Kerry Parents & Friends Association

Dying, Death & Bereavement

Policy & Procedures

Written by:	**End of Life Committee**
Reviewed by:	**End of Life Committee**
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KERRY PARENTS & FRIENDS ASSOCIATION

DYING, DEATH AND BEREAVEMENT

1.0 Introduction

It is the fundamental right of every human being to receive good quality end of life care that is individualised, promotes quality of life, and is totally respectful of the dying person's religious, spiritual, psychological needs and their family.

2.0 Policy Purpose

To ensure each person we support's care needs are met, ensuring their physical, emotional, spiritual, psychological, environmental and social well-being whilst respecting the individual and their family through maintaining autonomy, privacy and dignity at all times through to end of life.

3.0 Scope

The person in charge must ensure

- All staff involved in the delivery of such care should receive guidance in this area as appropriate to their role. The centre manager & the psychologist within the organisation will provide this guidance& any training as required to staff.
- Facilities are in place to support end of life care.
- Documentation on end of life care is in place, recognising that at the end of life, medical interventions will usually focus on improving quality of life rather than seeking cure.
- Documentation to support the person's wishes and their family regarding transfer to acute hospital including their wishes regarding resuscitation and end of life care.
- There is an End of Life Care Plan in place and is reviewed as appropriate.
- Clear instructions must be in place regarding defibrillation if a pacemaker is in-situ.

- Information is available to the person we support and their family about the signs and symptoms of dying and what to expect as well as information on how to deal with grief. This will be done in the form of open communication, information and access to spiritual and emotional support if required. Details will also be provided on how to access bereavement and counselling services.
- The person's needs are assessed by on-going comprehensive assessment and documented clearly, ensuring their needs are managed with appropriate skill and attention is paid to detail with the persons choice prevailing.
- Referrals are made to specialist services such as the Palliative Care Team in a timely manner based on on–going clinical assessment by GP / Consultant in order to effectively manage symptoms.
- All documentation around the care received must be accurately maintained and reviewed regularly. Following the death all documentation relating to the deceased is to be maintained in good order to ensure completeness, accuracy and ease of retrieval for a period of 7 years.

All Staff members must ensure:

- Staff can facilitate and engage in cultural practices at end of life ensuring they have a clear understanding and recognition of the unique and specific influences culture has on individual behaviour, attitudes, preferences and decisions around end of life care. Additionally, an assessment should be made of how acculturated a person and their family are, their language skills and whether (an) interpreter if required is available.
- The person's family and friends are facilitated as much as possible, with the provision of refreshments and open visiting where feasible.

4.0 End of life care planning

- The end of life care planning tool is 'Glancing back planning forward a guide for planning end of life care with people with intellectual disability' (Trinity College Dublin, 2017).
- End of life care planning is the process of discussion between the person we support and his/her care providers about future medical, social, emotional

and spiritual preferences, in the event that the person cannot speak for him/herself due to serious illness or emergency. (See appendix 1)

- The end of life care plan will potentially shape decisions outlined in the advance healthcare directives (AHD) (See appendix 2)
- The people we support should be given opportunities to engage in end of life planning but should not be put under pressure if they choose not to engage. This will be addressed as part of the assessment of needs.
- Each individual should have appropriate information to make informed decisions and be supported by someone who has the information relevant to their condition. The individual should have a right to choose the people that they want involved in their end of life planning and decision making process.
- This is a proactive ongoing approach which affords the individual the opportunity to express their choices around their care wishes.(See appendix 1).

4.1 Glancing Back Planning Forward Document

- This guide (Appendix 1) provides a tool for families and carers of people with intellectual disabilities to use as they pause to think about the future.
- This guide will help carers to reflect on their own thoughts and knowledge about end of life and on what to say when they begin this conversation with the person with an intellectual disability.
- The focus of end of life care is to promote life, ensure comfort and support to have the best possible health.
- End of life care planning and openness around death is an essential element ensuring people have a sense of control and autonomy in their final days.
- The aim of this document Glancing Back Planning Forward is to support carers to facilitate end of life conversations with people with intellectual disabilities.
- This will enable the person to feel an element of autonomy and control regarding their own death and will increase the likelihood that the person's wishes are respected as they approach the end of their life.

