Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

The Village Residence
Drogheda Services for Older People - Resuscitation Guidelines

Is this document a:

Policy [ ] Procedure [ ] Protocol [ ] Guideline [√]

Insert Service Name(s), Directorate and applicable Location(s):

Title of PPPG Development Group:	**Resuscitation**
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Version	**Date Approved**	**List section numbers changed**	**Author**
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Table of Contents:

Part a – Quick Guide

Covid 19

In response to the Corvid 19 guidance regarding cardiopulmonary resuscitation and DNAR Decision-Making during has been issued.

This guidance is applicable to all care environments where services are provided for and on behalf of the HSE including acute hospitals, the ambulance service, community hospitals, residential care settings, general practice and home care.

The guidance includes information on:

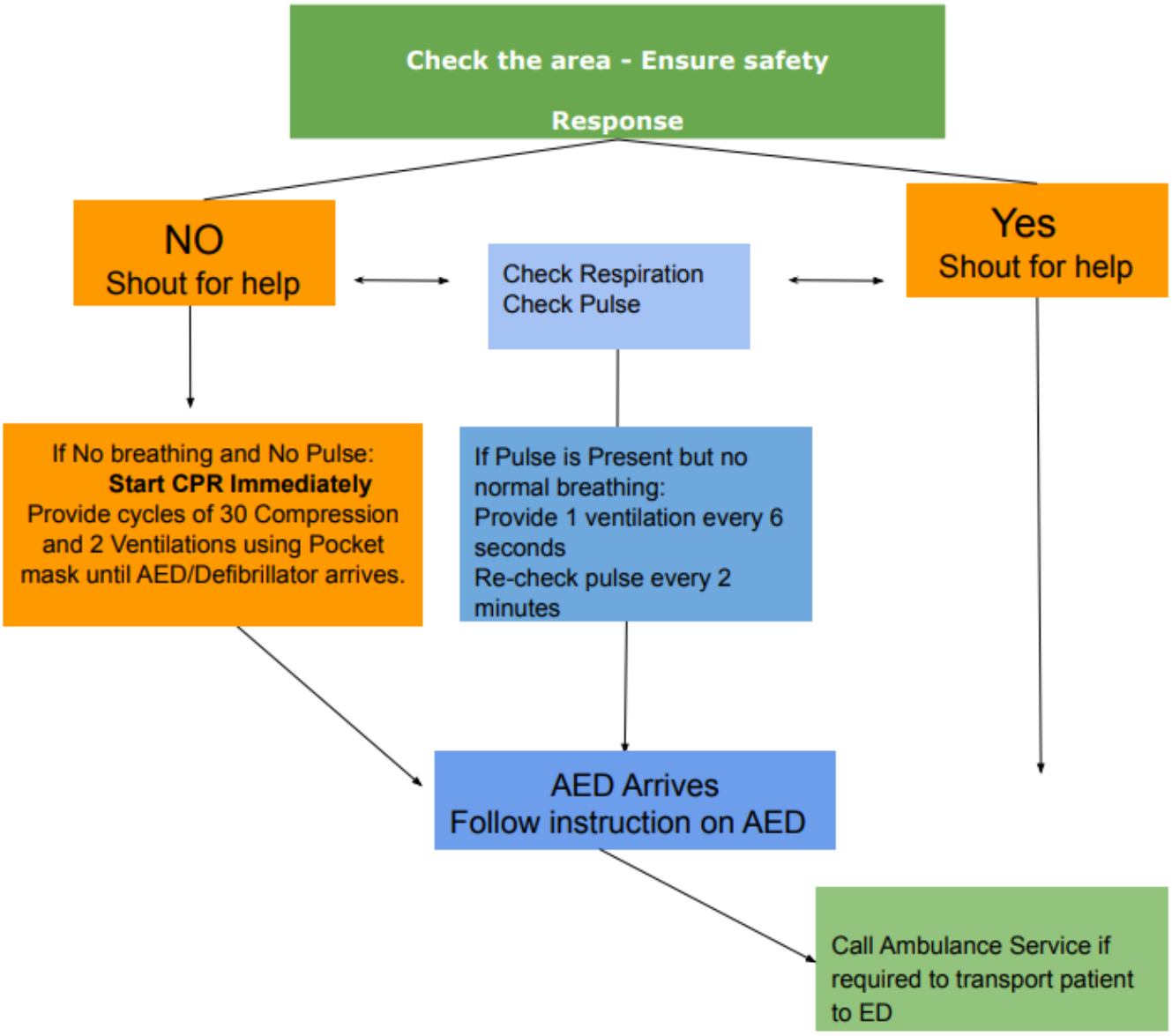
- Advance care planning and cardiopulmonary resuscitation (CPR)
- Advance Healthcare Directives
- Decision-making including making DO NO Attempt Resuscitation (DNAR) decisions
- Performance of CPR during the COVID-19 outbreak

