Resuscitation Policy and Procedure for Patients at Katharine House Hospice

Approved by:

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Originator: **Medical Director**

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Introduction

Cardiopulmonary resuscitation (CPR) carries a low chance of success in the hospice population (Appendix One), even when performed optimally. Pre-emptive decision-making must be performed very carefully, in a dispassionate and individualised manner that respects the legitimate rights of all parties. It is very important that all activities in this area comply with the standards of the Healthcare Commission and the published guidance from relevant professional bodies. Due to the sensitive nature of this area of clinical work, this Policy and Procedure is necessarily detailed. The Policy Statement explains the rationale for the hospice's stance whilst **the procedure, which can be read in isolation, gives a step-by-step summary to performing all the necessary activities**.

Related Hospice Policies/Procedures

- Katharine House Hospice Philosophy
- Mental Capacity Policy
- Procedure for Clinical decision Making
- Procedure for Obtaining Consent for Clinical Procedures

Responsibility/Accountability

Director of Nursing:	Ultimate responsibility for ensuring that there is an effective policy in place and that staff are aware of it and adhere to it.
Medical Director:	Full responsibility for any CPR decisions relating to individual patients.
Medical Staff:	Completion of a CPR decision form for all patients who regularly use services based at the hospice.
All Clinical Staff:	Adherence to the instructions documented on a CPR decision form in the event of a cardiac arrest, with the proviso that no health care professional can be obliged to perform CPR if they regard it as a futile activity in the given instance. Collective review of the appropriateness of the existing CPR each time a patient is discussed at an inpatient, day centre or lymphoedema multidisciplinary meeting To discuss any CPR decisions with which they do not feel comfortable with the Senior Nurse or Medical Director in the first instance.

Policy Monitoring & Review

This policy will be reviewed every twelve months or sooner if legislation, guidance or case review requires it.

Compliance with Statutory Requirements

- The European Convention for the Protection of Human Rights and Fundamental Freedoms, in particular Articles 2, 3, 8 and 14.
- Private and Voluntary Health Care (England) Regulations 2001, Regulations 16(1), 16(2), 16(3), 35(1) and 35(2).
- Independent Health Care. National Minimum Standards C27 and H7.

Policy Statement

Katharine House respects the first and second editions of "**Decisions Relating To Cardiopulmonary Resuscitation: A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing**", herein referred to as the "Joint Statement".

The Association of Palliative Medicine for Great Britain and Ireland and the National Council of Hospice and Specialist Palliative Care Services have also made a joint statement on CPR, entitled "**Ethical decision-making in palliative care: Cardiopulmonary resuscitation (CPR) for people who are terminally ill",** hereinreferred to as the "Palliative Care Statement".

The first edition of the Joint Statement

The first edition of the Joint Statement emphasised the role of the patient in the decision-making process without giving explicit guidance on how this might be done. It also provided the following observations regarding compliance with the European Convention for the Protection of Human Rights and Fundamental Freedoms:

Article Two: The right to life

CPR should be generally considered the default option in cases where it might be appropriate and no prior wish regarding CPR has been made by the patient. However, the Joint Statement went on to say that "although this is the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is in the terminal phase of illness or for whom the burdens of the treatment clearly outweigh the potential benefits". It also stated that "it is not an appropriate goal of medicine to prolong life at all costs with no regard to its quality or the burdens of treatment on the patient", and "for every person there comes a time when death is inevitable and it is essential to identify patients for whom cardiopulmonary arrest represents a terminal event in their illness and in whom attempted CPR is inappropriate".

