St Clare Hospice

Cardio-Pulmonary Resuscitation Guidelines

July 2001

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SECTION – A

INTRODUCTION

St Clare Hospice Trust is committed to serve the people in line with the philosophy of Hospice and Palliative Care. It serves a population of 250,000 from West Essex and East Hertfordshire corridor. It runs an 8-bedded In-Patient Unit and 40-Day Hospice places and is a Registered Nursing Home. The Trust has a duty to serve these patients keeping in view their best interests and needs.

Hospice Philosophy:

St Clare Hospice aims to provide a caring environment, offering comfort and support to patients, their families and their friends using skill and experience to increase quality of life where possible and to provide comfort and dignity to those who are dying.

SECTION – B

DEFINITIONS

1. Cardio-Pulmonary Resuscitation:

Cardio-pulmonary resuscitation (CPR) is a technique designed to maintain the body's circulation after the heart has stopped. whilst attempting to restore normal heart function. There are two forms of CPR.

- Basic
- Advanced

2. Basic CPR:

Basic CPR requires artificial ventilation using either a mask or mouth-to-mouth technique, with compression of the chest wall to maintain circulation. It also requires regular training to keep the staff skilled. Basic CPR also includes Automated External Defibrillation-AED. **(If available)**

3. Advanced CPR:

Advanced CPR involves invasive measurements and is a specialised skill requiring adequate resources and training, expensive instruments, immediate medical response and ready availability of High Dependency Unit. It involves

- Defibrillation: the delivery of electrical shocks to heart to try and stimulate heart
- Intubation: tubes placed in airway
- Intravenous drugs
- Continuous Cardiac Monitoring

SECTION – C

IN-PATIENT UNIT GUIDELINES

- ***Background:***

Most of the patients referred to St Clare Hospice have incurable diseases. The majority of them have widespread cancer. However, we acknowledge that at times there will be patients who are referred for difficult symptom control, who have good quality of life and may have a longer prognosis.

- ***Communication:***

It will be actively conveyed to the referring team (Hospital or Community) that St Clare Hospice does not offer Advanced CPR and would not expect to offer Basic CPR to patients except in unusual circumstances.

- ***Suitability:***

Patients not for resuscitation

Most of the patients referred to St Clare Hospice, for in-patient care have advanced cancer or other incurable disease. In these individuals, attempt at Cardio-Pulmonary Resuscitation is likely to be futile. It has been proven that in these cases, overall risk of the burden to the patient (e.g. sternal fracture, rib fracture, spleen rupture etc.) outweighs the justification to perform CPR.

If CPR is likely to be futile, there is no legal or ethical obligation to discuss that with all the patients.

Patients who are for resuscitation

Sometimes there are patients admitted for symptom control and respite care, who have a reasonable quality of life, a slowly progressive disease and an expected reasonable prognosis.
At the same time, deterioration in the general state may indicate the possibility of sudden cardiac event.
In this case, it is appropriate to discuss the issue of resuscitation with the patient. The limitations of the hospice to perform an advanced CPR should be the part of the discussion.

Before admission

If a patient is considered by the referring team to be appropriate for resuscitation, this should be discussed with the patient, by the referring team and the person accepting the referral should actively ask the referring person to:

a) take the responsibility to conduct the discussion
b) explain to the patient the possibility of transfer to hospital in case any such situation is anticipated whilst an in-patient in the hospice.

On or after admission

The referring team must make every effort to discuss the issue with the patient and explain hospice practice before admission. However, in those rare circumstances, when it was not possible, the hospice team, (doctor or a senior nurse) should seek to initiate the discussion and explain the limitations to the patient. In the case where a patient expresses the desire to be resuscitated, he/she should be transferred to the hospital and the palliative care should be handed over to the Hospital Palliative Care Team.

In the case of an unanticipated sudden cardiac event, for a patient with expected life of about a year, Basic CPR should be initiated and the patient should be transferred to hospital.
This should be conducted ***only*** after the indication is found in the notes that patient was suitable for resuscitation.
The patient who is suitable for resuscitation should have an indication on the board in the nurses' office.
The senior nurse on-call should be notified of the situation.

