit and review.

Any new developments arising from post incident learning or new guidance will trigger a review of the procedure.

9. Managerial Responsibilities

It is the responsibility of Ward Manager and Consultants to ensure that their staff understand and adhere to this procedure.

10. Retention and Archive

This procedure will be available via Health Board web site. The Directorate will retain all previous versions of this procedure for future reference. This procedure will be version controlled.

11. Non-Conformance

This Procedure will be monitored on a regular basis. Non conformance may be subject to investigation.

12. Equality Impact Assessment Statement

This procedure has been subject to a full equality assessment and no impact has been identified. (see Equality Impact Assessment - Appendix 3)

13. References

Barker, P. and Cutcliffe, J. (1999) Clinical Risk, a need for engagement not observation. Mental Health Practice, 2(8): pgs 8-12.

Department of Health (1999) standing Nursing and Advisory Committee (SNMAC) practice Guidance. Safe and Supportive Observation of Patients at Risk: Mental health Nursing, London HMSO. (guidance available on line at (http://wwwdh.gov.uk)

National Institute for Clinical Excellence (NICE). Excellence (2015) Violence and aggression: short term management in mental health, health and community settings NICE guideline 28 May 2015 (guidance available on line at http://www.nice.org)

Nursing and Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives. London: NMC.

Safe Management of Mental Health In-Patients" CNO (2008) 01 CMO (2008) 01

University of Manchester (2006) 'Avoidable Deaths' Five year report of the national confidential inquiry into suicide and homicide by people with mental illness.

Appendix 1a Record of Supportive Observations

GIG CYMRU NHS WALES | Bwrdd Iechyd Cwm Taf Health Board

Bed No:	Patient Name:	Morning Handover Check:	14.00 hrs Check:	Night Handover Check	20:00	21:00	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00
Sign															

NB: All patients will be ticked as present and the checking nurse to sign at the bottom of the column. The handover checks must be checked and signed by a nurse on the on-coming and off-going shift.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Record of Supportive Observations (PICU/ECU) Appendix 1b

Bed No:	Patients Name:	Morning Handover Check	14:00 Check	Night Handover Check	20:00	20:30	21:00	21:30	22:00	22:30	23:00	23:30	00:00	00:30
Sig														

Bed No:	Patients Name:	01:00	01:30	02:00	02:30	03:00	03:30	04:00	04.30	05:00	05:30	06:00	06:30
Sig													

NB: All patients will be ticked as present and the checking nurse to sign at the bottom of the column. The three handover checks must be checked and signed by a nurse on the on-coming and off-going shift.

Appendix 2 - Record of Safe and Supportive Engagement and Observations

GIG CYMRU NHS WALES | Bwrdd Iechyd Cwm Taf Health Board

Patient

Reason for Intermittent Observations

DATE	TIME	LEVEL	NURSE	SIG	COMMENT

DATE	TIME	LEVEL	NURSE	SIG	COMMENT

NB: Level Four and Three will be recorded on an hourly basis in the time box with the nurse responsible for the observations for that hour entering a comment. Level Two observations will be entered every 15 minutes with the patients whereabouts recorded in the comments box.

Appendix 3 - Equality Impact Assessment

Approved 12th January 2011 as part of the Policy for the Management, Identification and Authorisation of Policies and Procedures - Operational 1 January 2011

All Public Sector bodies have a legal duty to undertake an equality impact assessment (EqIA) as a requirement of the equality legislation.

EqIA's provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

The process itself ensures that individual staff, managers and teams think carefully about, and record, the likely impact of their work on staff, patients and other members of the community.

The need for collection of evidence to support decisions and for consultation mean the most effective and efficient EqIA is conducted as an integral part of policy development, with the EqIA commenced at the outset.

The documentation consider the effects that decisions, policies or services have on people on the basis of their gender, race, disability, sexual orientation, religion or belief, age, Welsh Language and human rights. Assessing impact across a broad range of equality dimensions (not just those required by law), helps organisations to embed equality and human rights and assist them in the delivery of their services.

Policies will not be approved by the Board/Sub Committee of the Board without a completed EqIA Report.

For further information or advice, contact the Diversity, Equality & Standards Manager on 01443 744800.

Form 1: Preparation

Part A must be completed at the beginning of a Policy/function/strategy development or review, and for every such occurrence. (Refer to the Step-by-Step Guide for additional information).

Step 1 - Preparation		
1.	Title of Policy - what are you equality impact assessing?	Safe and Supportive Engagement and Observation Procedure in Mental Health Wards
2.	Policy Aims and Brief Description - what are its aims? Give a brief description of the Policy (The What, Why and How?)	The purpose of this procedure is to set out the Mental Health Directorate Procedure on the safe and supportive engagement and observation of patients within the in-patient environment.
3.	Who Owns/Defines the Policy? - who is responsible for the Policy/work?	Mental Health Directorate
4.	Who is Involved in undertaking this EqIA? - who are the key contributors and what are their roles in the process?	Daphne Meredith-Smith Head of Mental Health Nursing
5.	Other Policies - Describe where this Policy/work fits in a wider context. Is it related to any other policies/activities that could be included in this EqIA?	It is fundamental to the clinical risk assessment process for all mental health in-patients
6.	Stakeholders - Who is involved with or affected by, this Policy?	Patients and staff
7.	What might help/hinder the success of the policy? These could be internal or external factors.	Staff awareness and understanding of this procedure. Availability of sufficient staffing resources

Form Two - Information Gathering

Is the policy relevant to the public duties relating to each equality strand. Tick as appropriate.	Race	Disability	Gender	Sexual Orientation	Age	Religion Belief	Welsh Language
Is the policy relevant to "eliminating discrimination and eliminating harassment?"	✓	✓	✓	✓	✓	✓	✓
Is the policy relevant to "promoting equality of opportunity?"	✓	✓	✓	✓	✓	✓	✓
Is the policy relevant to "promoting good relationships and positive attitudes?"	✓	✓	✓	✓	✓	✓	✓
Is the policy relevant to "encouragement of participation in public life?"	N/A	N/A	N/A	N/A	N/A	N/A	N/A
In relation to disability, is the policy relevant to "take account of difference, even if it involves treating some individuals more favourably?		✓					

The Human Rights Act contains 15 rights, all of which NHS organisation have a duty to act compatibly with and to respect, protect and fulfil. The 7 rights that are particularly relevant to healthcare are listed below. For a fuller explanation of these rights and other rights in the Human Rights Act please refer to Appendix A: The Legislative Framework. Consider the relevance of your Policy to these Human Rights and list any available information to suggest the Policy may interfere with, or restrict the enjoyment of these rights.
The right to life N/A
The right not be tortured or treated in an inhuman or degrading way N/A
The right to liberty N/A
The right to a fair trial N/A
The right to respect for private and family life, home and correspondence N/A
The right to freedom of thought, conscience and religion N/A
The right not be discriminated against in relation to any of the rights contained in the Human Rights Act N/A

Equality Strand	Evidence Gathered
Race	Applies equally to all groups covered by the Equality Legislation
Disability	Applies equally to all groups covered by the Equality Legislation
Gender	Applies equally to all groups covered by the Equality Legislation
Sexual Orientation	Applies equally to all groups covered by the Equality Legislation
Age	Applies equally to all groups covered by the Equality Legislation
Religion or Belief	Applies equally to all groups covered by the Equality Legislation
Welsh Language	Applies equally to all groups covered by the Equality Legislation

Form 3: Assessment of Relevance and Priority

Equality Strand	Evidence: Existing evidence to suggest some groups affected. Gathered from Step 2. (See Scoring Chart A)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C)
Race	1	0	1(P)
Disability	1	0	1(P)
Gender	1	0	1(P)
Sexual Orientation	1	0	1(P)
Age	1	0	1(P)
Religion or Belief	1	0	1(P)
Welsh Language	1	0	1(P)
Human Rights	1	0	1(P)

Scoring Chart A: Evidence Available

3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact

-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact Decision

-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

FORM 4: (Part A) Outcome Report

Policy Title:	Safe and Supportive Engagement and Observation Procedure in Mental Health Wards
Organisation:	Cwm Taf University Health Board
Name: Title: Department:	Daphne Meredith-Smith Head of Mental Health Nursing Mental Health
Summary of Assessment:	This policy is assessed as having no adverse impact on equality
Decision to Proceed to Part B Equality Impact Assessment:	Yes/No Please record reason(s) for decision

Action Plan You are advised to use the template below to detail any actions that are planned following the completion of Part A or Part B of the EqIA Toolkit. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual adverse impact, as well as any arrangements to collect data or undertake further research.					
	Action(s) proposed or taken	Reasons for action(s)	Who will benefit?	Who is responsible for this e for this action(s)?	Timescale
What changes have been made as a result of the EqIA?	None Not found to be discriminatory	N/A	N/A	N/A	N/A
Where a Policy may have differential impact on certain groups, state what arrangements are in place or are proposed to mitigate these impacts?	None	N/A	N/A	N/A	N/A
Justification: For when a policy may have adverse impact on certain groups, but there is good reason not to mitigate.	N/A	N/A	N/A	N/A	N/A

Describe any mitigating actions taken?	N/A	N/A	N/A	N/A	N/A
Provide details of any actions planned or taken to promote equality.					