Article Three: The right to be free from inhuman or degrading treatment

Health professionals can be in breach of the Convention if their attempts at CPR or the treatments subsequent to successful CPR result in patients being "deliberately ill-treated" or having "severe indignities inflicted upon them". With regard to the act of CPR, the Joint Statement said that "attempted CPR carries a risk of significant side effects (such as sternal fracture, rib fracture and splenic rupture) and most patients require either coronary care or intensive care treatment in the post resuscitation period. If there is delay between cardiopulmonary arrest and the resuscitation attempt, there is a risk that the patient will suffer brain damage. Some resuscitation attempts may be traumatic meaning that death occurs in a manner the patient and people close to the patient would not have wished." As for the potential outcome of successful CPR, the Joint Statement made the following comment: "It should be borne in mind that some people have a profound abhorrence of being kept alive in a state of total dependency or permanent lack of awareness. If patients express such views, health professionals should take note. They should refrain from artificially preserving life where it is clear that the patient would consider the resulting situation to be an inhuman or degrading state. The duty to protect life must be balanced with the obligation not to subject the patient to inhuman or degrading treatment".

Article Eight: The right to respect for privacy and family life
The Joint Statement observed that, whilst family members have no legal right in England to consent to treatment on behalf of a patient who lacks decision-making capacity (and doctors have authority to act in the best interest of the patient when patient consent is unavailable), it is good practice to involve people close to patients in decision-making processes.

Article Ten: The right to freedom of expression, which includes the right to hold opinions and to receive information
The Joint Statement advised that "written information about resuscitation policies should be included in the general literature provided to patients about health care establishments. Such information should be readily available to all patients and to people close to the patient, including relatives and partners". However, "information should not be forced on unwilling recipients, and if patients indicate that they do not wish to discuss resuscitation this should be respected". Furthermore, "there is no ethical or legal requirement to discuss every possible eventuality with all patients, although if patients for whom cardiopulmonary arrest is not a foreseeable likelihood do want to discuss resuscitation, the health team must be willing to do this and to answer any questions honestly".

Article Fourteen: The right to be free from discriminatory practices in respect of these rights
The Joint Statement suggested that whilst "local policy makers may find it helpful to tailor policies to their own particular setting to ensure they are relevant to the type of patients being cared for and take account of what facilities are available, decisions must always be made on an individual basis. Blanket policies which deny attempts at resuscitation to groups of patients, for example to all patients in a nursing home or to patients above a certain age, are unethical and probably unlawful under provisions of the Human Rights Act which prohibit discrimination in the enjoyment of Convention rights".

Whilst they lay outside the scope of the Convention, the first edition of the Joint Statement also made a number of comments regarding the decision-making process. Translating the guidance to the hospice setting, the hospice Consultant had overall responsibility for CPR decisions but s/he should always be prepared to discuss these with the patient's GP. However, no doctor was required to give treatment contrary to their own clinical judgement. Patients with decision-making capacity had an absolute right to provide advance refusal for CPR, and such refusals had to be honoured. They were also perfectly entitled to make an advance request for CPR in the potential event of a cardiopulmonary arrest. In this situation, doctors were advised to try and dissuade them from requesting such a line of action if they considered CPR to have a low likelihood of success but, if the patient persisted in requesting CPR, the medical team should honour the wish as far as they felt able, in order not to be in breach of Article Two of the Convention. Whilst people close to a patient who lacks decision-making capacity had no legal right in England to provide consent on their behalf, it was considered good practice to involve them in decision-making processes under such circumstances. Whenever a clinical decision was seriously challenged and agreement could not be reached, some form of legal review was considered likely to be necessary.

The second edition of the Joint Statement

The second edition of the Joint Statement paid much less attention to the European Convention of Human Rights and Fundamental Freedoms. However, it attempted to clarify the role of the patient in the decision-making process. Whilst the document as a whole would appear open to multiple interpretation, it does contain the following sentences which are completely unambiguous when read either in isolation or in the context of the whole document:

1. "Where no explicit decision has been made in advance there should be a presumption in favour of CPR".
2. "It is not necessary to initiate a discussion about CPR with a patient if there is no reason to believe that a patient is likely to suffer a cardiorespiratory arrest".
3. "If the clinical team believes that CPR will not restart the heart and maintain breathing, it should not be offered or attempted".
4. "Neither patients, nor those close to them, can demand treatment that is clinically inappropriate".
5. "When a clinical decision is made that CPR should not be attempted because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR".
6. "A Do Not Attempt resuscitation (DNAR) decision does not override clinical judgement in the unlikely event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged".