- People with intellectual disability have the right to know about death and have opportunities to make informed decisions about their care.
- Involvement in end of life planning allow the person to exercise control and autonomy about how they spend their last days.
- For people with intellectual disability end of life conversations may be an ongoing process, which involves a range of different people such as family. Friends, health and social care staff from their intellectual disability service, and medical professionals.
- People with intellectual disability should be given time to process information, with support from those with whom they are familiar family members and/or support staff or medical practitioners.
- Assumption of capacity: everyone is assumed to have capacity to understand unless otherwise shown not to have capacity.
- Use plain language supported with accessible material.
- Members of the interdisciplinary/multidisciplinary team should psychologically and emotionally support the person with an intellectual disability.

5.0 Advanced Healthcare Directives

- A person must put their decisions on future medical treatment in writing and their AHD must be witnessed.
- A person will be able to revoke an AHD at any time.
- No one will be under any obligation to create an AHD. People are free to do so but are not required to do so.
- Having witness to the AHD is a safeguard to prevent people being forced to make certain decisions.
- An AHD only comes into force when the person loses capacity and cannot make a decision.

- An AHD provides direction to healthcare professionals to care for a person in accordance with their specified wishes.
- An AHD provides clarity to families regarding the care requested by their relative.
- An AHD is a method of obtaining consent for treatment in advance.
- The AHD should be reviewed annually or as the need arises.

6.0 Resuscitation

It is currently the practice of Kerry Parents and Friends Association to commence Cardio-Pulmonary Resuscitation (CPR) immediately in the case of respiratory or cardiac arrest unless it has been discussed with the family/next of kin and healthcare professionals that such action may not be clinically indicated i.e. where **DNAR** may exist.

All health care staff in the organisation have a duty to act in the best interests of the people we support. However, in certain circumstances it may be in the person's best interest NOT to commence active resuscitation and it may be considered more appropriate to adopt a palliative care approach in the event of clinical deterioration. There is no rapid access to medical cover in KPFA, therefore,

- We ensure there are staff trained in first aid on duty at all times to administer emergency first aid and resuscitation (Call 999/112 to ensure access to emergency support from ambulance service)
- The extent to which we aim to resuscitate a person in our care, given certain circumstances, is determined in advance. It is determined by discussing the issues with the person in our care, their family and any appropriate medical advice.
- The issues discussed and the agreements arrived at regarding resuscitation are recorded in the person's Advance healthcare directive (Appendix 2) which can be found in their care plan and also on the 'advanced care directive & DNARlist' (Appendix 3) which will be clearly displayed on medication presses / medical rooms

- All staff need to be aware of individual wishes of the person and any decisions reached as detailed in the AHD.

6.1 Do not Resuscitate (DNAR)

Where a **DNAR** is in place as agreed in the AHD it is followed accordingly (See appendix 2).

- **DNAR** instructions are recorded the AHD and are signed by the G.P/consultant in consultation with the individual and the staff team involved in developing the end of life care plan & AHD.
- The 'advanced care directive &DNAR' list displayed in drug press/medical room also highlights those with recorded **DNAR** status (Appendix 3).
- Where **DNAR** is in place this is highlighted in Red in all Policies, AHD and Care Plans.

7.0 Care of the Dying Resident

Death and dying are not easy to deal with. Communication is essential. It is a difficult time for family, visitors and staff. Listening to fears and worries facilitates acceptance of death and the grieving process.

Empathic listening offers an opportunity to families to plan the future and bring much peace in reassuring them that the staff will offer a caring and peaceful death. Strategies for empathic listening include taking time, offer empathy, refrain from solutions, allow for silences.

- The wishes of individuals will be documented in their end of life care plan following on from ongoing discussion involving the individual, their family and the staff team.
- Decisions around life sustaining interventions will be inputted in the advance healthcare directive. It will also include directives regarding transfers to hospital. This directive may include some of the following points but the list is not exhaustive:

    - The GP/palliative care consultant may have prescribed medication in order to effectively manage symptoms as they arise. This will be introduced following on-going reassessment of clinical state and symptom awareness.

- Oral medications may be discontinued as per GP/palliative care consultant instruction

- The provision of diet and fluids orally may be replaced/discontinued on the instructions of the GP/palliative care consultant. This may also be indicated in their AHD.

