Phyllis Tuckwell Hospice

Resuscitation Policy

Policy Statement

Due to the nature of Hospice work it is anticipated that few patients are likely to be suitable for Cardiopulmonary Resuscitation (CPR)[1], the Hospice therefore operates an opt-in policy. Each patient will be medically assessed when they first attend the Hospice and a decision made as to whether they are likely to be suitable for resuscitation (Appendix 1). The majority of patients will be assessed as being unsuitable for CPR on the grounds of medical futility (i.e. the medical team are 'as certain as they can be' that resuscitation is unlikely to have a positive outcome) and discussion of CPR status/policy with these patients is not mandatory[1]. Patients who are assessed as being suitable for CPR will be given the choice of opting in. This is in line with the joint recommendations by the Resuscitation Council, BMA and RCN[2.]

Patients who choose to opt in will be given basic CPR (should the need arise) while awaiting paramedic transfer to hospital. The resuscitation status of patients who choose to opt in will be reassessed weekly for inpatients, at least 6 weekly for day-care patients and as required for outpatients.

Basic CPR will be provided to staff and visitors while waiting for paramedic response and hospital transfer.

Background

There is much confusion and uncertainty about resuscitation within the field of palliative care. Some hospices initially adopted a blanket no resuscitation policy which is now considered unethical[2]. This policy has been written taking into account recent guidelines[1-3], which comply with the Human Rights Act.

Definitions

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 main forms: basic and advanced.

Basic CPR involves artificial ventilation using either a mask or mouth-to-mouth techniques along with compression of the chest wall to maintain circulation. Basic CPR requires regular training in order not to become deskilled

Advanced CPR involves defibrillation (the delivery of electric shocks to try and stimulate the heart to return to its normal rhythm), intubation (tube placed in the airway) and the use of various drugs given into a vein or major blood vessel. Advanced CPR is a specialist skill requiring regular training and practice.

DNAR: Do Not Attempt Resuscitation

AR: Attempt Resuscitation

Responsibility/Accountability

Responsibility	Title and detail of responsibilities
Accountability	Chief Executive & Nominated Trustee
Legal responsibility	Director of Nursing (Registered Manager) & Medical Director

Scope

This policy applies in all hospice settings, i.e. inpatient, outpatient, and day care. While in the community, the GP is responsible for deciding patients' resuscitation status.

The contents of this policy will be made known to referring agencies: local GPs, District Nurses and Macmillan Nurses. Where possible, patients will receive a copy of the patient information booklet or day care leaflet containing a brief description of the policy prior to admission (Appendix 2). Further information will be available through staff in the form of a leaflet entitled "Decisions about Cardiopulmonary Resuscitation" (Appendix 3).

If a patient has made an advance directive requesting DNAR this will be respected. If they have made an advance directive requesting AR this will be taken into account when they are assessed for suitability for resuscitation.

Monitoring, Review and Compliance

- Policy review three yearly, or more frequently when legislation or guidance requires.
- Yearly audit by the Practice Development Nurse of a random selection of patients' records to ensure adherence with the policy and procedure.
- Annual report to the Board of Trustees and Clinical Governance Committee of audit information.

Staff Training Requirements

- Ongoing training in communication skills and ethical issues regarding care of the dying, for all clinical staff.
- Basic CPR training and updates for all nursing and medical staff on an annual basis.

Compliance with Statutory Requirements

- Private and Voluntary Health Care (England) Regulations 2001 Part IV, Regulation 35[4]
- National Care Standards Core Standard C27[4]
- National Care Standards Hospice Standard H7[4]

Related Hospice Policies/Procedures:

Resuscitation procedure
Consent Policy & Procedure (including Advanced Directives and Incapacity)
Advance Directive Procedure

Policy Creation, Approval and Review

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Created by	Louise Dallain	Practice Development Nurse
Consulted for comments	Clodagh Sowton	Director of Nursing
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	Dr Maggie Guy	Assistant Medical Director
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	Phyllis Tuckwell Hospice Policy Group	A multi-professional group of Hospice staff
Approved by	Kim Archer	Chief Executive
	John Tomlinson	Trustee