This guidance should be read in conjunction with other relevant guidance, including the Health Service Executive (HSE) National Consent Policy 2019, the Department of Health (DoH) Ethical Framework for Decision-Making in a Pandemic, the DoH Ethical Considerations relating to Critical Care in the context of COVID-19 and the DoH Ethical Considerations for Personal Protective Equipment (PPE) Use by Health Care Workers in a Pandemic.

A copy of the guidance is located at:

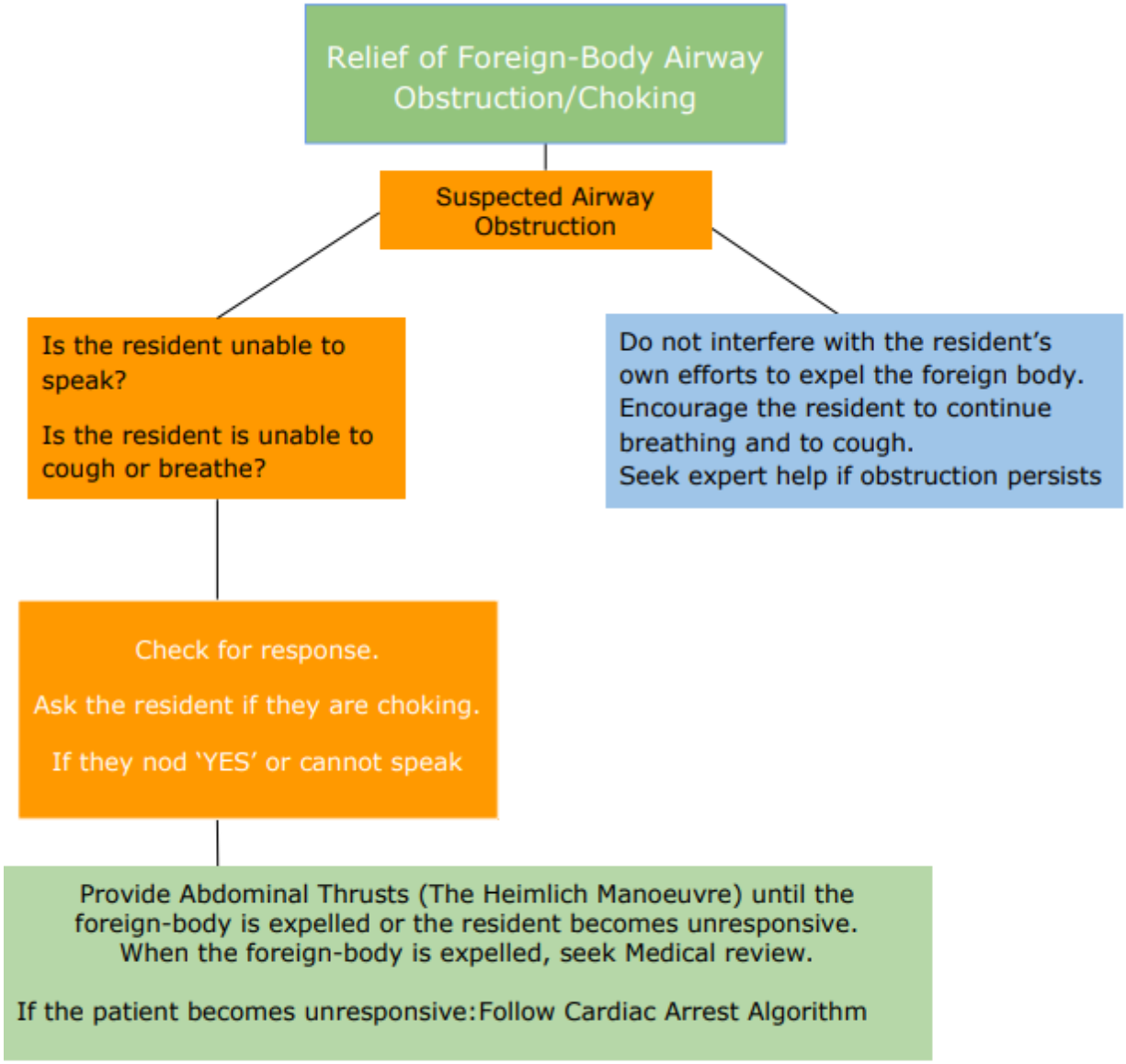
https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/assisteddecisionmaking/guidancecpranddnarduringcovid19.html.

