

# KATHARINE HOUSE HOSPICE

## Resuscitation Policy and Procedure for Patients at Katharine House Hospice

Approved by:

Date of approval:

Originator: Medical Director

## POLICY STATEMENT

Katharine House respects “**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 main concerns of this document are that the patient has a central role in the decision-making process and that legislation contained within the EC Convention for the Protection of Human Rights and Fundamental Freedoms is properly observed. It advises that the following steps are taken in order for a cardiopulmonary resuscitation (CPR) policy to satisfy each of the following Articles contained within the Convention:

### 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 goes 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 states 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 says 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 makes the following comment: “It should be borne in mind that some people have a profound abhorrence of being kept alive in

Resuscitation Policy and Procedure for Patients at katharinen House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 1 of 12	Revision No.:	1
		Date of approval:	01/02/07
		Revision due by:	01/02/10

# KATHARINE HOUSE HOSPICE

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 observes 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 advises 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 suggests 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 lie outside the scope of the Convention, the joint statement also makes a number of comments regarding the decision-making process. Translating the guidance to the hospice setting, the hospice Consultant has overall responsibility for CPR decisions but s/he should always be prepared to discuss these with the patient's GP. However, no doctor is required to give treatment contrary to their own clinical judgement. Patients with decision-making capacity have an absolute right to provide advance refusal for CPR, and such refusals must be honoured. They are also perfectly entitled to make an advance request for CPR in the potential event of a cardiopulmonary arrest. In this situation, doctors are advised to try and dissuade them from requesting such a line of action if they consider CPR to have a low likelihood of success but, if the patient persists in requesting CPR, the medical team should honour the wish as far as they feel 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 have no legal right in England to provide consent on their behalf, it is good practice to involve them in decision making processes under such circumstances. Whenever a clinical decision is seriously challenged and agreement cannot be reached, some form of legal review may be necessary.

Resuscitation Policy and Procedure for Patients at katharinen House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 2 of 12	Revision No.:	1
		Date of approval:	01/02/07
		Revision due by:	01/02/10

# KATHARINE HOUSE HOSPICE

In considering the act of CPR in the hospice setting, it is easy to imagine scenarios where Articles Two and Three cannot both be satisfied if the default option on discovering a dead person is to perform CPR. To prevent us being in breach of Article Ten, patients must receive some information about CPR and an opportunity to discuss it further. Whilst the joint statement observes that it is probably unreasonable to perform CPR on a patient in the terminal phase of their illness, to apply a blanket “no resuscitation” policy to all patients in a hospice would be in breach of Article Fourteen. The advice on decision-making sounds ideal so long as there are no significant differences of opinion between any of the key participants in the process, but it could quite obviously fall apart at very many points if such problems exist.

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**”. From herein, this document is referred to as the “supplementary statement”. The supplementary statement considers CPR an appropriate option if all three of the following conditions are met:

- There is a reasonable chance of CPR re-establishing cardiopulmonary function.
- Successful resuscitation would probably result in a quality of life acceptable to the patient.
- 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.

Resuscitation Policy and Procedure for Patients at katharinen House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 3 of 12	Revision No.:1	
		Date of approval:01/02/07	
		Revision due by:01/02/10	

# KATHARINE HOUSE HOSPICE

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

Katharine House Hospice prides itself on a patient-centred approach to the care of terminally-ill patients and it has no wish to act outside the law. The ideas contained within the supplementary statement play a central role our CPR policy as we assume in good faith that to apply them does not put us in breach of the EC Convention in any way. 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), but we accept that it is not lawful to adopt a blanket “do not resuscitate” policy within the building. In fifteen years of operation, 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 fifteen years, we have received just one advance request for CPR and this was dealt with to the satisfaction of the patient in an individualised manner.

We intend to respect the various Articles of the EC Convention in the following ways:

### Article Two: The right to life

This hospice aims to optimise the quality of remaining life in patients with terminal illness. 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, our default option is not to perform CPR at the moment of death, the only exception to this being when the patient has persistently stated a clear wish for CPR *and* the doctor in attendance at the time does not find CPR contrary to their own clinical judgement.

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

There is such a high risk of serious injury and/or a death when CPR is attempted on a patient with a terminal illness that we believe such an activity could easily be described as deliberate ill-treatment in which the patient has severe indignities inflicted upon them. If CPR is attempted on any patient in the hospice, then every effort must be made to ensure that the energy expended in cardiac compressions is not excessive and that the activity is undertaken in such a way that it cannot be considered inhuman or degrading for the patient, the family, other nearby patients or hospice staff.

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

Whilst family members have no legal right in England to consent to treatment on behalf of a patient who lacks decision-making capacity, it is our practice to give them the level of involvement in all clinical affairs that the patients themselves have indicated to be appropriate. 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 supplementary statement and agree whole-heartedly that forcing a discussion with all our patients about a treatment that is likely to be futile for the vast majority of them is distressing for all involved. We also believe that it would be a clear breach of Article Three of the Convention to act in this way. We will therefore have a small entry in our patient literature, explaining that it is not our practice to routinely offer CPR but

Resuscitation Policy and Procedure for Patients at katharine House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 4 of 12	Revision No.:	1
		Date of approval:	01/02/07
		Revision due by:	01/02/10

# KATHARINE HOUSE HOSPICE

that anyone is welcome to discuss this with a member of the medical team if they are concerned about it. (To put it in context, this scenario has arisen just once in fifteen years and was resolved in a manner that satisfied the patient).