Numbering, Approval & Review	
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Review Date	26th August 2006
Individual Responsible for Policy Review	Practice Development Nurse
Individual Responsible for Audit of Policy	Practice Development Nurse

References

1) National Council for Hospice and Specialist Palliative Care Services and Association for Palliative Medicine (1997) Ethical decision-making in palliative care: cardiopulmonary resuscitation for people who are terminally ill, Joint working party between the NCSPCS and the ethics committee of the Association for Palliative Medicine of Great Britain and Ireland, London, August, (http://www.hospice-spc-council.org.uk/)
2) BMA, Resuscitation Council & RCN (2001) Decisions relating to cardiopulmonary resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, London: BMA, March
3) British Medical Association (2000) Withholding or Withdrawing Life-Prolonging Medical Treatment, part 4, 2nd Edition, BMA Books, London
4) Department of Health (2000) National Minimum Standards and Regulations for Independent Health Care, Care Standards Act 2000, London
5) Newman R (2002) Developing guidelines for resuscitation in terminal care, European Journal of Palliative Care, 9 (2), 60-63

Bibliography

BMA (2002) Decisions about Cardiopulmonary Resuscitation, Model Information Leaflet, July

BMA (2003) Cessation of Treatment, Non-Resuscitation, Aiding Suicide and Euthanasia, Do-not-resuscitate orders, London

Costello J & Horne M (2003) Nurses and Health Support Workers Views on Cardiopulmonary Resuscitation in a Hospice Setting, International Journal of Palliative Nursing, Vol 9, No 4, 157-165

Hayward House Macmillan Specialist Palliative Care Cancer Unit (2003) Resuscitation Policy for Inpatients, (draft version, unpublished data) March

Help the Hospices (2002) Resuscitation Policy Guidelines, Health Quality Service Guideline Policy and Procedures, London

Help the Hospices (2002) Resuscitation Procedure Guidelines, Health Quality Service Guideline Policy and Procedures, London

Noble S, Newydd YB, Hargreaves, P & Dinewall A (2001) Successful Cardiopulmonary Resuscitation In A Hospice, Palliative Medicine, 15 (5): 440-1.

Northgate and Prudhoe NHS Trust and St Oswald's Hospice (2003) DNAR (Do Not Attempt Resuscitation Policy) for Northgate and Prudhoe NHS Trust and St Oswald's Hospice, (unpublished data) February

Resuscitation Council (2000) CPR Guidance for Clinical Practice and Training in Hospitals. February

St Oswald's Hospice (2003) Current Learning in Palliative Care (CLIP) Helping Patients With Symptoms Other Than Pain: Issues around resuscitation, 15 January

Thorns A (2003) The Potential Role for Automatic External Defibrillators In Palliative Care Units Palliative Medicine, 17, 465-467

Willard C (2000), Cardiopulmonary Resuscitation for Palliative Care Patients: A discussion of Ethical Issues, Palliative Medicine, 14, 308-312

All references are kept in the Policy and Procedure Supporting Evidence File in the library

Appendix 1

Identification of patients suitable for CPR

CPR is rarely indicated for patients that fulfil the criteria of ongoing specialist palliative care. However multi-professional nursing/medical assessments need to look positively for **patients who may be suitable for CPR**, based on an assessment of the following factors:

- Patients with the following features which have proved to be positive predictors regarding successful resuscitation attempts[5]:
    - Non-cancer diagnoses
    - Cancer patients without metastases or limited metastatic disease
    - Not housebound
    - Good renal function (Creatinine <220)
    - No known infection particularly no chest infection
    - Normotensive
    - Age <70 years
- Availability of further **disease modifying treatment** with a reasonable likelihood of impacting on survival and quality of life.
- **Good estimated prognosis** measured in months rather than days.
- **Good quality of life** pre-cardiopulmonary arrest, as described by the patient.
- **Specific patient life goals** that could justify CPR despite a negligible chance of success.
- Patients expressly **wishing for CPR.**
- Likely **concurrent condition** as a cause of the arrest e.g. iatrogenic cause.

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Appendix 2

Resuscitation section in the Phyllis Tuckwell Hospice Patient Information Booklet and Day Care Leaflet.