Cardiac Arrest

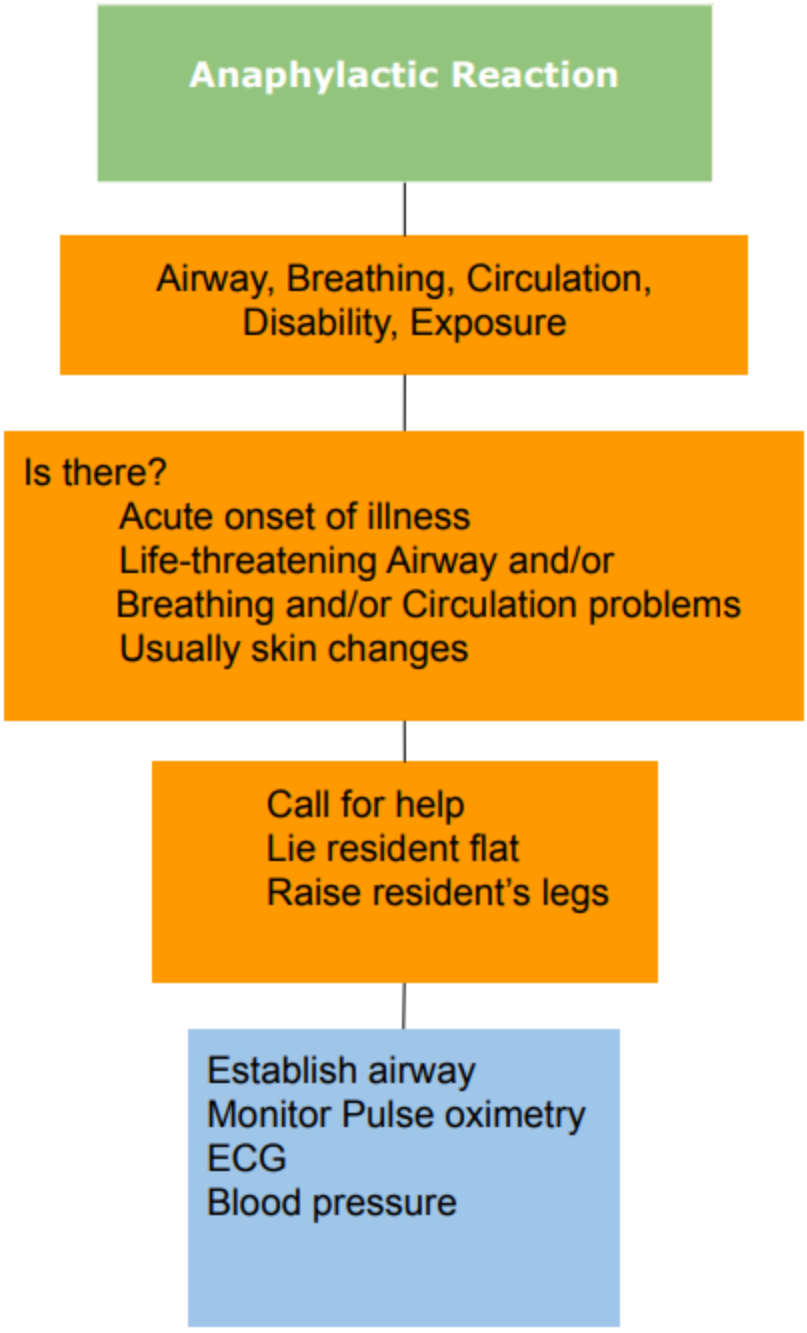


During CPR - Push Hard, at least 2 inches (5 cm)
Push Fast, 100-120 per minute - Ensure full Chest Recoil.
Minimise Interruptions to Chest Compressions.
Check Rhythm every 2 minutes (approximately every 5 cycles).

Foreign Body Airway Obstruction/Choking



Anaphylactic Reaction



Covid 19 Pandemic

In the light of the current pandemic and the possibility that the person who has collapsed may have COVID-19, there is an element of risk associated so we have to manage CPR in a new way. A person whose heart has stopped is unlikely to survive if CPR is not administered before the arrival of the ambulance service.

It is a personal choice if you decide to give CPR.

Here is the most up to date advice to minimise risk and improve safety for all involved:

1. At all times keep your hands away from your face.

2. If a person has collapsed in a public space, do look for signs of breathing and signs of life.

3. Don't listen or feel for breathing by placing your ear and cheek close to the person's mouth.

4. Dial 112 or 999 and ask for an ambulance. If COVID-19 is suspected, tell them when you call.

5. Use an AED as soon as possible. This significantly increases the person's chances of survival. Place the AED pads on the person's chest and apply a shock, if prompted by the AED. This is a safe procedure and should be attempted by a first responder.

6. Perform chest compressions only. Do not give mouth to mouth rescue breaths. If there is a perceived risk of infection, you should place a cloth/towel over the person's mouth and nose and attempt compression-only CPR and early defibrillation until help arrives.

7. Afterwards, clean your hands using soap and water or an alcohol-based hand sanitizer. Clean and disinfect the AED if used.