- The individual's wishes regarding comfort measures, will always be considered as in their AHD and may include some of the following points but the list is not exhaustive:
  - On-going personal care is essential including hygiene and mouth care, skin care and infection control. A separate care plan for oral care needs to be in place at end of life.
  - Elimination is addressed- a urethral catheter is passed to maintain comfort and incontinence wear is applied as appropriate.
  - Other comfort measures such as oxygen therapy & analgesia will be administered as prescribed.
  - Mobility status is updated and clear to all staff by means of documentation and verbal instruction.
- Family and Visitors are kept fully informed as to the resident's condition and provisions are made to facilitate visiting as appropriate.
- A quiet relaxing environment is provided for both the family and the dying person.
- If death is imminent, supported with a family/staff, a willing member of staff will remain with the resident to provide on-going support and reassurance.
- All efforts are made to meet their wishes around their spiritual needs as expressed in their end of life care plan.

7.1 When expected Death of a person we support occurs:

Care of the deceased person and relatives immediately after death:
When death occurs there should be no respirations. The person will be unresponsive to all stimuli. Pupils will be unresponsive and there will be no heartbeat.

- Note the actual time of death.
- Notify the most senior person on duty.
- Contact the G.P or Southdoc if out of hours as soon as possible.
- The G.P on call will record the death in the resident's medical notes, and notify the coroner.
- Next of kin are to be informed as soon as possible if they are not already present.
- Last Offices will be carried out, these are detailed in section 6.4.
- As per the person's Spiritual beliefs, pastoral care will be contacted, and a visit requested by Person in Charge.
- The person's body may not be removed from the Residential home until confirmed by the G.P. or Coroner.
- The person's belongings are to remain in place in the room to allow the family time to pick them up within a previously agreed timeframe. This will differ based on family circumstances. If the family wish for staff to pack the belongings the items are to be placed in boxes or specific property bags. Document details of all belongings returned including to whom and the date of return.
- The deceased person's records will be collected and stored in line with data protection by Director / Assistant Director of Services.

7.2 Planning Funeral Arrangements for expected deaths

- All efforts are made to respect the wishes expressed by the individual with regards to their funeral arrangements as outlined in their end of life plan.
- Next of kin or Manager are to inform the agreed choice of undertaker. The Person in charge will notify HIQA as per legislative guidelines and the HSE within 3 working days.
- Ensure the acute hospital, including the members of the multi-disciplinary team, is informed of the persons death so that no further correspondence is sent to the home of the family.

7.3 If the person's death was unexpected:

Considerations here are if a person we support is in the building for less than 24 hours or if death was unexpected or under unusual circumstances such as a fall, neglect, trauma, post–operative complications. In the event of an unexpected death the sudden death protocol (Appendix 4) should be adhered to:

- In the event of a sudden death, one staff to take charge of the incident.
- In the event the individual does not have a DNAR in place, commence CPR. If lone working, contact emergency services before commencing CPR.
- PIC / familiar staff will contact the emergency services, GP or Southdoc if during out of hours.
- PIC/ familiar staff will inform the next of kin and the Director of Services.
- The Doctor pronouncing the death will notify the Coroner when he attends KPFA Service to record the death, detailing time and date.
- The body may not be moved without the Coroner's instruction.
- The Person in Charge on duty will notify HIQA using NF01 within 3 working days. Incident will be recorded according to Association Policy.
- If the person is for post-mortem the limbs are straightened but the body is to be left intact, for example, no devices or tubes are to be removed and medications are to be retained. If dealing with an infection control issue, please contact Infection Control Nurse (HSE).

- The person's belongings are to remain untouched and this is explained to next of kin as a requirement by the Coroner, until they are satisfied the deceased body can be released to the undertaker or sent to the mortuary for post mortem.
- A Garda presence may be requested by the Coroner to sit with the person's remains until removal for post mortem.
- No funeral arrangement can be made until the coroner releases the deceased remains to the requested Undertaker.

7.4 Last offices:

The performance of last offices is the care given to a deceased person which demonstrates our respect for the dead and is focused on fulfilling religious and cultural beliefs. It is a way for Staff to demonstrate a final act of sensitive care.
Ideally last offices should be carried out before the onset of rigor mortis which starts at between 4-6 hours. However, if the death is unexpected last offices can only begin once the death has been pronounced by the GP / Coroner.

