

Resuscitation Procedure

Aim and Scope of Procedure

To provide guidelines and instruction on managing the decisions and process of resuscitation within the Phyllis Tuckwell Hospice.

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

Staff Responsibilities

Person Responsible	Areas of Responsibility
Registered Manager: Director of Nursing	To ensure that all internal procedures regarding the management of resuscitation are adhered to and that these comply with the Resuscitation Council (UK) Guidelines. ¹
Medical Director	To ensure that 'Resuscitation Decision Pathways' (Appendix 1) are completed for every patient and that resuscitation is discussed with those patients who should be given the option to opt in. To ensure that these decisions are clearly documented and reviewed as necessary.
Practice Development Nurse	Determine, implement and review the organisation's policy regarding resuscitation; to ensure that all staff within the organisation understand the actions to be taken given the capabilities and the facilities provided within the organisation; to lead audit regarding this policy and procedure.
Nurse Manager	Responsible for organising CPR training on an annual basis and for maintaining resuscitation equipment and ensuring its availability.
Medical & Nursing Staff & First Aiders	To follow all internal policies and procedures regarding resuscitation; to complete all necessary documentation; and to work within limits of own clinical competence and seek advice where appropriate. To attend CPR updates on an annual basis.

Method

1.1 Discussion of CPR status with patients

Discussion of CPR status with patients is not mandatory where CPR would be considered futile² (futility being that the medical team are 'as certain as they can be' that resuscitation is unlikely to have a positive outcome). Discussions around CPR are essential in cases where CPR would appear appropriate (as detailed in Appendix 2).

Patients will only be given the option to opt in for CPR when an overall benefit to the patient can reasonably be predicted (Appendix 3) following a full patient assessment, and discussion with other members of the medical team. The patient should be given enough information to make a fully informed decision (see Appendix 2).

1.2 Documentation/maintenance of CPR status:

All patients will be assessed when they first attend the Hospice (in-patient, out-patient or day-care) and a decision made with regards to their resuscitation status using the DNAR pathway (Appendix 1) which will be kept at the front of the patients' notes. Patients for whom resuscitation may be appropriate will be given the choice. The decision formed, and the reasons behind it will be clearly documented by the medical team. 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.

1.3 Irresolvable differences of opinion regarding CPR status

The final clinical decision on the CPR status of a patient lies with the medical director (or their designated proxy). Patients or relatives cannot demand CPR in situations that are considered medically futile. However such requests need to be explored fully, with the hope of reaching agreement. If agreement cannot be reached, the patient should be offered transfer to an alternative place of care if possible.

1.4 Arrest prior to establishing CPR status

If a patient arrests prior to their suitability for CPR being assessed, this assessment should be carried out immediately and a decision made as to whether it is appropriate to commence CPR. This assessment should be made by one of the medical team, in the event that they are not available it will be carried out by one of the nursing team. It is unethical to have a default policy whereby patients who have not been previously assessed automatically do not receive CPR³.

1.5 CPR should only be initiated when all the following criteria are met:

- A Resuscitation Decision Pathway has been completed stating AR (Attempt Resuscitation). If this form has not been completed a rapid assessment should be carried out as above.
- An **unexpected cardiopulmonary arrest occurs**, i.e. a sudden collapse.
- The **patient is not in a gradual terminal decline** with a prognosis of hours or days.
- The arrest is **witnessed** and staff trained in resuscitation are at hand.

1.6 Procedure following a cardiopulmonary arrest in a situation requiring CPR:

- a) Confirm a cardiac arrest following a collapse and recognise the need for assistance.
- b) Confirm that the person is either:
 - A patient who is "for resuscitation"
 - A member of staff or a visitor
- c) Dial 999 immediately and commence basic CPR⁴ until specialist help arrives.
- d) Offer family members/carers present at the time the opportunity to leave or remain at the scene as they wish.
- e) Inform reception to direct ambulance crew.
- f) The responsibility for ongoing resuscitation is passed to paramedic ambulance staff on arrival.
- g) If paramedic help does not arrive within 15 minutes to provide electrical defibrillation, the value of continuing basic CPR should be re-evaluated then by a doctor, and at every subsequent 5 minutes of delay. If the doctor is unavailable CPR should continue until the paramedics arrive.

1.7 Clinical Records are to be used to record:

- The initial assessment of the patient including the decision made regarding resuscitation, the patient and/or carers view of this (if discussed with them) and the agreement of the medical team (if the patient is considered suitable for resuscitation).
- Advance directives.
- Any discussions with carers or external health care professionals regarding resuscitation and actions to be taken in line with these discussions.
- Re-assessments of resuscitation decisions.
- All decisions taken on the patient's behalf and the justification for these.
- The event and outcome of any CPR incidences.