These sentences have been used by the hospice to create a decision-making tool for cardiopulmonary resuscitation (Appendix Two).

The Palliative Care Statement

The Palliative Care Statement considers CPR an appropriate option if all three of the following conditions are met:

1. There is a reasonable chance of CPR re-establishing cardiopulmonary function.
2. Successful resuscitation would probably result in a quality of life acceptable to the patient.
3. It is the competent patient's expressed wish to receive CPR in the event of a cardiopulmonary arrest.

However, it also notes that:

- For terminally ill patients (unambiguously defined as those with active and progressive disease for whom curative treatment is not possible or not appropriate, and for whom death can reasonably be expected within twelve months), the harms of CPR are likely to outweigh the benefits. CPR is almost invariably unsuccessful in this patient group. The rare instances of successful resuscitation typically result in death from a further cardiopulmonary arrest before the patient can be discharged home.
- There is no ethical obligation to discuss CPR with those palliative care patients for whom such treatment is considered futile. It is recognised that this represents the majority of palliative care patients. It can be potentially distressing for these patients if the subject of CPR is deliberately raised with them, only to advise them that CPR attempts would almost certainly be futile.
- Should a patient express a wish for CPR and it is considered likely that patient would benefit from the procedure in the event of a cardiopulmonary arrest, then the subject should be discussed fully with the patient at the earliest opportunity. This discussion

should ideally take place prior to hospice admission and it should cover the extent of CPR facilities and the level of expertise available in the hospice. The patient may still request admission to the hospice, accepting that only limited and basic CPR may be available but that emergency transfer to a hospital could be arranged in such circumstances.

- If no advance decision has been made by the patient about CPR then it is the doctor's legal responsibility to act in the patient's best interests in the event of a cardiorespiratory arrest as the patient is by definition incompetent to make a decision at the time.

How does Katharine House Hospice interpret and apply this legislation and advice?

Katharine House Hospice practices patient-centred care and has no wish to act outside the law. Our CPR decision-making process is firmly founded on the principles contained in the second Joint Statement and the Palliative Care Statement. Whilst we accept that it is not lawful to adopt a blanket "do not resuscitate" policy within the building, our own review of the medical literature has satisfied us beyond doubt that CPR is not an appropriate default activity to be undertaken on our patient group in the event of an identified cardiac arrest (Appendix One). Nonetheless, a presumption in favour of CPR is the requirement made in the Joint Statement that we must follow. Since opening in 1991, we have not identified a single patient at the hospice who has died from a cardiac arrest for whom CPR might have been appropriate. Our organisation therefore has no experience whatsoever of CPR on a real patient in a real clinical setting. In that same time, we have received just one advance request for CPR and this was dealt with to the satisfaction of that patient in an individualised manner by transferring them to a healthcare facility more suited to providing such a service.

We respect the various Articles of the European Convention in the following ways:

Article Two: The right to life

We always aim to optimise the quality of remaining life in our patients. Directly embracing the philosophy of palliative care as defined by the World Health Organisation, none of our actions are designed to hasten or postpone the moment of death, which we consider to be a natural part of any terminal illness. We believe that the deaths we witness within the hospice are inevitable and are typically the result of cachexia and a burden of pathology that makes life unsustainable. Under these circumstances, an advance decision in favour of CPR is rarely likely to be clinically appropriate, the only likely exceptions being when the patient has clearly stated a wish for CPR *and* the doctor in attendance at the time does not find CPR contrary to their own clinical judgement.

In accordance with the second edition of the Joint Statement, whenever no decision has been made in advance of a cardiac arrest, there will be a presumption in favour of CPR. However, the following sentence from the same document might prove relevant in some of these cases: "There will be some cases for whom attempting CPR is clearly inappropriate, for example a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNAR decision has been made. In such circumstances, healthcare workers who make a considered decision not to commence CPR should be supported by their senior colleagues and employers."