Date:	25.01.2016
Monitoring Arrangements:	Clinical Governance Forum, Mental Health
Review Date:	3 Years from Operational date
Signature of all Parties:	Daphne Meredith-Smith Head of Mental Health Nursing Mental Health

Appendix 4 - Training Impact Assessment

If training requirements are identified a policy training impact assessment is to be completed and forwarded to the Workforce and Organisational Development Directorate

1. Will training be required as a result of the policy?

Yes	Proceed to question 2
No	If no, please state how this policy will be communicated within the HB This procedure will be communicated via Nurse Handovers, Staff Meetings, Team Development Days and included in local induction procedures for the Mental Heath Directorate

2. Please complete the following information relating to training

Course/ policy title	
Course type	
Reference to KSF/NMC Dimensions	
Target Audience (refers to scope of policy)	
Course / policy training objectives	
Course / policy training content	
Duration of course / programme	
Name of trainer (or policy lead)	
Approximate cost of providing training	
Please embed lesson plan, link to e-learning, presentation or other relevant learning material	

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Ref CLP 11

Policy for Emergency Resuscitation and Cardiopulmonary Resuscitation

INITIATED BY: The Resuscitation Committee

APPROVED BY: Quality, Safety & Risk Committee

DATE APPROVED: 10th January 2018

VERSION: FINAL v2

OPERATIONAL DATE: March 2017

DATE FOR REVIEW: March 2020

DISTRIBUTION: Medical Director
Director of Nursing, Midwifery and Patient Services
Clinical Directors
Directorate Managers
Heads of Nursing

FREEDOM OF INFORMATION STATUS: OPEN

2 CONTENTS

1 PURPOSE

This policy is to ensure the Cwm Taf UHB provides an emergency resuscitation, and cardiopulmonary resuscitation (CPR) service, which reflects current national recommendations for the identification, assessment and management of patents who are acutely ill, or a sudden unexpected cardiopulmonary arrest, also ensuring concordance with relevant aspects of the European Human Rights Act, Mental Capacity Act, University Health Board (UHB) policies and procedures, and legal and ethical issues associated with emergency resuscitation, and cardiopulmonary resuscitation (CPR).

This policy will be the basis from which more detailed directorate or local procedural documents will be developed. See examples Appendix H

It is important to stress that this policy should not supersede the authority and responsibility of any patient's consultant to make the final decision on emergency resuscitation or cardiopulmonary resuscitation (CPR) provided their decision is in compliance with legal and ethical requirements and is intended to avoid inappropriate cardiopulmonary resuscitation (CPR).

2. POLICY STATEMENT

It is the policy of Cwm Taf UHB to make available the highest quality of care to patients being treated within the UHB. All patients requiring emergency resuscitation or cardiopulmonary resuscitation will be managed in accordance with this policy.

3. PRINCIPLES

This policy ensures that the Cwm Taf UHB has an appropriate emergency resuscitation and cardiopulmonary resuscitation (CPR) policy which respects patients' rights, understood by all relevant staff, and is accessible to those who need the policy; including patients, families, carers and appointed representatives.

All patients will be managed in accordance with the Cwm Taf UHB Emergency Resuscitation and Cardiopulmonary (CPR) policy.

Cwm Taf UHB Resuscitation and Clinical Skills Department will liaise with managers, manage and audit cardiopulmonary resuscitation and associated clinical skills training.

Clinical staff will undertake emergency resuscitation, and cardiopulmonary resuscitation training to a level appropriate for their expected clinical responsibilities.

Level 1.
All Cwm Taf Staff, on line E-Learning in compliance with core skills training framework.

Level 2.
Non registered Clinical staff / Registered community staff
Undertake training on a yearly basis. This also includes nursing staff in a non clinical area.
Cwm Taf UHB also provides Resuscitation training for Adult Carers for child with specific needs when requested Via Children services.
Through face to face classroom training.

Level 3.
All Ward base clinical staff.
Undertakes ILS/PILS training on a yearly basis depending on their role.
Through face to face classroom training.

Within Cwm Taf best practice for Level 3 training is extended to other registered health care professionals.
IE Physiotherapist / Radiographers.

All clinical staff will be made aware of the UHB policy and the local procedures for managing emergency resuscitation, and cardiopulmonary resuscitation.

All Cwm Taf UHB staff induction programmes will include awareness of the Emergency Resuscitation, Cardiopulmonary Resuscitation (CPR) policy and local procedures. This will be appropriate to level of clinical responsibility.

All Wales Cardiopulmonary Resuscitation information leaflets will be available to all patients, relatives and visitors within all UHB premises.

4. SCOPE

This policy will apply to all patients being treated within Cwm Taf University Health Board.

This policy will apply to all staff employed by Cwm Taf University Health Board.

This policy relates only to emergency resuscitation and cardiopulmonary resuscitation (CPR) and not to any other treatment, treatment escalation, or treatment withdrawal decisions.

This policy takes into account the joint statement from the British Medical Association, the Resuscitation Council (UK), the Royal College of Nursing (2014) and the Standards for Clinical Practice and Training document (the Royal College of Physicians, Royal College of Anaesthetists, the Intensive Care Society in addition to Guidance from the General Medical Council.
"Not for Resuscitation" orders have legal standing and are consistent with the Human Rights Act and the Mental Capacity Act.

4.1 DEFINITION OF TERMS

It is essential to the successful implementation of this policy, and the appropriate care of patients, that a differential is made between the terms: resuscitate emergency resuscitation, and cardiopulmonary resuscitation (CPR).

The term ***resuscitate*** will be used to reflect the administration of medications, fluids or other interventions in a non-emergency situation.

The term ***emergency resuscitation*** will be used to reflect the attempt to maintain life in a patient whose breathing and/or heart is at high risk of stopping but has not stopped.
The National Early Warning Score System (NEWSS) will be a common activator of emergency resuscitation system.

The term ***cardiopulmonary resuscitation*** (**CPR**) will be used to reflect the attempt to restart the breathing and/or heart of a patient whose breathing and/or heart has stopped.
The Cardiac Arrest System (2222) will be the activator of cardiopulmonary resuscitation teams.

The Resuscitation Team will respond to both emergency resuscitation and cardiopulmonary resuscitation calls.

The term ***National Early Warning Score System (NEWS)*** will be used to reflect the system within the UHB to identify and respond appropriately to the "at risk" patient as a result of their physiological observation chart scores.

5. LEGISLATIVE AND NHS REQUIREMENTS

A prime tenet which overarches all activity in the sphere of clinical care is that each health care professional is separately and individually accountable to her/his professional body and civil and criminal courts for the competent care of a patient.

See also appendix I

- Human Rights Act of 1998

Provisions of the act relevant to CPR are:

- Article 2. The right to life;
- Article 3. The right to be free of inhuman or degrading treatment;
- Article 8.The right to respect for privacy and family life;
- Article 10. The right to freedom of expression, which includes the right to hold opinions and to receive information;
- Article 14. The right to be free from discriminatory practices.
- The Mental Capacity Act 2005
- Children Act 1989 and the Family Law Reform Act
- Resuscitation Policy Health Service Circular 2000/028 Sept 2000.

6. PROCEDURE

The following procedure must be followed for all categories of patients as appropriate.

6.1 Guidelines to assist clinical decision-making.

6.1.1 Acutely ill patients

The majority of acutely ill patients will be found within the Prince Charles Hospital and Royal Glamorgan Hospital sites. These sites are deemed 'high risk' and a multi-professional resuscitation team is available twenty-four hours a day.
In these hospitals emergency resuscitation will be attempted on all patients, Cardiopulmonary Resuscitation (CPR) will be attempted on all patients unless any of the exemption criteria below have been identified or the All Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) procedure and the correct documentation has been completed.

Exceptions to attempting or continuing cardiopulmonary resuscitation (CPR) on all patients are:

- Cardiopulmonary resuscitation (CPR) would not restart the heart and breathing. In the opinion of someone a suitably qualified to make the decision.

- If CPR is not in accordance with a valid advance decision to refuse treatment (formally called advanced directive or "living will") that is applicable in the current clinical circumstances, or with the recorded, sustained wishes of a patient with capacity.

- Where successful CPR may not be followed by a length and/or quality of life that are in the best interests of the patient. The informed views of a patient with capacity are of paramount importance when considering this decision.

