

should include the option of paediatric paddles in areas where children are treated. Defibrillators with an external pacing facility should be located strategically.

9. Responsibility for checking resuscitation equipment rests with the department where the equipment is held and checking should be audited regularly. The frequency of checking will depend upon local circumstances but should ideally be daily.
10. A planned replacement programme should be in place for equipment and drugs with funding allocated for this purpose.

10. Decisions Relating to Cardiopulmonary Resuscitation

It is essential to identify:

- patients for whom cardiorespiratory arrest is an expected part of the process of dying and in whom cardiopulmonary resuscitation (CPR) is inappropriate
- patients who do not wish to receive CPR.

Detailed guidance on decisions relating to CPR has been published in 2007 in a Joint Statement by the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing (see www.resus.org.uk). This should be used as the main source of reference to guide clinical practice.

Based on this guidance we recommend the following:

1. Each institution should have a written policy about CPR decisions (including do not attempt resuscitation (DNAR) decisions) that is available to staff and, on request, to patients and those close to them.
2. Every decision about CPR must be made on the basis of individual assessment of each patient. There is no place for local policies that allocate CPR or do not attempt resuscitation (DNAR) decisions to groups of patients.
3. Advance care planning, including making decisions about CPR, is an important part of good clinical care for those at risk of cardiorespiratory arrest. Institutions should ensure that there is a clear and explicit resuscitation plan for all such patients.
4. If CPR would not re-start the heart and breathing, it should not be attempted.

5. If CPR is not in accord with a valid advance decision (formerly called advance directive or "living will") that is applicable in the current clinical circumstances, or with the recorded, sustained wishes of a patient with capacity, it should not be attempted.
6. 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 in planning decisions about CPR.
7. All healthcare organisations should have arrangements in place to ensure that appropriate decisions about CPR are made for patients who lack capacity. Such arrangements must comply with the law. For more detailed guidance, including the different legal situations in England and Wales, Scotland and Northern Ireland please refer to the Joint Statement.
8. If cardiorespiratory arrest occurs in a patient for whom no resuscitation plan has been established, and the wishes of the patient are unknown, resuscitation should be initiated.
9. Communication and the provision of information are essential parts of good quality care. All healthcare institutions should provide patients, whenever appropriate, with information about CPR and resuscitation decisions and be able to offer additional advice and support from appropriately trained staff. Discussion about resuscitation should not be forced on patients who indicate that they do not wish to discuss this topic.
10. Decisions concerning the resuscitation status of a patient must be clearly communicated to the appropriate members of the multidisciplinary team involved in the patient's care.
11. DNAR decisions apply only to CPR and not to any other aspects of treatment. It should be made clear to patients, those close to patients and to members of the healthcare team that all other appropriate treatment will continue to be considered and provided.
12. DNAR decisions should be reviewed whenever clinically appropriate, but particularly when there is a significant change in the patient's clinical condition or when the patient is transferred from one healthcare setting to another.
13. The overall responsibility for a DNAR decision rests with the most senior healthcare professional responsible for the patient's care. When a DNAR decision is made it should be recorded clearly, together with the reasons for it and the names and designation of those involved in the discussion and decision. If no discussion takes place either with the patient or with those close to them, the reasons for this should be recorded. The use of an easily identifiable, dedicated form to record DNAR decisions is recommended.