Although it respects the requirement, this hospice is not presently convinced that the presumption in favour of CPR in the absence of a CPR decision is a logical derivation from the "right to life" as described in Article Two of the European Convention of Human Rights and Fundamental Freedoms. When this Article is examined, it becomes immediately clear that the "right to life" is more accurately a right not to be killed, except in certain clearly defined circumstances when the state may legitimately take such action. Although untested in the law courts, in the absence of a legal definition of the state of death, it could be argued that a patient who has just suffered a cardiac arrest is dead by virtue of their non-functioning heart, lungs and brain. It then follows that a patient who is already dead cannot be killed by an act of omission. It also seems quite reasonable to claim that the dead cannot have a right to life.

Article Three: The right to be free from inhuman or degrading treatment

Post mortem studies have shown that the risk of sustaining a fractured sternum or fractured ribs as a result of receiving CPR are as high as 30% and 55% respectively, and the risk of a perforated body organ is also significant. Due to their frailty and the possibility of bone metastases, hospice patients arguably have a much higher fracture risk than most other people in the community, and their fracture rates can therefore be expected to be higher. The CPR success rate for a witnessed cardiac arrest in a Nursing Home setting is approximately 5%, but if it is unwitnessed it is probably as low as 0.5%. The chances of a successful CPR attempt falls by a factor of eight in the presence of advanced incurable illness such as cancer. 70% CPR survivors will die within the next 72 hours, and many who survive longer than this will have permanent neurological damage. Therefore, the chances of a successful resuscitation attempt are generally low in the hospice setting and the risk of significant harm is high. As the fracturing of bones is likely to be audible in the immediate vicinity of the CPR attempt, CPR in the hospice setting has a high risk of being an inhuman or degrading experience for the patient; their family; other nearby patients and visitors; and hospice staff.

Article Eight: The right to respect for privacy and family life

The rights and limitations of family members or significant others to make clinical decisions on behalf of patients who lack decision-making capacity are clearly described in the Mental Capacity Act 2005. Our clinical policies cover such eventualities, and we do not envisage any problems with this aspect of the Convention.

Article Ten: The right to freedom of expression, which includes the right to hold opinions and to receive information

We are heartened by the Palliative Care Statement and some of the comments in the second edition of the Joint Statement that indicate the inappropriateness of discussing CPR matters with all patients. Was this not the case, there would arguably be frequent breaches of Article Three. Our leaflet "A Way of Caring" clearly indicates to patients that we have never performed CPR in the hospice and that we do not have resuscitation equipment on site. It also invites patients to discuss any questions or concerns they might have regarding CPR with a member of the clinical staff. This helps to ensure that all patients and their families can legitimately raise the subject. The group of patients for whom CPR decision-making should be deliberately raised by clinical staff is clearly identified in the following procedure.

Article Fourteen: The right to be free from discriminatory practices in respect of these rights (Article 14)

It is perfectly evident from the Joint Statement that, whilst having a "default" CPR decision is not contrary to the Convention, having a "blanket" decision clearly is. Our preference would be to have a default position not to resuscitate hospice patients in the absence of a decision, but the Joint Statement requires the opposite default to be applied regardless of clinical setting. Nonetheless, patients and their families cannot demand CPR if the clinical team consider such an activity clinically inappropriate. It would be unethical to appear to give the patient a choice in the matter if they do not have one. This hospice's CPR decision tool objectively individualises the clinical decision-making process, using the criteria highlighted in the Joint Statement and the Palliative Care Statement. It also ensures that the involvement or non-involvement of the patient and family in the decision-making process is in line with the guidance in the Joint Statement.