- If the patient lacks capacity then discussions with people who may have information about the patient's wishes such as relatives, friends, carers, appointed representatives etc, are essential to discover what is in the patient's best interests.

- When a patient fails to respond after appropriate attempts at cardiopulmonary resuscitation, and the harms and risks associated with continued cardiopulmonary resuscitation

outweigh any expected benefits to the patient, the decision- maker (Team Leader) must consider the best interests of the patient who lacks capacity. The assessment may lead to the conclusion that it would be in the best interests of the patient to withdraw cardiopulmonary resuscitation. There should be a consensus within the resuscitation team on the decision to end the attempted cardiopulmonary resuscitation process.

- It is vital that the All Wales DNACPR procedure is adhered to, and that these exemption criteria are wherever possible discussed with the patient, following which an Adult or Child All Wales / Cwm Taf UHB DNACPR form (appendix A) is completed and if necessary additional information recorded in the patients case notes. If the patient lacks mental capacity and has appointed a life long attorney with powers of attorney over the patients' **welfare** then discussions must be with this attorney. If the patient lacks mental capacity and has not appointed a life long attorney with powers over their **welfare** all decisions must be in the patients' best interest. Discussions with relatives, friends, carers etc, may be helpful in attempts to establish what the patient might have wished with regard to cardiopulmonary resuscitation.

- Patients who lack mental capacity and who do not have any relatives, friends or carers to consult are entitled to the representation of an Independent Mental Capacity Advocate (IMCA). Where an IMCA has been appointed they must be consulted regarding healthcare decisions. In an emergency situation decisions must be made in the patients best interests and the IMCA consulted as soon as possible.

- It is also vital to recognise that there will be occasions when a patient is admitted to hospital and nursing staff will not be required to perform and record physiological observations at regular intervals. It is possible in this patient group that the patient may die in their sleep at night, and be discovered by nursing staff in the morning with obvious signs that they have died in the night. Attempting cardiopulmonary resuscitation (CPR) in this situation is physiologically futile and not appropriate. In this situation a doctor will be called immediately and a cardiac arrest audit form will be completed to record the event.

6.1.2 Patients in an intermediate or long term care setting

Patients in an intermediate or long term care setting may be admitted acutely ill, or may unexpectedly become acutely ill during their stay. Such patients should have the benefit of attempted cardiopulmonary resuscitation to the level of their individual patient care plan.

Cardiopulmonary resuscitation will be attempted unless a valid All Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order has been made or the exemption criteria stated in 6.1.1 above has been identified.

6.1.3 Patients with a poor prognosis

Resuscitation attempts or discussions regarding cardiopulmonary resuscitation (CPR) in the gravely ill do not enhance the dignity or serenity that we hope for our relatives and ourselves when we die. Inevitably there will be situations where the patient is approaching the end of their natural life and it would be inappropriate or possibly harmful to initiate discussions regarding cardiopulmonary resuscitation (CPR) with them, their family or friends, yet a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision needs to be made (See Decision making framework Appendix B).
In this situation the consultant in charge of the patients care will, following discussion with nursing staff caring for the patient complete a DNACPR form. It must be clearly identified on the form that this DNACPR decision has not been discussed with the patient and/or their relatives and the reason for not having these discussions.
Other health care professionals involved in the care or transfer of the patient should respect and adhere to the DNACPR decision and its confidentiality.

There may be occasions specifically in specialist palliative care wards where a patient who does not have a DNACPR order suffers an unexpected cardiopulmonary arrest, where-upon initial assessment of the situation and patients condition may suggest that attempting cardiopulmonary resuscitation would not be beneficial. The clinician in charge of the patients care or the

patient themselves may however believe that there will be benefit in attempting cardiopulmonary resuscitation. In order to ensure the commencement of cardiopulmonary resuscitation in situations such as this, when these considerations have taken place a "for CPR" decision system will be used in specialist palliative care wards only (Appendix C Palliative care for CPR Form).

6.1.4 DNACPR in the community

The All-Wales DNA-CPR form has been introduced as part of the Care Pathway for the Last Days of Life in the community.
The form has been developed in conjunction with the Welsh Ambulance Services NHS Trust, GP Macmillan facilitator and the Welsh Health Legal Services.

Any staff providing care for patients at home or in a nursing home, or who may encounter patients admitted from home, should be aware of the existence of this form, and the guidance which accompanies it.
It will help prevent inappropriate resuscitation (CPR) attempts on patients who are dying from terminal illness in their own home or nursing homes.

The form (appendix B) and guidance notes available from the Implementation Board website at http://www.wales.nhs.uk/sites3/home.cfm?orgid=831 (see Key Documents). If you have any questions or comments about the form, please contact Lead Clinician in Palliative Care, Cwm Taf University Health Board

6.1.5 Relatives in Cardiopulmonary resuscitation (CPR)

On occasions relatives may wish to remain with the patient during resuscitation (e.g. parent with their child). Wherever possible, medical and nursing staff should respect relatives' wishes. An experienced, appropriately trained nurse should be allocated to support the relatives present during the resuscitation event. The relatives should be asked to leave the area if their actions interfere with the resuscitation process, or compromise safety.

6.1.6 Communication and record keeping

The decision about whether or not to attempt resuscitation is likely to be distressing because the natural instinct of the healing professions is to maintain life. Nevertheless where death is likely in the not too distant future or the quality of continual life is likely to be extremely poor, then patients should be told, as should the relatives with the patients consent, and they should be given the opportunity to participate in the provision of information, which may be of help to you in making a decision. However, there is a major caveat, namely that relatives' recollections of what is said or explained might, under duress, differ from that of a clinician or nurse. It is imperative, therefore not only that the position be explained, but that the relatives clearly acknowledge that they understand the situation. This may require time and tact. It is imperative that such duties should not be delegated to inappropriately trained staff.

Emphasis has been laid on the need to make a clear contemporaneous record of the patient's diagnosis, general prognosis, discussion with relatives and/or patient, and if a decision not toattempt cardiopulmonary resuscitation, the reason for the decision. Such discussions should take place in the presence of another health care professional as witness, wherever possible. If no record is made the patient will be deemed worthy of attempting cardiopulmonary resuscitation and proceedings might then be brought for physical assault. Both medical and nursing notes should contain the same information.

The all Wales DNACPR form should be used to record all DNACPR decisions. Where more detail needs to be included, this should be entered in the patients case notes and a comment "see notes and the date of the entry" written in the relevant section of the DNACPR form.

Where an active DNACPR form exists and a surgical or other procedure is to be performed which may include risks which require the need for cardiopulmonary resuscitation the existing DNACPR order will need to be discussed as part of the consent process and the DNACPR order may need to be suspended for the intervention and peri-operative or intervention period.

Communication is essential to ensure all staff expected to participate in the direct care of any patient have adequate

information to enable them to perform their role safely and effectively. All Wales DNACPR orders will be communicated to other, essential staff delivering direct care to the patient, the ambulance service staff when transporting the patient and, health care professionals who are expected to continue direct care of the patient upon discharge. When a patient is discharged from hospital with an active DNACPR order, a member of staff should be appointed to communicate this essential information and relevant copies of the active DNACPR order should be provided for their information. Confirmation of an active DNACPR order will be included in the discharge documentation.

Staff have access to both the Sensory Loss and Cultural toolkits to aid in communication relating to cultural/religious needs, communication in the medium of Welsh as well as other languages, this will also include the use of British Sign Language and other sign languages, where there may be an issue with a learning or communication disability. This will apply to all patients and those who may be consulted about their wishes e.g. family members.

6.1.7 Cardiopulmonary resuscitation teams

One adult and one Paediatric Resuscitation team supported by a major trauma team will be available twenty-four hours a day at both Prince Charles Hospital and Royal Glamorgan Hospital sites. (Compositions, Roles and responsibilities: see Appendix E)

Newborn resuscitation will be managed by the staff present at the delivery. If further assistance is required this will be called using 2222 emergency telephone number for cardiac arrest team.

All other hospitals within the UHB will have nurse led resuscitation teams using advisory defibrillators (AED). These teams will be supported by the Ambulance Paramedic service (via the 999 system), and if available medical staff who may be on site.

Out of Hours General Practitioner Service sites and mobile response units will provide Immediate Life Support (ILS) with automated external defibrillation. These teams will be supported by the Ambulance Paramedic service (via the 999 system), and if available medical staff who may be on site.

General Medical Practices will provide basic life support with automated external defibrillation. These teams will be supported by the Ambulance Paramedic service (via the 999 system), and if available medical staff who may be on site.

General Dental Practices will provide basic life support with automated external defibrillation. These teams will be supported by the Ambulance Paramedic service (via the 999 system), and if available medical staff who may be on site.

Community services will provide basic life support and utilise the Ambulance Paramedic service via the 999 system for support.