- Lay the person on his/her back. Close his/her eyelids. Remove all but one pillow.
- Support jaw by placing a neck collar or rolled up towel on the chest underneath the jaw, do not bandage. Straighten all limbs.
- If there is a urinary catheter or other devices such as a sub-cut line this will be removed. Ensure open wounds are redressed.
- There is a possibility that when you roll the body onto its side the fluids that are still in the stomach may expel through the mouth, and this fluid may be very offensive smelling.
- Also when a body is moved for the first time after death the lungs may expel any remaining air which is often witnessed as a groan which may cause distress to someone who is not aware of the possibility.
- Both of these occurrences are normal and a natural sequence of death. When someone dies the blood in the body gravitates to the dependant areas therefore if the body was lying on its back, this is where the blood will settle, which means that the whole of the back area of the body including the arms, legs, back and buttocks will appear bruised and blotchy.
- When shaving a male resident, razor burn can still occur at this stage if you are not careful.

- Full body wash is preformed while still (maintaining) the persons dignity and respect.
- Insert the person's dentures where available.
- Dress the body in appropriate clothing.
- All bed linen is changed and specific bed set for laying out person is applied to their bed.

Laying out of the Deceased Resident

The hands are usually clasped across or just below the chest often presented with a rosary bead on top of a bible or prayer book, depending on religious beliefs.

Remove all clutter, medical appliances from the bedroom, providing seating, appropriate lighting and appropriate bed height for the family to sit with the resident.

No bedrails are required, display photos, flowers etc. to make the room (more) meaningful for the family.

Each person's circumstances will be different. It is important to know what to expect.

7.5 Removal of the deceased from his/her own room

Family/ Visitors will be facilitated in spending as much time as they wish with the deceased prior to removal of the body.

- Firstly, ensure that the funeral directors are guided to the most appropriate exit door from the person's room and away from communal areas and other bedrooms. Ensure room doors are closed and that the corridors are free from visitors/ residents.
- Staff are to support other residents during the removal according to individual needs and wishes
- (PIC) / senior staff to remain in the room with the funeral directors, recording in care plan, the funeral directors, time of removal, and skin condition of the deceased remains is documented in a Body Diagram.
- The deceased is to be transferred and removed in a professional, calm, respectful and dignified manner.

8.0 Informing other people we support and staff of death and funeral arrangements

- The death is to be communicated sensitively and privately to each resident and staff member as appropriate.
- Staff are informed of the death as soon as possible.
- Management will encourage reminiscences of the deceased
- Staff will listen if it prompts other people we support to think or talk about their own death. Ensure all information received is clearly documented in their advance care plans.
- Arrange for people we support to attend the funeral if they so wish, if appropriate.
- Assist the people we support and staff to sign a remembrance book, which will be passed onto the family on their behalf.

9.0 Funeral Arrangements

This will be established in the end of life planningstage having had discussion with the individual and their family

Residents and those attending day services will be supported to attend the funeral if they so wish and we will try to manage rotas to facilitate staff that also wish to attend.

10.0 Registering the Death

- It is a legal requirement in Ireland that every death is registered.
- The next of kin will obtain a letter from the person's GP/Hospital confirming date, time and cause of an expected death.

- The next of kin will register the death by giving the GP letter confirming death and other necessary information to the Registrar of Births and Deaths in their local area.
- This must be done as soon as possible and no later than 3 months.
- Death Certificates can be then obtained from the Register of Births and Deaths office for a fee.
- If it has been referred to the Coroner the next of kin will liaise with the Coroner's office.

11.0 Bereavement Support for the family, other people we support and staff

Bereavement support for the people we support

- The news of the death should be told slowly and honestly, a simple factual description of what has taken place should be given using the correct language associated with death. Words such as dead, dying and died have only one meaning. It is necessary to avoid the confusion of euphemisms such as 'gone to sleep 'or 'passed on 'which may be misleading.
- All staff are aware that each individual may react differently and will require support accordingly.
- Following the death, a member of staff (key worker) should take responsibility for the support of the individual. This person should have a good relationship with the individual and should feel comfortable talking about death. This may include being present with the person, being aware and acknowledging their sadness and supporting them in their grief.
- Staff need to be vigilant to signs of distress and anxiety, particularly in individuals who are unable to express such emotions verbally.
- The grief process varies from one individual to another. Sometimes there may be delayed reaction or unexpressed grief may manifest in other ways. The person may require specialist support at this time. Psychological support is available. Referral can be made to mary.breen@kpfa.ie .
- Easy read documents such as:**Lets-Talk-about-Death-2012 (See appendix 5)** may be beneficial to help the person we support gain some understanding around what has happened. A social story specific to the person may also be useful.