1.8 Internal Management Systems

- There is an on call system for senior medical and nursing staff who can be contacted to discuss issues regarding resuscitation.
- Complex resuscitation issues can be discussed at: an appropriate clinical meeting; journal club; or case review following difficult situations.

Monitoring, Review and Compliance

- Procedure 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.

Related Policy

Resuscitation Policy
Consent Policy and Procedure
Advance Directive Procedure

Procedure Creation, Approval and Review

	Name	Job Title
Created by	Louise Dallain	Practice Development Nurse
Consulted for comments	Clodagh Sowton	Director of Nursing
	Dr Carey Morris	Medical Director
	Rebecca Callanan	Nurse Manager
	John Tomlinson	Trustee
	Jane Watts	Ward Sister
	Sally Hall	Ward Sister
	Laura Myers	Ward Sister
	Sue Lattey	Daycare Sister
	Dr Maggie Guy	Assistant Medical Director
	Dr Cathy Dent	Staff Grade Doctor
	Dr Teresa Merino	Staff Grade Doctor
	Dr Angela Curran	Staff Grade Doctor
	Phyllis Tuckwell Hospice Policy Group	A multi-professional group of Hospice staff
Approved by	Dr Carey Morris	Medical Director
	Clodagh Sowton	Director of Nursing

Numbering, Approval & Review	
Procedure and Version Number	Clinical#4B/ Version:1
Approval Date	26 th August 2003
Review Date	26 th August 2006
Individual Responsible for Procedure Review	Practice Development Nurse
Individual Responsible for Audit of Procedure	Practice Development Nurse

References

- 1) 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
- 2) 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/>)
- 3) 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
- 4) Resuscitation Council (UK) (2000) Basic Life Support, Resuscitation Guidelines, London
- 5) Newman R (2002) Developing guidelines for resuscitation in terminal care, European Journal of Palliative Care, 9 (2), 60-63

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British Medical Association (2000) Withholding or Withdrawing life-prolonging medical treatment, part 4, 2nd Edition, BMA Books, London

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

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

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

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

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

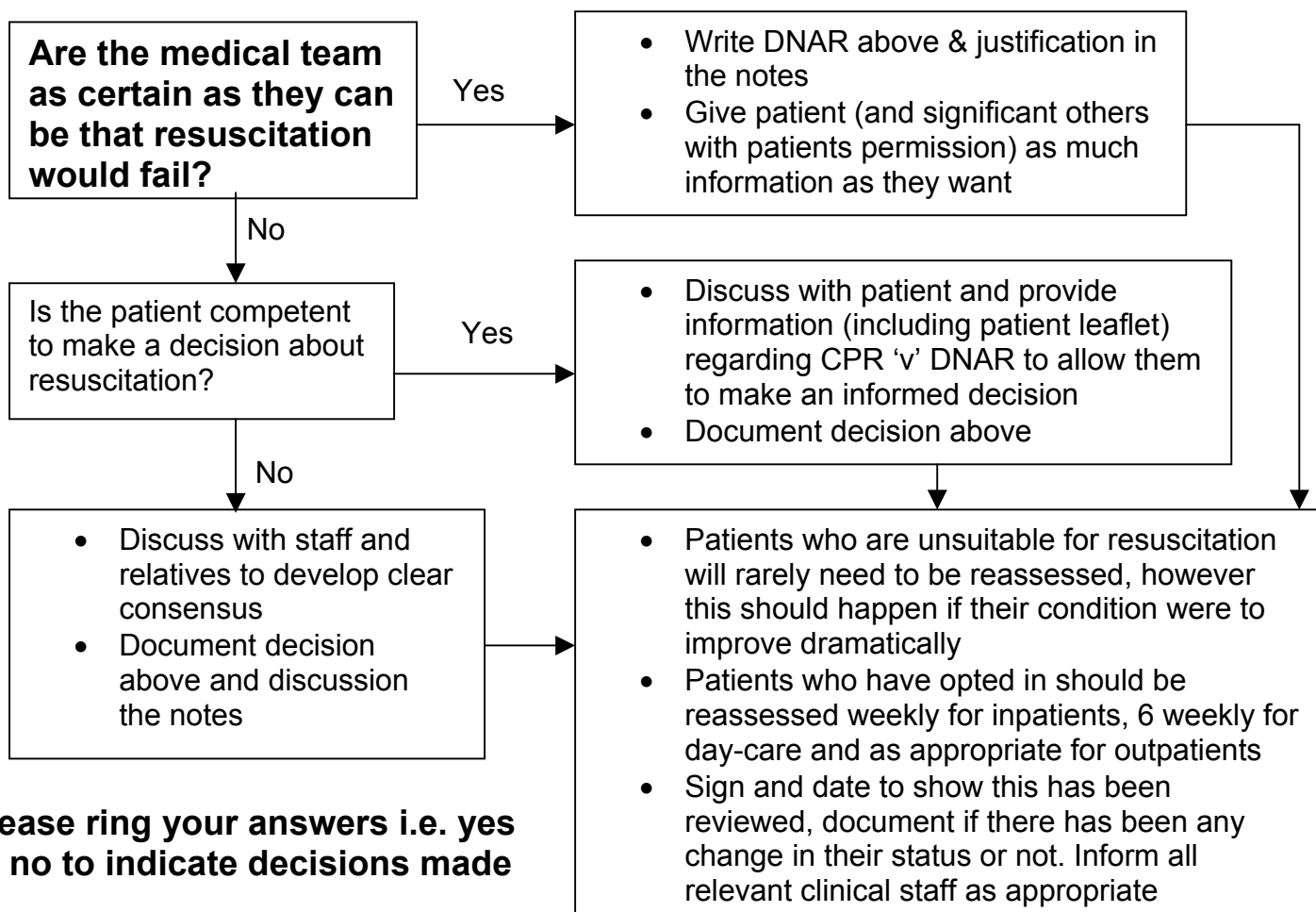
Phyllis Tuckwell Hospice
Resuscitation Decision Pathway