References for the Policy Statement

1. The EC Convention for the Protection of Human Rights and Fundamental Freedoms.
2. Decisions Relating To Cardiopulmonary Resuscitation: A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (First Edition)
3. Decisions Relating To Cardiopulmonary Resuscitation: A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (Second Edition)
4. Ethical decision-making in palliative care: Cardiopulmonary resuscitation (CPR) for people who are terminally ill. A joint statement by The Association of Palliative Medicine of Great Britain and Ireland, and the National Council of Hospice and Specialist Palliative Care Services.

(Copies of these documents are available in electronic format on the computer in the hospice library).

Procedure

1 The following extract is taken directly from the leaflet "A Way of Caring", that is given to all patients when they first make contact with the hospice:

> "We believe that our popularity and success lies in our 'way of caring'. Patients tell us repeatedly that what they want most is a simple and unrushed approach in peaceful surroundings, free from any unnecessary high-tech gadgetry, where they can relax and feel able to raise whatever issues are important to them. They appreciate being at the centre of their own care. Such environments can be created in the community or hospice whilst still providing patients with the treatment they need. For example, our care may include the appropriate use of blood transfusions, antibiotics, and other treatments that have a proven role. However, the greatest gains often come through making things simpler rather than more complicated. Comfort, quality of life and the preservation of dignity are essential considerations. Our work is designed to neither hasten nor postpone death. Since opening, there has been no clinical need to perform cardiopulmonary resuscitation on a single patient. Therefore we do not store a cardiac defibrillator. We are confident that this does not compromise care, but please discuss this with a member of the clinical team if it causes you concern".

This extract clearly describes a healthcare organisation that has deliberated very carefully over its culture and its values. It describes a slow-paced, low-tech environment that is explicitly devoid of cardiopulmonary resuscitation equipment. The leaflet, like all our literature for patients and their families, positively invites further discussion on any matter if the patient wants this, thereby making information freely accessible whilst respecting privacy.

2 All hospice patients who regularly spend time on the hospice premises, in the day centre, lymphoedema clinic or inpatient settings, must have a CPR decision sheet completed at the earliest opportunity by a member of the medical team. The back of this sheet sets out the process to be followed in making decisions, to ensure that they are as individualised and as objective as possible and in line with the following principles:

- "It is not necessary to initiate a discussion about CPR with a patient if there is no reason to believe that a patient is likely to suffer a cardiorespiratory arrest".
- "If the clinical team believes that CPR will not restart the heart and maintain breathing, it should not be offered or attempted".
- "Neither patients, nor those close to them, can demand treatment that is clinically inappropriate".
- "When a clinical decision is made that CPR should not be attempted because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR".
- "A Do Not Attempt resuscitation (DNAR) decision does not override clinical judgement in the unlikely event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged".

3 In the absence of such a completed sheet the presumption must be in favour of CPR if the patient has a cardiac arrest, although the following caveat applies:

> "There will be some cases for whom attempting CPR is clearly inappropriate, for example a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNAR decision has been made. In such circumstances, healthcare workers who make a considered decision not to commence CPR should be supported by their senior colleagues and employers."

4 CPR decisions can be divided into the following categories:

- **CPR is considered clinically appropriate by the clinical team, but the patient (or in certain limited circumstances defined by the Mental Capacity Act, their representative) has indicated that they would not like CPR to be performed in the event of a cardiac arrest.**
  Whenever CPR is considered a clinically appropriate option in the event of a cardiorespiratory arrest, it must be discussed with the patient. However, if the patient indicates that they **would not** like CPR to be performed in the event of a cardiac arrest, this wish must be respected.
- **CPR is considered clinically appropriate by the clinical team, and the patient (or in certain limited circumstances defined by the Mental Capacity Act, their representative) wishes for CPR to be performed in the event of a cardiac arrest.**
  Whenever CPR is considered a clinically appropriate option in the event of a cardiorespiratory arrest, it must be discussed with the patient. If the patient indicates that they **would** like CPR to be performed in the event of a cardiac arrest, then it must be established with them where their preferred place of care is. It should be specifically highlighted that, in the context of the inpatient care of a patient at risk of a cardiorespiratory arrest, the facilities potentially available at an acute hospital are probably preferable to those of a hospice. Subject to an individualised assessment of the situation, these might include:
  - pre-emptive cardiac monitoring;
  - reversal of certain cardiac arrest risk factors
  - an experienced and fully equipped cardiac arrest team on site
  - post-cardiac arrest intensive care facilities