When it has already been decided and documented that a patient **is** for resuscitation, if there is a reaction to a drug or blood transfusion, active treatment should be given and the doctor notified.
Basic CPR can be attempted depending upon the circumstances.

- **Responsibility to enforce the policy:**

  IPU Physician
  IPU Sisters

SECTION – D

DAY HOSPICE GUIDELINES

The principle remains the same.
If the life expectancy is estimated at about a year, the discussion about resuscitation should be conducted by Community Healthcare Professionals before admission or Day Hospice staff on or after admission and documented in the notes.
If there is no documentation, it is reasonable to assume that CPR is inappropriate and it has been discussed or the Healthcare professionals did not feel it appropriate to discuss with the patient.

- **Responsibility to enforce the policy:**

  Day Hospice Managers

SECTION – E

STAFF, VISITORS AND VOLUNTEERS

Basic CPR should be initiated and an Ambulance (999) should be called immediately to transfer the person to hospital. Ambulance control must be notified that the person involved is **not a patient**. An incident report should be completed and passed on to Risk Assessment Group via the line manager.

- **Responsibility to enforce the policy:**

  Director of Nursing

SECTION – F

DECISION AND DOCUMENTATION:

Responsibility to decide:

The responsibility of deciding the suitability of a patient for resuscitation rests with the doctor-in-charge of the patient's care. In the hospital, it is the Consultant, in the Community it is the GP and in the Hospice it is the Hospice doctor.

Senior nursing staff can conduct the discussion with the patient to gather/convey information.

Documentation:

The decision that a patient is suitable for CPR needs to be clearly written in the notes and should be conveyed to the IPU/DH staff.
The decision will be reviewed on a weekly basis and any change will be communicated to the staff, and whenever appropriate, to the patient and family members.

It should also be marked on the board in the case of in-patients.

Differences regarding opinions:

It is not surprising to find differences of opinion between the families or even among the staff. A patient or the family cannot demand CPR if the medical staff have considered this futile. However, it should be explored fully, with a hope of reaching an agreement. Remember, families often feel that CPR is ALWAYS successful.

'For resuscitation' decisions should be discussed in the daily morning staff meetings and the rationale should be conveyed. It should also be handed over in each shift hand-over.

SECTION – G

TRAINING AND PROCEDURE:

The Director of Nursing has the responsibility to ensure that nursing staff have undergone the Basic CPR training. This responsibility can be shared with the IPU Sisters and Day Hospice Managers.

Procedure:

Basic CPR should only be commenced if:

1. The patient 's notes are clearly marked 'For Resuscitation'
   and
   An unexpected Cardio-pulmonary arrest occurs
   and
   The arrest is witnessed (i.e. it is no longer than a minute since the patient was last seen and he/she is still pink)
   and
   Staff trained in basic CPR are present

2. The person who collapsed is staff/visitor/volunteer

Basic CPR:

- Confirm Cardiac arrest
  ABC i.e., Airway, Breathing, Circulation
- Call for assistance and ask someone to dial 999 immediately. (The person making the 999 call must explain that this person is still for resuscitation in a hospice)
- Commence Basic CPR with chest compression and mouth-to-mouth breathing, rate 5:1; if single-handed, 15:2
- Family members should be given support
- Continue Basic CPR till the Ambulance arrives
- If possible, a nurse should accompany the patient to the Accident and Emergency Department of the hospital to hand over to the staff there. If this is not possible, hand over the patient on the telephone along with the information why the patient was for CPR.

SECTION – H

REFERENCES:

1) Decisions relating to Cardiopulmonary resuscitation- A Joint statement from the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing. February 2001
2) Cardiopulmonary resuscitation for people who are terminally ill. National Council for Hospice and Specialist palliative care Services, London 1998
3) CPR Policy for terminally ill patients, East Cheshire Hospice, Macclesfield
4) CPR Policy, Princess Alice Hospice, Esher Surrey

SECTION – I

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