If CPR is performed on people with COVID-19, there is the potential for HCWs to be exposed to bodily fluids, and for some procedures (e.g. chest compressions, tracheal intubation or ventilation) to generate an infectious aerosol. In those circumstances, CPR

HSE Guidance CPR-DNAR V1.1
should not be commenced without the appropriate PPE recommended in national guidelines12
. This may cause a delay of some minutes to starting CPR and may lead to worse outcomes from CPR.
.
In the interest of HCW safety, people with known and with suspected (e.g. awaiting swab results) COVID-19 must be treated alike. In some units, for example, in residential care facilities, evidence of general widespread transmission may mean that all occupants need to be treated as potentially positive for COVID-19.

Part B

1.0 Introduction:

The Village Residence recognises in the event of a medical emergency, intervention must be activated to maintain, restore health and well-being, improve functional level, or relieve symptoms based on the resident's choice in the event of:

- Cardiopulmonary resuscitation (CPR)
- Foreign Airway Obstruction (FBAO)

- Anaphylactic Reaction (AR)

1.1 Scope:

This guideline is intended for use by within The Village Residence:

- medical team,
- registered nurses,
- agency registered nurses,
- healthcare, cleaning and catering staff

1.2 Objective(s):

- For residents who have made a decision to be resuscitated in the case of emergency all staff will comply with the Irish Heart Foundation (IHF)/American Heart Association (AHA) guidelines.
- For residents for whom it has been decided it Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order, staff will fulfill this in accordance with the recorded decision no emergency resuscitation will not be activated.
- DSOP is committed to promoting and providing services that meet the needs of Individuals and does not discriminate against any employee, resident or visitor.