Resuscitation

It is very rare for the heart or breathing to suddenly stop unexpectedly. If it were to happen, experience tells us that in people with conditions such as cancer or motor neurone disease, cardiopulmonary resuscitation (CPR) is rarely successful in restarting the heart and breathing. At the Hospice each patient is assessed individually by a doctor, and a decision made as to whether CPR may be beneficial, for the majority of our patients it will not be. This will not affect any other treatment that you are given. If your medical condition is such that the doctor thinks you might respond to CPR they will discuss this with you. If you would like more information, please ask your doctor or nurse. There is also a more detailed leaflet available from staff called 'Decisions about cardiopulmonary resuscitation'.

Basic CPR will be provided for visitors and staff, while waiting for paramedic response and a transfer to hospital.

Appendix 3

Patient Information Leaflet

Decisions about Cardiopulmonary Resuscitation (CPR)

This leaflet provides information about cardiopulmonary resuscitation (CPR) for you and those close to you. If you prefer to discuss CPR rather than read about it, please ask the doctors or nurses caring for you.

1. What is CPR?
A cardiopulmonary arrest is when a person's heart and breathing stop unexpectedly. This is very rare in people with cancer or motor neurone disease. CPR is an emergency treatment given to try and restart the heart and breathing. Basic CPR involves inflating the lungs by 'mouth-to-mouth' breathing and repeatedly pushing down firmly on the chest. Advanced CPR involves inflating the lungs through a tube inserted into the windpipe and using electric shocks and drugs to try and restart the heart. Nursing & Medical Staff and first aiders at Phyllis Tuckwell Hospice can provide 'basic' CPR until an ambulance arrives.

2. How is the decision made about whether or not to provide CPR?
When you first attend the Hospice, the doctors assess how appropriate CPR might be for you. It is most appropriate to provide CPR when the cause of a cardiopulmonary arrest is potentially reversible or treatable, e.g. a heart attack, and there is a reasonable chance of success. Unfortunately, people with cancer or motor neurone disease generally do not have reversible or treatable causes and CPR rarely succeeds. CPR is therefore *not* appropriate for the vast majority of people attending Phyllis Tuckwell Hospice. This decision is not routinely discussed with you unless you wish us to do so. If the doctors think that CPR could potentially be appropriate for you, they will discuss this with you and seek your opinion as to whether or not you wish to receive CPR. This will require you to consider:

- That contrary to what is shown in the media, the success rate for CPR is very low.
- Even when successful, CPR is associated with a short survival.
- The 'side effects' of CPR, e.g. bruised or fractured ribs, requiring artificial ventilation in an intensive care unit, brain damage.
- Successful CPR is more likely in a hospital than the Hospice because access to experienced staff and equipment is quicker
- Attempting CPR at the Hospice would necessitate emergency transfer to a hospital, as we do not have the facilities to monitor and treat patients who have had a cardiopulmonary arrest.

If you are too ill to make a decision, the doctors and nurses will make the decision for you. Those close to you can be involved in the discussion but can't make up your mind for you.
No one can insist on CPR if the doctors assess it as unlikely to succeed.

3. Will I be denied other treatments if CPR isn't appropriate for me or I decide not to have it?
No. You can still receive all treatments that may benefit you, such as antibiotics for a chest infection or radiotherapy to alleviate pain.

4. Can I change my mind?
If CPR is appropriate for you, then you can change your mind whether or not to receive it:

I no longer wish to have CPR – your wishes would be respected and you would not be given a treatment against your will.
I now wish to have CPR – this is an option as long as the doctors assess that CPR is still appropriate for you.

5. Will the decision about CPR be reviewed?
The doctors will review decisions about CPR regularly. If you have opted to receive CPR and it becomes inappropriate, e.g. due to your condition changing, this will be discussed with you.

6. Who else can I talk to about CPR?

- The Hospice chaplain and counsellors
- Your GP
- Your Hospital Consultant
- District Nurse

If you feel that you have not had the chance to have a proper discussion with the healthcare team, or you are not happy with the discussions you have had, please contact the Medical Director, Dr Morris at Phyllis Tuckwell Hospice to discuss your suggestions, worries or complaints.