Selected community sites/clinics will provide basic life support and automated external defibrillation. These sites will be selected on a needs/risk assessment basis.

The nurse in charge of the area will ensure a Cardiac arrest audit form is completed for all cardiac arrest calls attended. One copy will be retained in the patients notes and a second copy will be stored in the cardiac arrest audit folder, for collection by the resuscitation training department for Audit purposes.
(Appendix E)

6.1.8 Cardiopulmonary resuscitation equipment

All hospital based resuscitation equipment is functionally interdependent and located such as to enable access to another resuscitation trolley and defibrillator from a neighbouring location within 2 minutes.

A standard, fully equipped resuscitation trolley or crash bag relevant to the patient category (adult, paediatric or newborn), and defibrillator will be available within two minutes of all in- hospital patient care areas. Other clinical areas, Health Centres, Clinics and community based staff will have an appropriate level of equipment to meet local need: (See Appendix G)

Defibrillator/monitors with temporary external cardiac pacing facilities will be available at the following locations:

Royal Glamorgan Hospital: A&E, CCU. ITU, Theatres, Cardiac Catheter Suite.

Prince Charles Hospital: A&E, CCU, ITU, Theatres, CPU,

A Defibrillator/monitor with temporary external cardiac pacing, end tidal carbon dioxide and non-invasive blood pressure monitoring will be available in Accident and Emergency Departments for patient transfers.

6.1.9 Latex

All resuscitation trolley and crash bag equipment will be **LATEX FREE** and will be provided by the resuscitation and clinical skills department, or from the central resuscitation equipment store room. **Under no circumstances** is any other equipment be stored on the resuscitation trolleys or in the crash bags.

7.0 Training implications

The principles which underpin all training activity are that:

Clinical staff working within the Cwm Taf University Health Board will be able to initiate basic life support.

Clinical staff will be able to initiate in-hospital Cardiopulmonary Resuscitation in their clinical area.

Nursing staff or Allied Health Care professionals in charge of a ward or clinical area will be able to use an automated external advisory defibrillator.

Selected nurses in critical care areas will be able to use automated or manual defibrillators.

Each member of the resuscitation team will be independently competent.

Resuscitation Team leaders will be trained to national standards in Advanced Life Support relevant to the speciality of their resuscitation team (adult, paediatric, newborn).

Resuscitation team members will be trained in advanced life support standards relevant to the speciality of their resuscitation response team. (Adult, Paediatric, Newborn).

All resuscitation trainers operating within Cwm Taf UHB must be registered with the resuscitation training department.
Operating department practitioners who are members of the cardiopulmonary resuscitation team will be trained and authorised to provide:

- Airway management with adjuncts;
- Endotracheal intubation for use in cardiopulmonary arrest situation only;
- Peripheral vascular access;
- Defibrillation.

Staff performing patient observations will be able to accurately measure and record a patient's vital signs.

Training programmes will be provided to meet the need of staff appropriate to their expected clinical responsibilities.
Department Heads will liaise with the Resuscitation & Clinical Skills Manager on behalf of the Committee, to perform a training needs analysis which identifies the emergency resuscitation and cardiopulmonary resuscitation training requirements of their staff.

Nursing staff responsible to review/assess a patient as a result of a change in the patients NEWS will be able to identify a "Sick Patient" and initiate appropriate escalation of a more senior clinical review/assessment, using the NEWS activation criteria or their own professional judgement.

Medical staff with responsibility to respond as a result of an NEWS clinical response, will be able to assess and manage a "Sick Patient" and if necessary commence emergency resuscitation and cardiopulmonary resuscitation.

The resuscitation and clinical skills department will organise an appropriate range and number of courses or updates each year to provided staff with an adequate opportunity to attend training or update their skills appropriate to their clinical responsibilities on a yearly basis.

A dedicated Cardiopulmonary Resuscitation training room will be provided at each main hospital site, one at Prince Charles Hospital and one at the Royal Glamorgan Hospital.

Records of staff training and updates will be maintained at department level.

8.0 Review, Monitoring and Audit Arrangements

Cwm Taf University Health Board Resuscitation Committee will formally review this policy and associated procedural documents.

The policy will be reviewed in line with the Cwm Taf University Health Board policy of three years, but earlier if there is any change in national standards from the Resuscitation Council (UK) guidelines or any other legislation that would affect this policy.

Cwm Taf University Health Board Resuscitation Committee will meet at least three times per year and monitor several types of audit and report their finds to the UHB via the Quality, Safety and Risk committee.

8.1 Clinical Audit and Effectiveness

Clinical audit is widely recognised as the systematic and critical analysis of the quality of clinical care, including the procedures used for diagnosis, treatment and care, the associated use of resources, and the resulting outcome and quality of life for the patient.

Clinical effectiveness builds upon the quality issues identified by clinical audit and provides a framework for linking research, implementation and evaluation in clinical practice. It is about the extent to which specific clinical interventions do what they are intended to do, and can therefore be described as doing the right thing; and doing it right. The following audit programmes will gather evidence for use in such evaluation programmes.

8.2 2222 calls Audit

Cardiopulmonary Arrest Audit forms will be located on each resuscitation trolley, and will be completed for all **TRUE** or **FALSE** **2222** Calls. The original copy will be entered into the patients notes, the carbon copy to be placed in the cardiopulmonary arrest audit folder on the resuscitation trolley for collection by the resuscitation department. The completion of the audit form will remove the need for the resuscitation event to be written up in the patient's notes; additional information may be entered in the patient's case notes if required.

The Cardiopulmonary resuscitation audit form will comply with the Utstein data set recommended by the Resuscitation Committee (UK).

The Resuscitation and Clinical Skills Manager will present a cardiopulmonary arrest and DNACPR audit report to the Resuscitation Committee annually.

The Accident and Emergency Medicine representative on the resuscitation committee will present a Major Trauma Audit to the Resuscitation Committee annually.

The anaesthetic medical representative on the resuscitation committee will present a NEWS/outreach audit report to the Resuscitation Committee annually.

8.3 Cardiac Arrest Team Response Audit

This will assess the resuscitation team call system, availability of resuscitation equipment and the implementation of Resuscitation Council (UK) guidelines.

8.4 Training Audit

The Resuscitation and Clinical Skills Manager will present a report of performance against the identified training standards of this policy to the resuscitation committee annually.

9.0 MANAGERIAL RESPONSIBILITIES

The Chief Executive is ultimately responsible and accountable for the implementation, management, and audit of all Emergency

Resuscitation and Cardiopulmonary Resuscitation (CPR) events within the UHB. Responsibility for operational implementation will be delegated to the Medical Director, Heads of Nursing and the Director of Therapies and Health Science.

A Non-Executive Director of the University Health Board will be designated to hold responsibility on behalf of the University Health Board Board to ensure that Emergency Resuscitation and Cardiopulmonary Resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework. He/She will present a progress report to the University Health Board board meeting at least annually.

A senior manager within Cwm Taf University Health Board will be allocated responsibility to process recommendations of the Resuscitation and Cardiopulmonary Resuscitation Committee through the University Health Board planning and business case procedures.

The Heads of Nursing will be responsible for the identification of training needs for nursing staff employed and their conformance with policy standards.

Clinical Directors will be responsible for the identification of training needs for medical staff working in their area of responsibility and their conformance with policy standards.

Directorate Managers will be responsible for the identification of training needs for non nursing and medical staff working in their area of responsibility and their conformance with policy standards.

The Resuscitation Committee via its chair is responsible to the Medical Director for advising Cwm Taf University Health Board on the implementation of the Emergency Resuscitation, and Cardiopulmonary Resuscitation policy, practice and equipment.

The Resuscitation and Clinical Skills Manager is responsible to the Chair of the Resuscitation Committee and the Medical Director for the development, implementation and audit of resuscitation training programmes, resuscitation trolleys and resuscitation practice audit and outcomes.

Resuscitation officers will be responsible to the Resuscitation and Clinical Skills Manager to ensure compliance to the University Health Board Resuscitation and Cardiopulmonary Resuscitation policy within their area of responsibility.

One Resuscitation Officer will be based at Prince Charles Hospital and one at Royal Glamorgan Hospital, these individuals will be responsible for the organisation of Cardiopulmonary Resuscitation and associated clinical skills training and audit for their allocated sites, and will whenever available attend Cardiopulmonary Resuscitation calls for audit purposes and also provide support to the team when required.

10.0 RETENTION OR ARCHIVING

In cases involving legal processes it is often necessary to demonstrate the policy in place at the time of the incident. The Director of Nursing, Midwifery & Patient Services must therefore ensure that copies of this policy are archived and stored in line with the University Health Board's Records Management Policy and are made available for reference purposes should the situation arise.