  Before having such a discussion with the patient, it might be prudent to carefully discuss the case with the on call consultant physician at the hospital to establish which, if any, of these benefits might actually be available. In the discussion, it should also be noted that specialist palliative care advice will still be available at the hospital through the Hospital Palliative Care Support Team. If the patient makes an informed decision to turn down the clear benefits of an acute hospital that cannot be replicated in the hospice setting, then the conversation must then explore the expectations of the patient to see if this can be realistically matched against what the hospice can reasonably provide. Even if the patient decides to stay at the hospice and it is agreed that the decision is to perform cardiopulmonary resuscitation in the event of a cardiac arrest, the following statement might become relevant at the moment of a cardiac arrest, depending upon the clinical circumstances leading up to the event:

  > "If the clinical team believes that CPR will not restart the heart and maintain breathing, it should not be offered or attempted."

- **CPR is considered clinically inappropriate by the clinical team, and the patient (or in certain limited circumstances defined by the Mental Capacity Act, their representative) has not volunteered an opinion regarding CPR or has indicated that they would not like CPR to be performed in the event of a cardiac arrest.**
  When a clinical decision is made that CPR should not be attempted because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR.
  When a clinical decision is made that CPR should not be attempted because it will not be successful, and the patient has expressed a wish not to receive CPR, it is not appropriate to perform CPR in the event of a cardiac arrest.
- **CPR is considered clinically inappropriate by the clinical team, but the patient (or in certain limited circumstances defined by the Mental Capacity Act, their representative) has indicated a wish to have CPR performed in the event of a cardiac arrest.**
  In such a situation, no member of the clinical team is obliged to perform CPR against their own clinical judgement. However, the following sequence of events must be followed:
  a) Careful explanation with the patient and family as to why it is the clinical opinion that CPR would be inappropriate in the event of a cardiac arrest.
  b) If the patient/patient representative still wishes CPR to be performed in the event of a cardiac arrest, the hospice must offer the patient an independent second opinion regarding CPR by a doctor from outside the organisation. If the doctor providing the second opinion believes that CPR is an appropriate action to take in the event of a cardiac arrest, it might be necessary to transfer the patient to a healthcare setting where the clinical team would be happy to follow this through in the event of a cardiac arrest. This being the case, it would be appropriate for the second opinion to be made by a consultant physician with access to hospital beds.
  c) If the patient/patient representative remains dissatisfied with the clinical opinion regarding CPR, it may be necessary to arrange a formal legal review of the case. In such situations, no health care worker is obliged to perform CPR against their own clinical judgement in the event of a cardiac arrest.

5 Being ultimately responsible for all CPR decisions within the hospice, the Medical Director must be advised of any difficulties that arise in CPR decision-making. The Medical Director also reserves the right to revisit any CPR decision that has been made, and will typically involve the Senior Ward Nurse, Day Centre Co-ordinator and/or any other appropriate people in order to reach a satisfactory collective opinion. Members of the clinical team are encouraged to challenge the Medical Director, either individually or collectively, about any CPR decision with which they are not comfortable. They must also follow the "Raising Concerns About Poor Practice (Whistle blowing) Policy" if they believe that repeated or systematic errors in CPR decision making appear to be taking place.

6 Completed CPR decision sheets must be placed in the front of the clinical notes for easy access, directly behind the patient summary sheets. Where necessary, supplementary information must be placed in the information box on the CPR decision sheet. When more space is required for such supplementary information, this must be placed in the

main body of the clinical notes, and its presence must be highlighted in the comments box of the CPR decision sheet.