- The people we support will be afforded the opportunity to participate in the removal or funeral mass, bearing in mind the wishes of the deceased and his/her family.
- The resident meetings will provide an opportunity for people we support to discuss the recently deceased and reminisce.
- People we support are afforded the opportunity to talk about the deceased and share memories if they so wish, photographs and albums can be on display.
- Ongoing support will be provided and visits to the deceased grave will be facilitated if the person we support so wishes.
- Acknowledgement of recent bereavements will be included in Resident Meetings, management meeting, annual house services and in the Annual report.

Bereavement support for the family

- Provide the opportunity to listen rather than talk, and allow the family talk things over, providing encouragement, support and advice through the grieving process.
- Assist families in putting forward ideas and strategies to help them to cope with their bereavement.
- Create an environment where family members feel safe and can express what their feeling, and respect how they feel.
- Understand that everyone grieves differently and for varying lengths of time therefore, continue to maintain support after the funeral.
- Don't let fears about saying or doing the wrong thing stop you from reaching out. Being genuine in your communication and body language will provide comfort simply from being in your company.
- Provide information on grief support services who will provide Counselling, Support and education to bereaved families.
- Be specific and practical with offers of assistance, this is more useful than general ones, practical assistance will always be of benefit.
- The family will be offered the option of a removal service in the person's residence, support with contacting an Undertaker, advice on how to obtain a Death Certificate.
- In the instance of a Sudden Death, specific supports will be given to the family to assist then with accepting and understanding the sudden death protocol.

- Supporting family with understanding and accepting the bereaved person's Advance Care Directive in relation to preferences after death.
- The Irish Hospice Foundation have developed a bereavement resource pack to assist those living with loss during Covid-19 pandemic.
- Citizens Information Board have also published information on a range of practical concerns the family may have when a death occurs. https://www.citizensinformationboard.ie/downloads/guides/Bereavement_Guide_2021.pd
- Where a Power of Attorney exists there may be legal issues associated with the death, which the family may require support and advice on.

Bereavement support for the staff members

- On the day of the death, provide staff with an opportunity to grieve & pay their respects to the individual who passed away.
- Contact staff who are off duty as soon as reasonably possible to allow them pay their respects to the individual if they wish.
- If staff need to, afford staff the opportunity to finish their shift & go home if they would like to.
- If staff were present for the death of an individual, provide staff the opportunity to debrief as part of the team or on a 1;1 if they wish before they finish their shift.
- Provide staff with an opportunity to talk about and remember the individual. Encourage staff to reflect on the person's life & what they brought to the house.
- The centre manager should liaise with staff who were on duty at the time of death post incident. The manager should offer support & provide the staff with another opportunity to debrief.
- Psychological support is available for both staff and people we support. Referral can be made to mary.breen@kpfa.ie
- Employee Assistance Programme (EAP) – also in place to support staff, residents and families. Telephone 1800 995955.
- Make provisions for staff to attend the funeral service of the individual if appropriate.
  Afford staff the opportunity to participate in any removal or funeral services if this was an expressed wish of the deceased resident or is a request of family members.

12.0 References

- Health information Quality Authority (2009) National Quality Standards for residential care settings for older people in Ireland.
- Mangam 1 (2003) older people in long stay care. Dublin: The human rights commission.
- Department of Health and children (1995) Code of practise for nursing homes Dublin: DoHC
- World health organisation (2004) Better palliative care for older people Copenhagen: WHO
- Irish Hospice Foundation (2004) A nationwide survey of public attitudes and Experience Regarding Death and Dying. Dublin: Irish Hospice Foundation.
- https://www.citizensinformationboard.ie/downloads/guides/Bereavement_Guide_2021.pd
- Burke, E., O'Dwyer, C., Ryan, K., McCallion, P., McCarron, M (2017) Glancing back, planning forward, A guide for planning end of lifecare with people with intellectual disability. Intellectual Disability Supplements to The Irish Longitudinal Study on Ageing. Trinity College Dublin.