11.0 NON CONFORMANCE

There is a requirement of all staff to comply with the provisions of this Policy and where requested to demonstrate such compliance. Failure to comply will be dealt with in accordance with the appropriate Human Resources Policy

12.0 EQUALITY IMPACT ASSESSMENT STATEMENT

Following assessment, this policy is not felt to be discriminatory or detrimental in any way with regard to the following equality strands:
Gender; Race; Disability; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human Rights.

This policy promotes equality of opportunity and aims to treats all employees equally when applied consistently.

Appendix (A) All Wales Do Not Attempt Cardiopulmonary Resuscitation

DNACPR Form (Adult) DO NOT ATTEMPT CARDIO-RESPIRATORY RESUSCITATION (DNACPR) DISCUSSION

Date of DNACPR Discussion:	/ /
Review Date:	/ /
Reviewed by (Signature/GMC No)	

Surname: _____

First Name: _____

NHS/Hospital No. _____

Date of Birth: _____

Home Address: _____

_____

WHILST ACTIVE, THIS FORM **MUST** BE FILED AT THE FRONT OF THE PATIENT'S HEALTHCARE RECORD

1. **Does the patient have capacity to make and communicate decisions about CPR?** YES/NO

If "NO", are you aware of a valid Lasting Power of Attorney (Health & Welfare) or Advance Decision to refuse treatment (only valid for adults over 18) refusing CPR which is relevant to the current condition?" YES/NO

If "YES" go to Box 6

If "NO", has the patient appointed a Health & Welfare Attorney to make decisions on their behalf? YES/NO

If "YES" they must be consulted.

All other decisions must be made in the patient's best interests and comply with current law. Go to box 2

2. **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests: Tick all that apply (go to box 3)**

Clinical Summary:

Reasons:

Not in the best interest/harm from CPR>benefit	☐	This is a natural anticipated and accepted death	
Patient refused CPR	☐	Other (please elaborate in patient's healthcare record)	

3. **Has a discussion taken place with the patient, a Health and Welfare Attorney, or IMCA? If CPR has NOT been discussed please clearly record reasons (go to box 4)**

Yes ☐
No ☐

4. **Has appropriate discussion taken place with those close to the patient? (e.g. spouse / partner, family and/or trusted friends, carers, or advocate) (go to box 5)**

Yes ☐
No ☐

Name of NOK/Proxy:..... Relationship to patient:.....

5. **Healthcare Professional completing this form:**
(Document is ONLY active when signed, timed and dated with GMC no.)

Name (PRINT):..... Position: .....

Contact Details:..... GMC No: ..... **or** NMC No: .....
(nurse – form NOT active unless countersigned in box 6)

Signature: ..... Date: ……/……/……/ Time: .....

6. **Senior Responsible Clinician with oversight to sign below:**
(Must inform other team members/teams of the decision – please record overleaf)

Name (PRINT):..... Position: .....

Contact Details:..... GMC No: .....

Signature: ..... Date: ……/……/……/ Time: .....

7. **CANCELLATION of decision: NB: Cross form CLEARLY and write "CANCELLED" across form – notify ALL copy holders (see details overleaf)**

Name (PRINT):..... Position: .....

Contact Details:..... GMC No: .....

Signature:..... Date: ……/……/……/ Time: .....

In the event of a cardiac or respiratory arrest no attempts at cardio-respiratory resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

- The patient's full name, date of birth and address must be **written** clearly.
- The date of completing the form must be entered.
- The decision must be communicated to all parties involved in the active care of the patient.
- The patient's clinical and DNACPR status should undergo routine review of circumstances, by the agreed review date at top of the form.

1. Capacity / Advance decisions

If the patient does not have capacity please ensure that an **Assessment of Mental Capacity and Best Interests Decision** form is completed. Ensure that any Advance Decision is specific and valid and applicable to the patient's current circumstances. Legal advice can be considered in the event of disagreements, as recommended in the All Wales policy.

2. Summary of main clinical problems and reasons why CPR would be inappropriate, likely to be unsuccessful or not in the patient's best interests.

Please be as specific as possible. More detailed information can be recorded in the patient's healthcare record.

3. Summary of communication with patient

State clearly what was discussed and agreed. If the decision was NOT discussed with the patient clearly state the reason why. If an interpreter is used they must be approved by the organisation.

4. Summary of discussion with those close to the patient (e.g. spouse/partner, family and trusted friends, carer, or advocate)

If the patient does not have capacity those close to the patient must be consulted and may be able to help by indicating the patient's recent wishes. They **cannot** make the decision to withhold cardio-respiratory resuscitation - this is a medical decision. If the patient has made a Lasting Power of Attorney for Health & Welfare (ensure that it is registered) or patient has appointed a Health & Welfare Attorney to make decisions on their behalf, that person must be consulted. A Health & Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.

If the patient has capacity - ensure that discussion with others is with their consent and does not breach confidentiality. State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes.

5. Health professional completing this DNACPR form

This will vary according to circumstances and local arrangements. This should be a senior professional when available. **The form becomes active when a medical professional signs, times and dates the form and provides their GMC number.**

The decision must be overseen by the senior responsible clinician (usually the patient's Consultant or General Practitioner) at the earliest opportunity. If the senior responsible clinician is NOT the doctor initially completing the form, they must be informed as soon as reasonably possible. If a review of circumstances around the DNACPR form is necessary, this should be undertaken in line with the all Wales policy. **Any review of the decision is subject to communication requirements as outlined in All Wales policy.**

6. Details of the senior responsible clinician involved in the decision

Ensure all details (name and position) are completed (see All Wales policy) and that the DNACPR decision is communicated to all those involved in the patient's care as in All Wales policy.

7. Cancellation of the Decision

Ensure all details are completed. The form should be crossed through diagonally using 2 lines and **"CANCELLED"** should be written clearly between them, and signed and dated by the doctor cancelling the decision. The cancelled form must be filed within the current clinical record and this should be communicated to all copy holders below - as per All Wales policy.

COPIES of this DNACPR decision form have been sent to:

1.

2.

3.

4.

5

Cwm Taf LHB

DO NOT ATTEMPT CARDIOPULMONARY (CPR) RESUSCITATION

Children less than 16 years of age

DO NOT PHOTOCOPY

Name _____

Address _____

Date of birth _____

NHS or hospital number

Date of DNAR order:

/ /

Please document additional information in the patient's medical notes

1 **1a. Does the child have capacity to make and communicate decisions about CPR?** If "YES" go to 1b. If "NO" go to 1c. YES / NO

1b. Has the child been involved in the decision making process of this order? Now go to 1c. YES / NO

1c. Have the child's parents (or those holding legal parental responsibility) been consulted and agreed to the application of this order? If "YES" go to box 2. YES / NO

1d. Has a Court made an order in respect of this decision? If "YES" go to 1e. YES / NO

If the answers to both 1c and 1d are "NO", legal advice must be taken before proceeding. All other decisions must be made in the child's best interests and comply with current law.

1e. Date, time, location and name of Judge/Court making order:

2 **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the child's best interests:**

3 **Summary of communication with child. If this decision has not been discussed with the child state the reason why:**

4 **Name of person(s) holding parental responsibility and summary of communication with them:**