1.3 Outcome(s)

- Residents who develop respiratory/cardiac arrest will receive immediate CPR based on current AHA/IHF guidelines.
- Staff will be trained in CPR appropriate to their level of skill in accordance with AHA/IHF guidelines.
- The guideline will incorporate quick guide algorithms CPR,FBAO, AR which will be outlined in part A:

In the event of a cardiac arrest, residents have a right to expect:

Consideration to be given to their privacy and dignity, with respect for them as individuals at all times.

- For the staff on duty, who are responsible for the resident, to be aware of their resuscitation status/Advanced Care Directive.
- The resident's priority of care will be followed.
- Immediate recognition of cardiac arrest on assessment of airway, breathing and circulation.
- Immediate effective basic life support.
- Prompt access to appropriate resuscitation equipment that is in full working order and which has been checked.

- Unless a Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) statement has been made, a resident in cardiopulmonary arrest should receive cardiopulmonary resuscitation (CPR).
- Accurate written records of the event.

1.4 Supporting Evidence:

- Infection Control Policy.
- Manual Handing Policy.
- Health & Safety Policy.
- National Consent Policy 2013.
- American Heart Association 2016.

1.5 Glossary of Terms:

- **Abdominal Thrust (Heimlich maneuver):** A thrust applied to the abdomen just above the navel and well below the xiphoid to expel a foreign-body airway obstruction.

- **Anaphylaxis:** Anaphylaxis is an allergic reaction characterised by multisystem involvement, including skin, airway, vascular system and gastrointestinal tract.

- **Automated External Defibrillator (AED):** An external computerised defibrillator designed for use on unresponsive victims with no normal breathing and no signs of circulation. The AED captures the victim's ECG signal through adhesive electrodes placed on the victim's chest and analyses the victim's heart rhythm, identifying shockable rhythms. Once a shockable rhythm is identified, the AED automatically charges to a pre-set energy level and provides voice prompts for the operator. When activated, the AED will deliver a shock through the adhesive electrodes.

- **Basic Life Support (BLS):** A group of actions and interventions used to treat, stabilise, and resuscitate victims of cardiac or respiratory arrest.

- **Cardiac Arrest:** The cessation of a functional heartbeat.

- **Cardiopulmonary Resuscitation (CPR):** A technique combining artificial ventilation and chest compressions designed to perfuse vital organs or restore circulation to a victim of cardiopulmonary arrest.

- **Do Not Attempt Resuscitation (DNACPR) Order:** The term 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR), is used to indicate that in the event of a cardiac arrest, no cardiopulmonary resuscitative measures should be initiated.

- **Foreign-body Airway Obstruction (FBAO):** An obstruction of the airway in any location from the mouth to the bronchioles, caused by food, toys, or other external objects.

- **Respiratory Arrest:** Cessation of breathing.

- **Sudden Cardiac Arrest:** Sudden or unexpected cessation of heart function, most often caused by a sudden arrhythmia, such as VF or pulseless VT.

2.0 Development: Resuscitation Guidelines

2.1 Literature search

"Approximately 10,000 people die each year from cardiovascular disease (CVD) - including coronary heart disease (CHD), stroke and other circulatory diseases. CVD is the most common cause of death in Ireland, accounting for 36% of all deaths. The largest number of these deaths relate to CHD - mainly heart attack - at 5,000. 22% of premature deaths (under age 65) are from CVD" HSE (2018).

Heart attacks or acute myocardial infarctions (AMIs) are one of the leading causes of death in Ireland. By 2020 it is expected that 103,000 people will be at risk of a heart attack as a result of coronary heart disease (National Patient Safety Office, 2018).

Cardiopulmonary resuscitation is a life-saving emergency procedure that is a combination of chest compression and artificial ventilation conducted when the heart stops beating. The appropriateness of CPR depends on three main factors: the outcome, the cost, and the patient's preference. Numerous studies have reported outcomes among elderly patients who have undergone CPR (Murphy et al, 1994).