7 The CPR decision will be mentioned and reviewed whenever a patient is discussed at an inpatient, day centre or lymphoedema multidisciplinary meeting.

8 All clinical staff at the hospice receive mandatory annual training in adult basic life support. Whenever CPR is performed in the hospice setting, it must be administered in accordance with the "Adult Basic Life Support" algorithm of the Resuscitation Council (UK) until such time as a 999 ambulance arrives to take the patient to the nearest casualty department. Any CPR activities must be documented accurately in the patient's clinical notes and the details of the circumstances surrounding the cardiac arrest must also be documented carefully.

Resuscitation Council (UK) Adult Basic Life Support

1. Establish that the person is unresponsive.
2. Shout for help.
3. Open the person's airway.
4. Establish that the person is not breathing normally.
5. Call 999.
6. 30 chest compressions.
7. Repeat cycles of 2 rescue breaths followed by 30 chest compressions.

9 As we are not aware of the full clinical picture of any visitor, volunteer or member of staff at the hospice in the same way that we have a detailed understanding of the clinical problems of our patients, it will be our default position to provide basic CPR as described in the "Adult Basic Life Support" algorithm of the Resuscitation Council (UK) to any such person who sustains a witnessed cardiac arrest in the hospice, until such time as a 999 ambulance arrives to take the patient to the nearest casualty department.

10 Any issues relating to this policy and procedure must be reported to the Katharine House Hospice Clinical Practice Committee who will review this policy and procedure. The Trustees must also be made aware.

Appendix One: Review of the medical literature on cardiopulmonary resuscitation as it might relate to hospice inpatients

There is near universal overestimation of the success of cardiopulmonary resuscitation, both in the lay sector and amongst health care professionals [1 2 3 4 5]. It has been demonstrated beyond doubt that, when predicting the likelihood of survival following cardiopulmonary resuscitation, the deliberations of doctors are typically no better than guesses [6].

Cardiopulmonary resuscitation carries a high level of morbidity. Post mortem studies have shown that the risk of sustaining a fractured sternum is as high as 30% and the risk of a fractured rib as high as 55% during the procedure [7 8]. Other serious complications include:

- Cardiac rupture [9 10]
- Pneumothorax [11]
- Serious airway injury, including tracheal rupture [12 13]
- Osteomyelitis at a fracture site [14 15]
- Ruptured stomach [16 17 18 19]
- Ruptured liver [20 21 22]
- Ruptured spleen [23 24]
- Infarction of the caecum [23]
- Tension pneumoperitoneum [25 19]
- Rhabdomyloysis and acute renal failure [26]
- Retinal haemorrhage [27]

24% of patients who are successfully resuscitated develop pneumonia [28] and 72% of initial survivors die within the next 72 hours. Only 10-15% patients survive to be discharged home again [29] and many of these will have permanent neurological impairment [30].

Analysis of hospital data has confirmed that the likelihood of successful cardiopulmonary resuscitation varies between different disease groups [31 32 33]. Patients with cancer or kidney failure are half as likely to survive as patients who have had a heart attack. Patients aged over 70 are half as likely to survive as those under 70 [34]. In one hospital-based series, 8 out of 83 cancer patients who sustained a cardiac arrest survived the first few days and a further 3 died in the next 6 weeks whilst receiving hospice inpatient care [35]. It is generally accepted that patients in the hospice almost never survive cardiopulmonary resuscitation [36].

Cardiac arrest in the nursing home is associated with a 5% chance of survival, and those whose cardiac arrests are observed are ten times more likely to survive [37]. Out of the hospital setting, patients are 8 times more likely to survive a cardiac arrest if they do not have a severe chronic illness such as cancer [38].

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Patient name: _____

Should the team attempt cardiopulmonary resuscitation in the event of a cardiac arrest? YES NO

Has cardiopulmonary resuscitation been discussed with this patient? YES NO

Signature: _____ Designation: _____

Printed name: _____ Date: _____

PLEASE:

1. DEMONSTRATE YOUR CAREFUL INDIVIDUALISED CONSIDERATION OF THIS MATTER BY COMPLETING THE INFORMATION OVERLEAF.
2 DESTROY THIS SHEET AND REPLACE IT WITH A NEW ONE IF THE DECISION CHANGES.