5 **Names of members of multidisciplinary team contributing to this decision:**

6 **Healthcare professional making this DNAR order:**

Name _____ **Position** _____

Signature _____ **Date** _____ **Time** _____

7 **Review and endorsement by most senior health professional:**

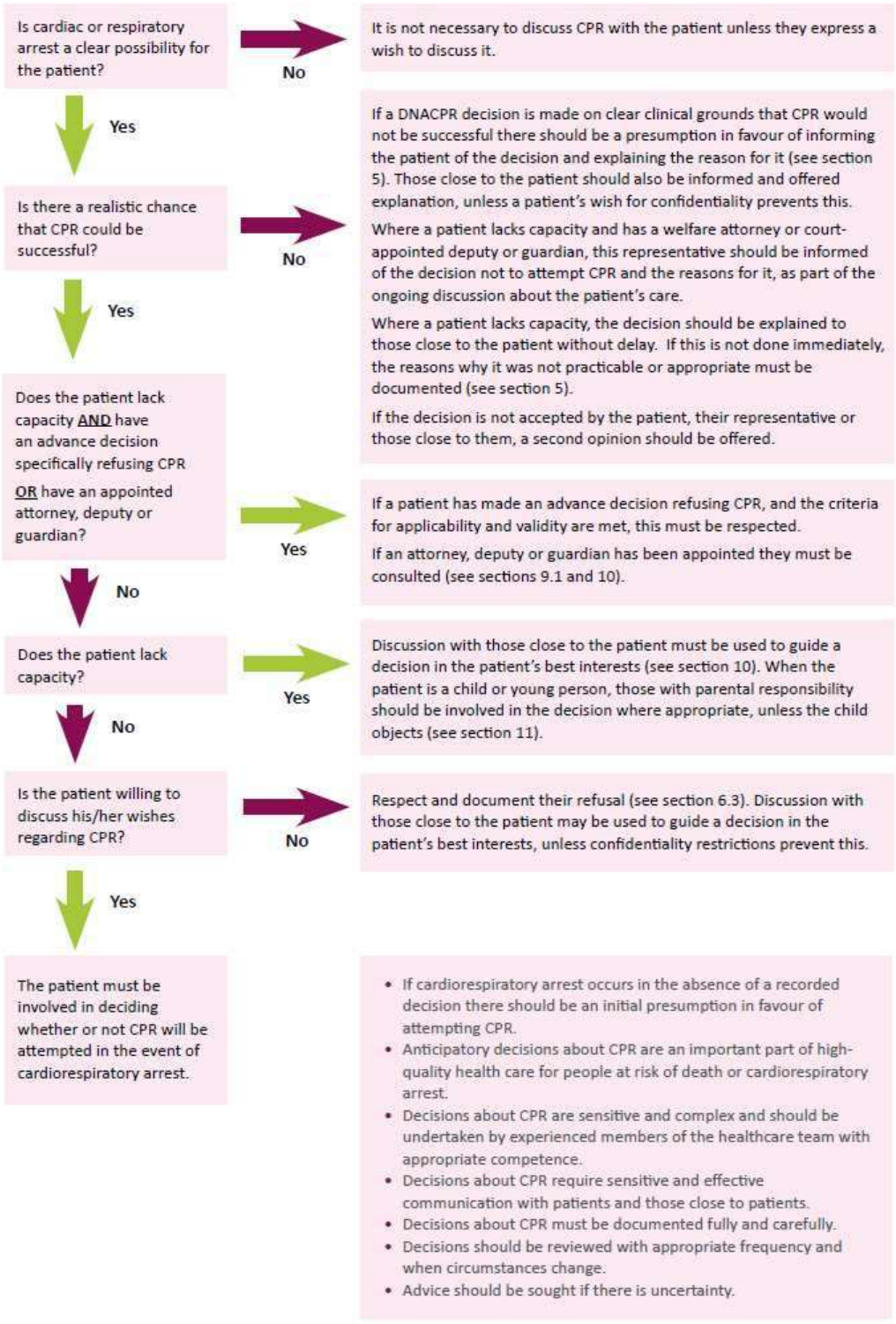
Signature _____ **Name** _____ **Date** _____

Review date (if appropriate)

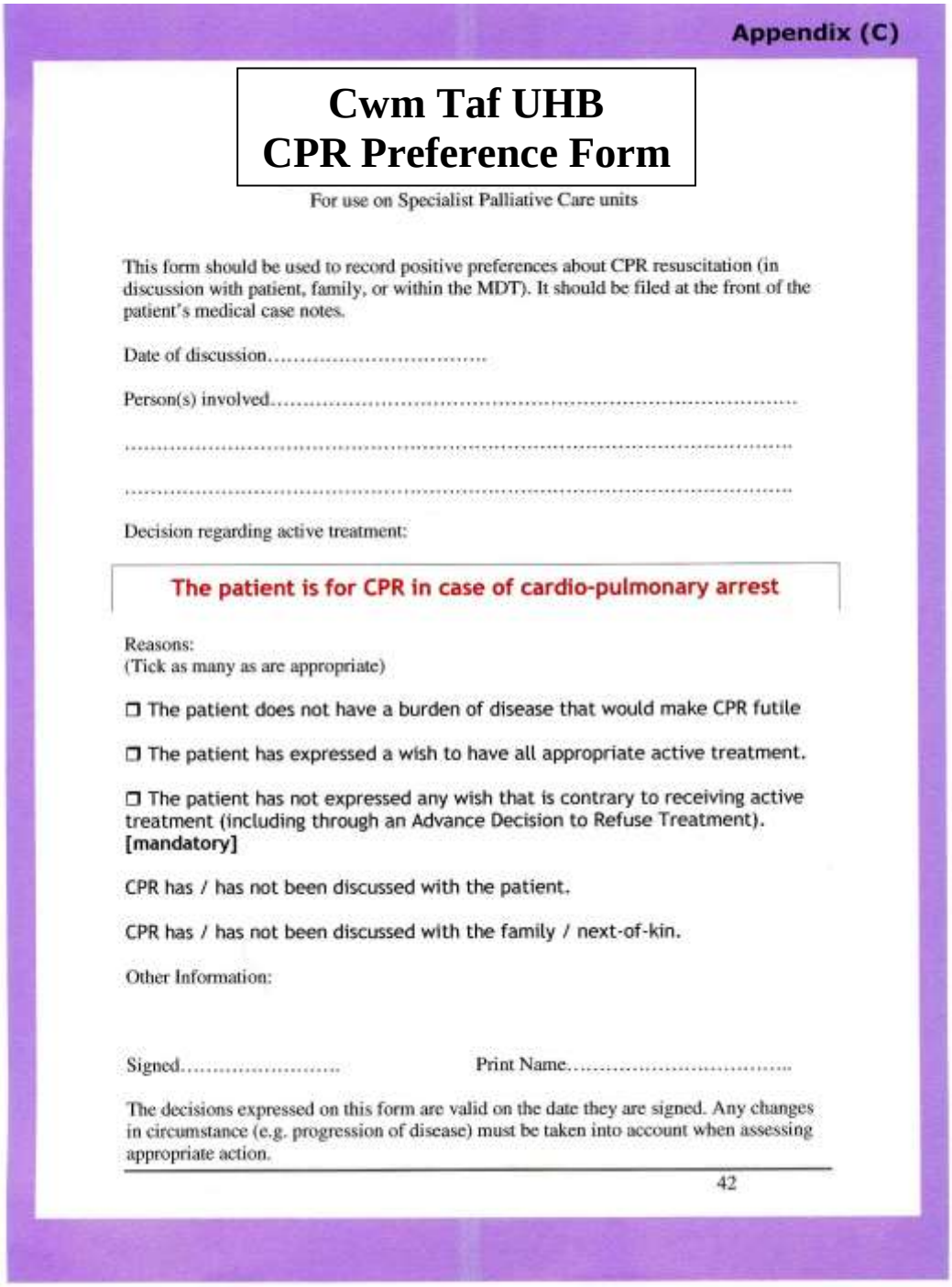
Signature _____ **Name** _____ **Date** _____

Appendix (B) – Flowchart DO Not Attempt Cardiopulmonary Resuscitation

Decision-making framework



Appendix (C) – Palliative Care Preference Form



Appendix (C)

Cwm Taf UHB
CPR Preference Form

For use on Specialist Palliative Care units

This form should be used to record positive preferences about CPR resuscitation (in discussion with patient, family, or within the MDT). It should be filed at the front of the patient's medical case notes.

Date of discussion……

Person(s) involved……

……

……

Decision regarding active treatment:

The patient is for CPR in case of cardio-pulmonary arrest

Reasons:
(Tick as many as are appropriate)

❒ The patient does not have a burden of disease that would make CPR futile

❒ The patient has expressed a wish to have all appropriate active treatment.

❒ The patient has not expressed any wish that is contrary to receiving active treatment (including through an Advance Decision to Refuse Treatment). **[mandatory]**

CPR has / has not been discussed with the patient.

CPR has / has not been discussed with the family / next-of-kin.

Other Information:

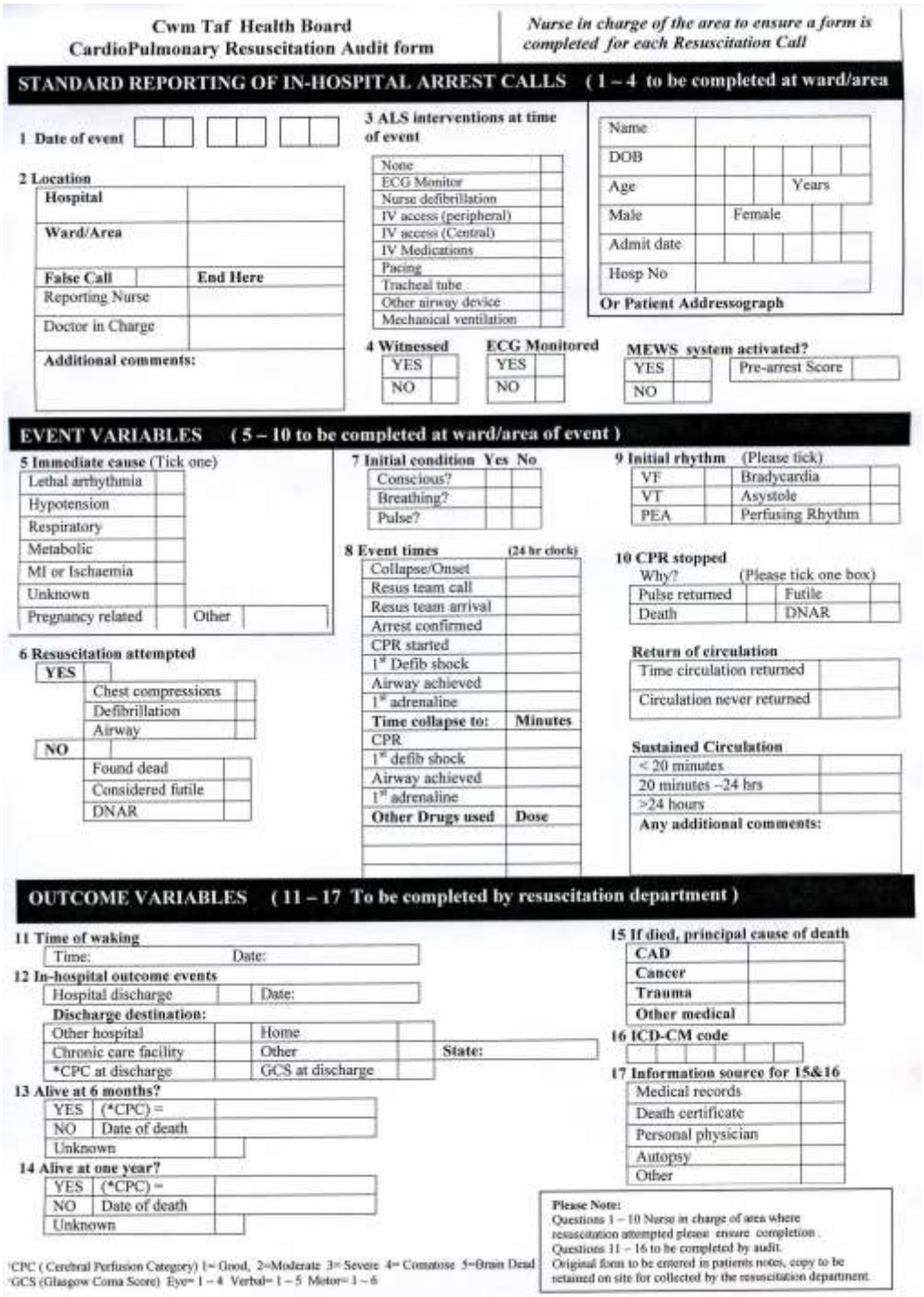
Signed…… Print Name……..

The decisions expressed on this form are valid on the date they are signed. Any changes in circumstance (e.g. progression of disease) must be taken into account when assessing appropriate action.

42

Appendix (D) Cardiopulmonary Resuscitation Audit Form

Nurse in charge of the area to ensure a form is completed for each Resuscitation Call



Cwm Taf Health Board
CardioPulmonary Resuscitation Audit form

Nurse in charge of the area to ensure a form is completed for each Resuscitation Call

STANDARD REPORTING OF IN-HOSPITAL ARREST CALLS (1 – 4 to be completed at ward/area

1 Date of event

2 Location

Hospital	
Ward/Area	
False Call	**End Here**
Reporting Nurse	
Doctor in Charge	
Additional comments:	

3 ALS interventions at time of event

None	
ECG Monitor	
Nurse defibrillation	
IV access (peripheral)	
IV access (Central)	
IV Medications	
Pacing	
Tracheal tube	
Other airway device	
Mechanical ventilation	

Name	
DOB	
Age	Years
Male	Female
Admit date	
Hosp No	

Or Patient Addressograph

4 Witnessed

YES	
NO	

ECG Monitored

YES	
NO	

MEWS system activated?

YES	
NO	

Pre-arrest Score

EVENT VARIABLES (5 – 10 to be completed at ward/area of event)

5 Immediate cause (Tick one)

Lethal arrhythmia			
Hypotension			
Respiratory			
Metabolic			
MI or Ischaemia			
Unknown			
Pregnancy related		Other	

6 Resuscitation attempted

YES

Chest compressions	
Defibrillation	
Airway	

NO

Found dead	
Considered futile	
DNAR	

7 Initial condition Yes No

Conscious?		
Breathing?		
Pulse?		

8 Event times (24 hr clock)

Collapse/Onset	
Resus team call	
Resus team arrival	
Arrest confirmed	
CPR started	
1st Defib shock	
Airway achieved	
1st adrenaline	
Time collapse to:	**Minutes**
CPR	
1st defib shock	
Airway achieved	
1st adrenaline	
Other Drugs used	**Dose**

9 Initial rhythm (Please tick)

VF		Bradycardia	
VT		Asystole	
PEA		Perfusing Rhythm	

10 CPR stopped

Why? (Please tick one box)

Pulse returned		Futile	
Death		DNAR	

Return of circulation

Time circulation returned	
Circulation never returned	

Sustained Circulation

< 20 minutes	
20 minutes –24 hrs	
>24 hours	

Any additional comments:

OUTCOME VARIABLES (11 – 17 To be completed by resuscitation department)

11 Time of waking

Time: Date:

12 In-hospital outcome events

Hospital discharge Date:

Discharge destination:

Other hospital		Home		
Chronic care facility		Other		State:
*CPC at discharge		GCS at discharge		

13 Alive at 6 months?

YES	(*CPC) =
NO	Date of death
Unknown	

14 Alive at one year?

YES	(*CPC) =
NO	Date of death
Unknown	

15 If died, principal cause of death

CAD	
Cancer	
Trauma	
Other medical	

16 ICD-CM code

17 Information source for 15&16

Medical records	
Death certificate	
Personal physician	
Autopsy	
Other	

*CPC (Cerebral Perfusion Category) 1= Good, 2=Moderate 3= Severe 4= Comatose 5=Brain Dead
*GCS (Glasgow Coma Score) Eye= 1 – 4 Verbal= 1 – 5 Motor= 1 – 6

Please Note:
Questions 1 – 10 Nurse in charge of area where resuscitation attempted please ensure completion.
Questions 11 – 16 to be completed by audit.
Original form to be entered in patients notes, copy to be retained on site for collected by the resuscitation department.

Appendix E – Resuscitation Team Composition roles and Responsibilities

Note: Major Trauma team composition, roles and responsibilities are stated in Major Trauma Procedure

(PCH and RGH sites): The resuscitation teams will be called (using the 2222 emergency telephone number) to provide emergency care to patients who have been identified as requiring an emergency response, either by their high NEWS score or cardiopulmonary arrest.

Emergency cardiopulmonary resuscitation and cardiopulmonary resuscitation (CPR) bleeps will be carried by the following team members at all times when on duty: It is the responsibility of the bleep holder to pass their bleep on to their relief.

- Medicine on-call team
- Anaesthetist and/or Operating department Practitioner
- Nurse practitioner
- Bed manager
- Coronary Care nurse (When available)
- Resuscitation Officer (When available)
- Theatre manager (Bleep carrier ONLY)

The minimum number required to attend a call to support the clinical staff in the area in the first instance is four. Ideally this should include two ward staff, a doctor from Medicine, one of the Anaesthetic staff anaesthetist or ODP.

Roles and responsibilities: The role of team leader will be provided by the most senior response from medicine for Adults, Paediatrics for children and Infants calls.

The team leader will ensure appropriate assessment and management of the patient with appropriate completion of all documentation and communication processes.

The team leader will manage the team ensuring safety at all times.

The anaesthetic response will, as and when required by the team leader provide airway, provide breathing and circulatory support, also assisting with the assessment and transfer of the patient to a higher level of care.

The coronary care nurse (when available) will provide ECG monitoring, defibrillation, cardioversion and if required advice and support with transfer to coronary care.

The bed manager will provide management support to nursing staff within the area to ensure the safety of other patients.

The nurse practitioner will provide support to the team and where necessary support to nursing staff to ensure the safety of other patients.

A resuscitation officer will respond when available. Their response is to audit the system and where necessary provide support to the team leader.

Appendix F – Resuscitation Equipment

Equipment provided will comply with the Resuscitation Council (UK) recommendations.

Appropriate resuscitation equipment will be provided to meet the needs of the responding resuscitation team.

This will be specific to the needs of the following sites:

1. Prince Charles Hospital and Royal Glamorgan Hospital
2. Peripheral hospitals
3. Out of hours GP services, Medical and Dental General Practices
4. Clinics
5. Community

(For a detailed list of equipment requirements, See: Cwm Taf LHB Procedure document for the management of Resuscitation)

Prince Charles Hospital and Royal Glamorgan Hospital Sites

A standard resuscitation equipment trolley or resuscitation equipment Crash bag with a manual or automated defibrillator will be provided within two minutes of any potential emergency resuscitation or cardiopulmonary resuscitation event.