Studies suggest elderly patients with primary cardiac diseases have an up to 40% chance of surviving CPR if performed in the hospital (Quill & Bennett 1992). This is however dependant on the severity of their illness, chronically ill elderly patients has a 5% chance of surviving to discharge after CPR (Applebaum, 1990). Therefore detailed discussions of CPR with residents are necessary before determining their preferences regarding CPR. Residents should be given information in relation to the survival rate as some older people do not want CPR once they understand the probability of survival after the procedure.

In research carried out by Awoke (1992) forty-five elderly residents underwent resuscitation during a three year period by skilled staff, 20% were successfully resuscitated, with seven dying within 24 hours of hospitalisation. No residents survived to return to long-term care. The survival rate after CPR is only about 13-20% in hospital and even lower if the cardiac arrest happened out of hospital (Irish Heart Foundation).

When a patient is in the final stages of an incurable illness and death is expected within a few days, the success rate of CPR is very low (various studies have suggested it is less than 5%) The diagnoses were consistent with age-related chronic disease. This is supported by Barash (2019) who identified that survival rates among the elderly in general are dismal.
In conclusion decisions about cardiopulmonary resuscitation may be based on medical prognosis, quality of life and residents' choices. In order to avoid misuse it must be based on well documented data and a clear and explicit consensus regarding the situations where it applies.

2.2 From the evidence in the literature review

Decisions about cardiopulmonary resuscitation are an often difficult yet a vital part of medical practice and each resident must have their choice respected. Each resident has the right to decide on their CPR status and the priority of care is given to each resident/family on admission to be completed with 48 hours.

If a person is incapable of making a decision the Medical Officer or appropriate G.P. has the authority to act in the best interest of the resident. Those close to the resident should be informed of their role in providing information about the individual but they cannot make decisions on behalf of the resident.

CPR status is important to be communicated; thorough documentation is imperative. The nurse in charge is responsible for informing other members of the nursing team and should record the decision in the nursing notes and nursing care plan where it is

visible to staff members. The CPR status should be noted at every nursing handover, as should any changes to this status. In addition a red circle should be placed inside the locker of the residents for those not for resuscitation and a green one for residents who are for resuscitation. This is the responsibility of the staff nurses caring for the resident and this must be checked and updated if there are changes.

2.3 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR):

1. Must be recorded in the residents file and be updated 3 monthly by the named nurse/registered nurse caring for the resident.

2. Do not Resuscitate (DNACPR) and HSE National Consent Policy – Do not attempt resuscitation signifies that if a resident has a sudden cardiac arrest the emergency response system will not be activated and neither basic nor advanced life support will be given. It is important to emphasise that all other treatment and care that may be appropriate are neither precluded nor influenced by a DNACPR decision.

3. Each case must be considered individually following discussion with the resident, family, person in charge (PIC), senior nursing staff and named nurse and the DNACPR decision must be taken in the best interest of the resident.

4. In the presence or absence of an end stage condition which should guide individualised decision making about DNACPR orders. The diagnosis of an end stage condition should be based on robust clinical evidence.

5. The Medical Officer has overall responsibility for DNACPR orders for all residents in the continuing care, transitional care units and respite units. The DNACPR decision should be made after appropriate consultation, with the resident or where the resident is unable, their relatives, and consideration of all aspects of the residents' condition.

6. If the resident is conscious and cognitively aware, the DNACPR decision must be discussed with him/her especially with those residents who are at risk of cardiac arrest or respiratory failure or who have a terminal illness. Such decisions must be clearly documented in the resident's medical and nursing notes.

All DNACPR decisions are to be recorded in the medical notes/epicCare as follows:

- Date and time of the decision and who was involved in the decision.
- The reasons for the decision and the grounds on which it was made.
- Discussion with the resident and the decision reached or view expressed.
- Any discussion with relatives and their expressed wishes.
- Review date.
- Name of Doctor completing the record.
- The date and the decision should be clearly documented inside the front of the Medical notes.
- A Red Circle should be placed inside the cupboard of those residents that are not for Resuscitation.
- This information must form part of the handover on each shift.