APPENDIX 1

Accessible Tool.pdf – Glancing Back Planning Forward Tool Link (sharepoint.com)

APPENDIX 2

Advance Health Care Directive.docx (sharepoint.com)

APPENDIX 3

Resuscitation Treatment Agreement List.docx (sharepoint.com)

APPENDIX 4

KERRY PARENTS AND FRIENDS ASSOCIATION

SUDDEN DEATH PROTOCOL

PART 1	**If there is a sudden death the centre:** One staff to take charge of the incident and assign staff to: • Contact the emergency services • Commence CPR **If there is only one staff on duty remember to contact the emergency services before commencing CPR** CPR is to continue until the emergency services arrive Identified staff notifies: 1. **Emergency services:** 112/999. Ambulance and Garda. Commence CPR (if No DNAR in place) /go for defibrillator Use CPR packs for COVID-19 with FFP2 masks If lone working, contact senior management for support once emergency services arrive. 2. **Residents G.P.: Name, Address & Phone number** 3. **Family of person we support** 4. **Local priest: Name & Number (If applicable)**

	5. Centre / Senior Management: Centre manager Deputy Centre Manager: Maura Crowley: 087-2838343 / 064 – 6641231 Marie Linehan: 086 – 8518618 Sheila Doyle: 087 – 2630225 Liz Lernihan: 087-7611283

PART 2	**If the person has a DNAR in place:** • Stay with the person • Direct the staff making the call to G.P/South Doc that a DNAR is in place. • Follow points 2-5 as above. • Assess the situation to the best of your ability. • Stay with the person until GP/South Doc arrive.

Part 3	If a person with a DNAR stops breathing following a first aid situation such as choking the first aid management of condition should be continued until emergency services arrive

APPENDIX 5

Lets Talk about Death Document (sharepoint.com)

Kerry Parents and Friends Association

Addendum to End of Life Policy, May 2020.

In line with HSE guidance Regarding Cardiopulmonary Resuscitation and DNAR Decision-Making during the COVID-19 Pandemic.

Performance of Cardiopulmonary Resuscitation {CPR} during the COVID-19 outbreak

Covid=19 raises specific safety concerns for Health Care Workers in relation to the provision of CPR as these can be a serious risk of aerosol exposure and infection from some procedures.If CPR is performed on people with COVID-19 or with suspected Covid-19, there is the potential for Health Care Worker's to be exposed to bodily fluids during some procedures e.g. chest compressions which will generate an infectious aerosol.

In those circumstances, CPR should not be commenced without the appropriate PPE recommended in the HSE National guidelines.

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. There Should be no discrimination for or against persons who have or are suspected to have Covid-19 in relation to DNAR Decisions.