Appendix G – Resuscitation Committee Terms of Reference and Membership

Constitution: The Clinical Governance Committee has resolved to establish a sub committee to be known as the Resuscitation Committee. The Committee has no executive powers, other than those specifically delegated within these Terms of Reference.

Membership: The membership shall be agreed and ratified by the Clinical Governance Committee, and will comprise:

Chairperson: Nominated from the committee members and appointed by the Medical Director for a three year period

Quality, Safety & Risk Committee representation:

Clinical Governance
Clinical Audit & Effectiveness
Clinical Risk
Head of Resuscitation

Pharmacy: Pharmacist

Medical Representation:

Medicine
Emergency Medicine
Intermediate Care
Surgery
Anaesthetics
Child & Adolescents
Obstetrics
Mental Health
Palliative Care

Nursing Representation:

Director of Nursing, Midwifery and Patient Care
Heads of Nursing

EBME: Senior EBME Technician

Staff Side Representative: Junior Medical Staff Representative

Non-Executive Board Representative: Non-Executive Director with Responsibility for Clinical Governance

Quorum: A quorum will be one half of the total membership, which must include the Chairman, Resuscitation & Clinical Skills Manager, Quality/Safety & Risk representation, The Non-executive Board Representation, an anaesthetist and at least two Heads of Nursing or appropriate deputies.

Attendance: The Committee may invite other staff to attend as when appropriate.

Support for the committee: The Chairman will provide secretariat with their secretary or alternative acting as secretary to the Committee who will ensure that all papers are distributed at least 5 working days prior to meetings.

Frequency of meetings: The Committee will meet at least three times a year normally at quarterly intervals.

Relationships and context: The Resuscitation Committee will primarily be concerned with the quality and safety of patient care.

The Resuscitation Committee will work closely with Directorate Managers to provide assurance to the UHB through the Quality Safety & Risk Committee (QSRC) that the UHB has effective processes in place for internal monitoring.

The Resuscitation committee will work closely with other Committee/Groups as appropriate to address operational issues and make recommendations and required actions.

Role of the Committee: The Resuscitation Committee will support the implementation of clinical audit and provide assurance to the Quality, Safety & Risk Committee (QSRC) that appropriate arrangements are in place to ensure the effective review and management of cardiopulmonary resuscitation, and National Early Warning Score (NEWS). To discharge these obligations the Committee will:

- Develop and maintain a Cwm Taf UHB Resuscitation Strategy/Policy
- Define and develop resuscitation team roles/responsibilities
- Review and advise the Cwm Taf UHB on implementation of published external guidance including UK and European council guidance and standards including recommended resuscitation equipment.
- Ensure incidents and complaints are considered on a regular basis to ensure action plans are developed and lessons are learned are disseminated.
- Commission Clinical Audit/Research and Development in response to internal/external triggers.
- Identify and monitor the range, levels and location of training and education in relation to Cardiopulmonary resuscitation.
- Refer clinical ethic issues to Cwm Taf University Health Board Clinical Ethics Committee for discussion.

The Resuscitation Committee will not hold a budget or allocate resources.

Self Assessment: The Committee will undertake an annual self assessment exercise in order to ensure best practice is being maintained, and appropriate training requirements are identified and provided.

Reporting: The minutes of the Committee shall be formally recorded and reported to the Quality, Safety & Risk (QS&RC). The Committee will also provide a six monthly summary report to the (QS&RC).

Review: The Terms of reference will be adopted by the Committee at its first meeting and will be subject to review at least on an annual basis thereafter.

Appendix H – Development of Documentation

Development of local directorate and /or site based Guidelines

Each directorate/site must ensure the development of local guidelines, which set out the following:

- The procedure to be enacted on suspecting a cardiopulmonary arrest including details of where equipment is kept.

- The on-call arrangements and responsibilities of medical, nursing staff.

- Whether advanced life support is to be provided by medical, nursing or ambulance paramedical staff.

- The responsibilities of the nurse in charge of the area and or hospital/site.

Examples below:

- Procedure for the management of cardiopulmonary Resuscitation at Prince Charles Hospital (PCH) and Royal Glamorgan Hospital (RGH)
- Procedure for the management of cardiopulmonary resuscitation at peripheral hospitals and Minor Injuries Units.
- Procedure for the management of major at trauma PCH and RGH
- Procedure for the management of maternal cardiopulmonary resuscitation at PCH, RGH and in the community
- Procedure for the management of newborn resuscitation at PCH, RGH and in the community
- Procedure for the management of cardiopulmonary resuscitation in the community
- Procedure for the management of cardiopulmonary resuscitation in non-clinical areas, corridors and car parks

See: Cwm Taf UHB Procedure document for the management of Emergency Resuscitation and Cardiopulmonary Resuscitation.

Appendix I – Legislation

Health and Safety at Work Act

Nursing and Midwifery Council (NMC) the Code: Standards of conduct, performance and ethics for nurses and midwives

General Medical Council (GMC) Good Medical Practice (2006)

Modernising Medical Careers (MMC) Core Curriculum

Health Professions Council (HPC) Standards

Cardiopulmonary Resuscitation Standards for Clinical Practice and Training

A Joint Statement from:
The Royal College of Anaesthetists
The Royal College of Physicians of London
The Intensive Care Society
The Resuscitation Council (UK)

This document has been endorsed by:
The Council for Professionals as Resuscitation Officers
The National Patient Safety Agency
The Royal College of Physicians of Edinburgh
The Royal College of Physicians and Surgeons of Glasgow
The Royal College of Surgeons of England
The Royal College of Surgeons of Edinburgh
The Royal College of Paediatrics and Child Health
The Royal College of Nursing
The Faculty of Accident and Emergency Medicine
Published October 2004 Updated June 2008 (Chapter 10)

NICE clinical guideline 50 - acutely ill patients in hospital

National Patient Safety Agency (NPSA) Patient Safety Alert - establishing a standard crash call telephone number in hospitals

National Patient Safety Agency (NPSA) Rapid Response Report NPSA/2008/RRR010: Resuscitation in Mental Health and Learning Disability settings November 2008

National Patient Safety Agency (NPSA) Predicting and preventing cardiac arrests in acute hospitals

National Patient Safety Agency (NPSA) Protecting Patients who are neck breathers

NHS Wales Saving a 1000 lives campaign

Appendix J – References and additional information

Associated UHB Policies, procedures and guidelines
(This list is not exhaustive; there are many more policies and procedures, guidelines within the UHB which have relevance within the area of emergency resuscitation and cardiopulmonary resuscitation).

- Procedure for the management of cardiopulmonary resuscitation at PCH and RGH
- Procedure for the management of cardiopulmonary resuscitation at peripheral Hospitals
- Procedure for the management of maternal cardiopulmonary Resuscitation at PCH and RGH
- Procedure for the management of newborn resuscitation at PCH and RGH
- Procedure for the management of cardiopulmonary resuscitation in the community
- Procedure for the management of cardiopulmonary resuscitation in non-clinical areas, corridors and car parks
- UHB staff training in emergency resuscitation and cardiopulmonary resuscitation guideline
- National Early Warning Score (NEWS) procedure
- Do Not Attempt Resuscitation Procedure
- Health and Safety policy
- Infection control Policy
- Capability Policy
- Consent Policy
- Incident reporting policy
- Dignity at work
- Confidentiality
- Consent
- Minimal handling
- Latex policy
- Emergency Transfer of patients

References

Witnessing Resuscitation. *Royal College of Nursing*, Guidance for Nursing Staff, April 2002.

Ethical Decision-Making in Palliative Care: Cardiopulmonary Resuscitation (CPR) for People who are Terminally Ill. National Council for Hospice and Specialist Palliative Care Services. Ethics Working Party, 1997 revised Jan 2002.

Common faults in resuscitation equipment – Guidelines for checking equipment and drugs used in adult cardiopulmonary resuscitation. Dyson E, Smith GB. *Resuscitation* 2002; **55**:137-49.

Resuscitation policy. Health Services Circular (HSC) 2000/028. London, Department of Health, 2000.

International Guidelines 2000 – A Consensus on Science. *Resuscitation* 2000; **46**:1-448.

Guidelines for the Provision of Anaesthetic Services. Anaesthetic Practice in Respect of Resuscitation. *Royal College of Anaesthetists*, 1999.

Recommended guidelines for uniform reporting of data from in-hospital resuscitation: the in-hospital 'Utstein style'. Cummins R.O. Chamberlain D.A. et al. *Resuscitation* 1997; **34**: 151-183.

Should Relatives Witness Resuscitation? *A Report from a Project Team of the Resuscitation Council (UK)* 1996.

Resuscitation from Cardiopulmonary Arrest: Training and Organisation. *A Report of the Royal College of Physicians*, 1987.

NPSA ALERT 0149 - Protecting people who are neck breathers - Patient Safety Information - 2007-03-07 - V1