If a resident has made the decision not to have CPR performed in the case of a sudden cardiac incident this should be irrespective of whether the health care professional feels it is a wise decision or not.

2.4 Training Requirements:

Basic Life Support (BLS) Training must be undertaking every two years: All doctors, nurses and other allied healthcare professionals are required to have current BLS certification.

All staff must have a certificate of competence.

Heart saver CPR & AED Training: Healthcare assistants are required to have current BLS HSAED certification.
DSOP recommend that all other (i.e. non-medical, nursing or allied healthcare professionals) have Heartsaver CPR & AED certification.

3.0 GOVERNANCE AND APPROVAL

3.1 Governance Arrangements

3.1.1 Director of Nursing (DON)/ Person in Charge (PIC); will ensure the effective and efficient delivery of training in resuscitation in collaboration with the multi-professional team in line with Irish Heart Foundation (IHF)/American Heart Association (AHA) guidelines.

3.1.2 DON/PIC; will implement the resuscitation guideline throughout The Village

Residence in collaboration with the multi-professional team.

3.1.3 DON/PIC; will determine the standardisation of resuscitation equipment in each area of DSOP.

3.1.4 DON/PIC; will ensure compliance with clinical and training audit.

3.1.5 DON/PIC: will implement a Training Strategy/Data base on Resuscitation training in accordance with current practice and guidelines published by the Irish Heart Foundation (IHF)/American Heart Association (AHA) guidelines and HIQA.

3.2 Membership of PPPG group.

- Outlined in the appendix 1.

3.3 Membership of Approval Committee

- Outlined in the appendix 2.

4.0 COMMUNICATION AND DISSEMINATION

4.1 Clinical Nurse Managers: are responsible for:

- Making this guideline accessible to all staff.
- Ensuring that the staff has read and act within the resuscitation guidance.
- Ensuring staff are compliant with resuscitation training requirements and release them from clinical duties to undertake the required mandatory training.
- Ensuring that the emergency trolley is checked weekly and the entire trolley contents are checked and checklist completed.
- Ensuring that any adverse events or near misses, relating to a resuscitation event are reported via incident reporting system.
- Work in collaboration with emergency support worker (Ambulance/Paramedics) and ensure that the EIRCODE and AED location is displayed.

4.2 All Registered nurses & Healthcare staff:

- Responsible for reading and complying with the resuscitation guidelines.
- Responsible for ensuring they have completed the training relevant to their level.
- Report any incidences or near misses to their line manager and Incident reporting guidelines.
- Summoning Ambulance services – All staff are required to identify the location for the collapsed resident and must communicate clearly any relevant information e.g. EIRCODE
- All staff will follow the quick guide as outlined in part A.

- The service will be delivered in accordance with and compliance to the HSE/DSOP's Infection Prevention and Control Policy.
- Standard precautions will be followed.
- All single use items must be used in accordance with the supplier's recommendations.

4.3 Nursing Staff/Agency Nursing staff:

- All Nursing staff is required to be able to recognise and respond to signs of a deteriorating resident.
- The Nursing staff must ensure that those residents who are for resuscitation have a green circle inside their cupboards and this information will be passed on during every handover.
- The Nursing staff must ensure that those residents not for resuscitation have a red circle inside their cupboards indicating their choice.

All Nursing Staff will ensure:

Resuscitation Equipment: will be checked every Week by registered nurses (Appendix 3)

- All emergency equipment including the defibrillator, suction machine, pocket mask and resuscitation trolley should be checked: Ensure all equipment is in working order and in date Any oxygen cylinders are at least a quarter full and in date.
- The entire trolley contents checked for expiry dates.
- Expired or damaged items must be replaced within 24 hours.
- The drawer is cleaned in line with infection control policy.
- All medication must have the date and dosage checked weekly by the registered nurse and replaced within 24 hours if discrepancies.
- AED – The battery/pads must be check weekly. In addition the AED must be turned on weekly to ensure that the sound works.

Following conclusion of a resuscitation event:

- The entire contents of the trolley should be checked.
- Used, expired or damaged items must be replaced.
- A signed record of completion of each check should be maintained.