COMMENTS (Please date and sign)

N.B.

1. "Where no explicit decision has been made in advance there should be a presumption in favour of CPR."[1]
2. "The overall clinical responsibility for decisions about CPR, including DNAR decisions, rests with the most senior clinician in charge of the patient's care as defined by local policy."[1]
3. "Clinicians should document the reason why a patient has not been informed of a DNAR order if the decision is made not to inform the patient. Clinicians may be asked to justify their decision." [1] (Completion of the information overleaf should satisfy that requirement).
4. "A Do Not Attempt resuscitation (DNAR) decision does not override clinical judgement in the unlikely event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged." [1]

1. Decisions relating to cardiopulmonary resuscitation. A joint statement from the BMA, Resuscitation Council UK and the RCN (October 2007)

Does this patient have an identifiable risk factor for cardiac arrest?
("It is not necessary to initiate a discussion about CPR with a patient if there is no reason to believe that a patient is likely to suffer a cardiorespiratory arrest"[1]).

	Yes	No
Previous cardiac arrest		
Previous myocardial infarction (75% sudden cardiac deaths have a previous history of myocardial infarction)		
Coronary artery disease (80% sudden cardiac deaths have a history of coronary artery disease)		
Cardiac failure (This increases the risk of cardiac arrest 6- to 9-fold)		
A known cardiac defect that increases the risk of cardiac arrest (e.g. WPW syndrome; long QT syndrome; dilated cardiomyopathy; valvular heart disease).		
Recreational drug use.		
Hypoxia risk (e.g. severe asthma; endotracheal tube that could block; choking attacks)		
Stroke		

How successful is cardiopulmonary resuscitation likely to be in this patient?
("If the clinical team believes that CPR will not restart the heart and maintain breathing, it should not be offered or attempted." [1])

	Yes	No
Is it too early in this patient's illness trajectory to describe them as terminally ill?[2]		
Is there a reasonable chance of CPR re-establishing cardiopulmonary function in this patient in the event of a cardiac arrest? [2]		
If CPR were successful in this patient, would it probably result in a quality of life acceptable to the patient? [2]		

Would you personally consider it clinically appropriate to perform cardiopulmonary resuscitation?
"Neither patients, nor those close to them, can demand treatment that is clinically inappropriate. [1]"

	Yes	No
Having considered the risk factors for cardiac arrest, the likelihood of success if CPR were performed, and the likely quality of life if CPR were successful, is it your professional opinion that cardiopulmonary resuscitation is a procedure that you would be prepared to undertake in the event of a cardiac arrest in this particular patient?		

Has the patient expressed a wish regarding CPR?
"When a clinical decision is made that CPR should not be attempted because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR. [1]"

	Yes	No
Has this patient, if competent to do so, expressed a wish to receive cardiopulmonary resuscitation?		

Things to consider if the patient definitely wants cardiopulmonary resuscitation

	Yes	No
If the wish to receive CPR seems clinically appropriate to the clinical team, has the option of transfer to a hospital been discussed with the patient, where the chance of a successful intervention might be heightened?		
If the wish to receive CPR seems clinically inappropriate to the clinical team, is the following sequence of events being followed until a satisfactory outcome is arrived at: (i) careful and sensitive explanation of why the clinical opinion is against CPR; (ii) option of a second (independent) opinion; (iii) recourse to a legal review?		

1. Decisions relating to cardiopulmonary resuscitation. A joint statement from the BMA, Resuscitation Council UK and the RCN (October 2007)
2. These questions are derived from the National Council/APM joint paper entitled "Ethical decision-making in palliative care: Cardiopulmonary resuscitation (CPR) for people who are terminally ill".

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