Name Hospice no.....

D.O.B Date of assessment.....

Dr completing form (print name & signature).....

Resuscitation Instructions

DNAR= Do not attempt resuscitation
AR= Attempt resuscitation

Please ring your answers i.e. yes or no to indicate decisions made

Resuscitation status reviewed

Date review due by	Date of review	Dr carrying out review (print name)	Signature of Dr carrying out review	Outcome of review

Appendix 2

Discussion of CPR status/policy with patients

Open sensitive communication is a core component of the palliative care approach covering many potentially distressing end-of-life decisions that includes CPR. Professional judgement is required in determining whether to embark on discussions of CPR with an individual patient. Several key factors must be considered.

- Patients deemed **medically suitable** for CPR **must always** be involved in open discussions regarding the necessary interventions, likelihood of limited success, and subsequent predicted quality of life to ensure informed consent before their notes are marked as opting in “for CPR”.
- Patients deemed **not suitable** for CPR **on grounds of quality of life** (e.g. non-cancer patients) must always be involved in open discussions regarding their resuscitation status to check and incorporate their perspective of quality of life.
- Patients deemed not medically suitable for CPR do not have to be included in making this decision. However they can be involved in open discussions regarding the process that led to this decision. Such patients have the right to be informed, require assurances that they will receive all appropriate treatment, and it may be helpful to get a degree of acceptance and understanding regarding their DNAR status.
- Neither patients nor relatives can demand treatment which the health care team judges to be inappropriate¹.

Key points to include in discussing CPR with patients:

- The patient's current understanding of CPR needs to be explored.
- The low chances of successful resuscitation for any patient arresting outside of hospital. Patients/families mistakenly think CPR is “always” successful.
- The two most significant negative predictors of survival following cardiac arrest are poor performance status and advanced/metastatic cancer⁵.
- The need for transfer by 999 paramedic ambulance to an acute hospital for ongoing (advanced) resuscitation as the hospice has limited facilities.
- The possible physical and mental burden to the patient and their loved-ones from failed attempts at resuscitation, including pain and loss of dignity.
- The risks that even if cardiopulmonary function is restored, they may be severely disabled and may never regain consciousness.
- Reassurance that a decision not to pursue resuscitation would not jeopardise the patient's right to all other active treatments (as appropriate).
- The patient retains the right to change their mind, if so it is their responsibility to notify medical and/or nursing staff.
- As a patient's condition declines any decision to pursue CPR will need to be regularly reviewed by hospice staff. The patient must be prepared that the time will come when CPR will cease to be offered on the grounds of medical futility. This decision is a medical duty, and once medical futility is confirmed the patient and those appropriate will be informed that CPR will no longer be offered at the hospice.

Appendix 3

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 attempts⁵:
 - 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 decided 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.