5.0 IMPLEMENTATION

5.1 All staff will sign that they have read, understand and will adhere to the guidelines. (Appendix 4).

5.2 In addition the policy will be discussed at handovers/staff meeting.

6.0 MONITORING, AUDIT AND EVALUATION

- All cardiac arrest events should be reported via the Director of Nursing report.

- Audit tool must be undertaken after each cardiac event in the best interests of Residents and / or the DSOP (appendix 5).

7.0 REVISION/UPDATE

7.1 The guideline will be reviewed 2 yearly and submitted to the DSOP Nursing Governance Meeting for agreement and final sign off will be by the Director of Nursing.

7.2 Any amendment will have a version number and be amended locally using a version control cover sheet.

8.0 REFERENCES

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9.0 APPENDICES

Appendix 1 – Membership of PPPG group

Membership of the PPPG Development Group

Please list all members of the development group (and title) involved in the development of the

document.

Michael S McCaul Person in Charge	Signature: _____ Date: _____
Mairead McGahon Interim Director Centre for Nursing & Midwifery Education	Signature: _____ Date: _____
Jolly Varghese Assistant Director of Nursing And Person in Charge Boyne View House	Signature: _____ Date: _____
Chairperson: Eimear Hickeys Practice development DSOP	Signature: _____ Date: _____

Appendix 2- Membership of Approval Governance Group

Membership of the Approval Governance Group

Please list all members of the relevant approval governance group (and title) who have final approval of the PPPG document.

Seamus McCaul Director of Nursing DSOP	Signature: _____ Date: _____
Jolly Varghese Assistant Director of Nursing The Village Residence. Leenamma Varghese A/ Assistant Director of Nursing The Village Residence.	Signature: _____ Date: _____
Eimear Hickeys Practice development Louth Meath Area **Chairperson:**	Signature: _____ Date: _____ Signature: _____ Date: _____

Appendix 3

Checklist – Resuscitation/Emergency/AEB checklists Drogheda Older Peoples Services

Site/Unit:_____Date:_____Weekly Routine Check List **(R) √** Post Emergency **(P)√**

Item	Checked By (Initials) Date	R	P	Checked By (Initials) Date	R	P	Checked By (Initials) Date	R	P	Checked By (Initials) Date	R	P	Checked By (Initials) Date	R	P	Checked By (Initials) Date	R	P	Checked By (Initials) Date	R	P	Checked By (Initials) Date	R	P	Comments
High Concentration Oxygen mask																									
Oxygen Tubing																									
Blue/Orange needles																									
Syringe 2mls & 5mls																									
Airways x 3																									
Adrenaline 1mg in 1ml (1:1000) 10 Ampules																									
Glucagen Hypo Kit 1mg Injection (Stored in the fridge)																									
Glucogel 25mg Fast Acting dextrose oral gel (Stored in the Fridge)																									

Aspirin 75mgs (Dispersible)																									
Prednisolone 5mgs (Dispersible)																									
AED Exterior Intact																									
Battery - Green Ready Blinking																									
AED Sound (Turn on to check speaker																									
Electrodes Pad *Note expiry date																									
Spare Electrodes *Note Expiry date																									
Spare battery available																									
AED user guide Available																									
Pocket Mask																									
Razor																									
Shears																									
Disposable Gloves x 2																									
Gauze																									

Appendix 4 - Signature Sheet

I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:

Print Name	Signature	Area of Work	Date

Appendix 5

Saint Mary's Cardiac Arrest Audit Form

Residents Details:	**Unit**
Early Warning Score	
Type of Arrest:	Cardiac□ Respiratory□
Witness Arrest:	Yes□ No□
Time of Arrest:	
Time BLS initiated:	
Termination of Resus Attempt:	
Emergency Equipment present	Yes□ No□
Defibrillation:	AED □
Shock Delivered	Yes□ No□

Resuscitation Sequence:

Time 24 Hours	Rhythm	AED	Drugs used	Result Rhythm

Staff Present:	

Further comments