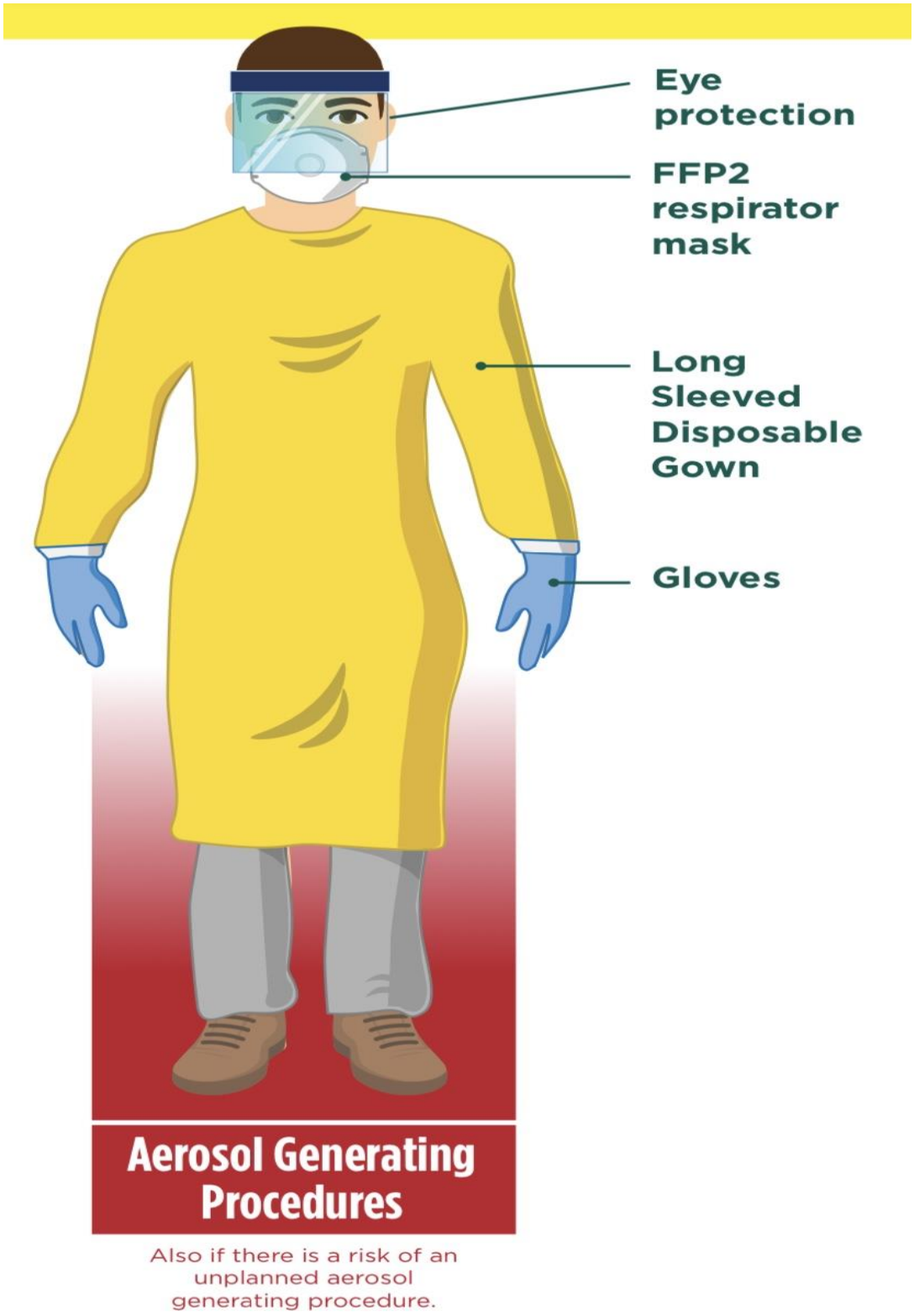
In Residential care facilities, evidence of general widespread transmission may mean that all occupants need be treated as potentially positive for COVID-19.

As per the HSE National PPE Guidelines;

All KPFA residential and day centres will have a minimum supply available of aerosol generating PPE packs x 2 to be used for CPR where a DNAR directive is not in place. The designated storage of same will be communicated with all Health Care Worker's, clearly marked and checked as part of unit safety checks.

Only Kerry Parents and Friends Association staff who are trained and competent to carry out CPR, will commence CPR, while waiting for an ambulance, and adhere to the HSE CPR Guidelines for individuals with suspected and confirmed Covid-19.

- Once you have applied your Aerosol generating PPE as per HSE National Guidelines, keep your hands away from your face at all times. This includes using a phone, a supporting HCW to liaise with Ambulance, family etc.
- Do not listen or feel for breathing by placing your ear and cheek close to the person's mouth. Look for signs of breathing and signs of life within a protective distance.
- When dialling 999 or 112 and Covid-19 is suspected and/or confirmed please tell them.
- Use a defibrillator as soon as possible, this significantly increases the person's chance of survival.
- Perform chest compressions only. Do not give mouth to mouth rescue breaths. If there is a perceived risk of infection, you could place a cloth/ towel over the person's mouth and nose and continue compression only CPR and early defibrillation until help arrives.
- Afterwards, doff your PPE as per HSE National Guidelines, and clean and disinfect the defibrillator if used.


Eye protection
FFP2 respirator mask
Long Sleeved Disposable Gown
Gloves
Aerosol Generating Procedures
Also if there is a risk of an unplanned aerosol generating procedure.