## 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 having a “default” CPR decision is not contrary to the Convention. Furthermore, it is evident from the same joint statement that a “default” option of *performing* CPR is *not appropriate* for patients who are terminally ill. Therefore we believe that our stance of having a default “do not resuscitate” decision is valid and not in breach of the convention so long as we remain happy to carefully explore CPR decisions on an individual basis whenever we are asked to do so. If and when such a situation arises, we will always do our best to formulate a plan that meets the satisfaction of the patient.

## 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
3. 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).

Resuscitation Policy and Procedure for Patients at katharien House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 5 of 12	Revision No.:	1
		Date of approval:	01/02/07
		Revision due by:	01/02/10

# KATHARINE HOUSE HOSPICE

## Related Hospice Policies/Procedures

- Katharine House Hospice Philosophy
- Procedure for Patients Unable to Give Valid Consent to Treatment
- Advance Directive Procedure.

## Responsibility/Accountability

Ultimate responsibility: The Director of Nursing is responsible for ensuring that there is an effective policy in place and that staff are aware of it and adhere to it.

First Line Management Responsibility: The Medical Director has full responsibility for any CPR decisions relating to individual patients and must be personally involved in any CPR decisions that deviate from our default approach.

All Clinical Staff: Are responsible for the delivery of sensitive individualised holistic care determined through multi-disciplinary team working, which includes decisions and discussions about resuscitation. They are also entitled not to act in a manner that is inconsistent with their own clinical judgement.

## Policy Monitoring & Review

This policy will be reviewed every year or sooner if legislation, guidance or case review requires it. At the time of review any changes to this policy should be shared with external referring colleagues in the Community and Hospital.

## Compliance with Statutory Requirements

- The EC Convention for the Protection of Human Rights and Fundamental Freedoms.
- Private and Voluntary Health Care (England) Regulations 2001 Part IV Regulation 35
- National Care Standards Core Standard C27
- National Care Standards Hospice Standard H7

Resuscitation Policy and Procedure for Patients at katharine House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 6 of 12	Revision No.:1	
		Date of approval:01/02/07	
		Revision due by:01/02/10	

# KATHARINE HOUSE HOSPICE

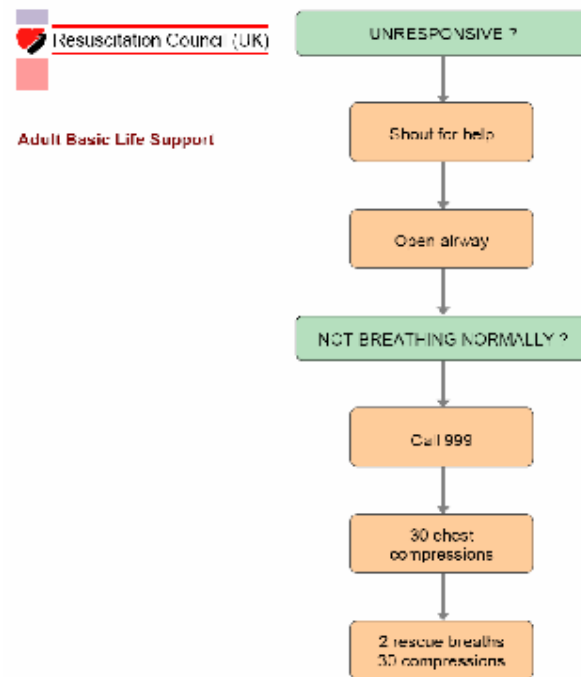
## Procedure

- The following paragraph will feature in the patient information literature:  
“Katharine House provides a full range of palliative care services for patients attending the hospice. This includes the appropriate use of blood transfusions, antibiotics and other treatments that have a proven role in symptom management. Since opening in 1992, we have never had to perform cardiopulmonary resuscitation on a single patient. Therefore we do not store and maintain a cardiac defibrillator on the site. We do not believe this will compromise your care in any way, but if you are at all concerned about this then you are welcome to discuss it with a member of the medical team”.
- The Trustees do not presently require clinical staff to routinely ask patients what their wishes are regarding cardiopulmonary resuscitation. However, if a patient or family member wishes to discuss or explore this area, then the Trustees do require clinical staff to assist with this. There must be a very low threshold for referring the patient on to a member of the medical team. Any discussion about cardiopulmonary resuscitation must be clearly documented in the clinical notes and must include a summary of the exact concerns raised and the responses given.
- Any decision about cardiopulmonary resuscitation that deviates from our default position must *always* involve the Medical Director. The Medical Director will, as a matter of routine, involve the Senior Ward Nurse and/or Day Centre Co-ordinator as appropriate in addition to any other people required to make a satisfactory collective opinion for the individual patient in question.
- Any CPR decision that deviates from our default position must be clearly and unambiguously documented in the medical and nursing notes. A bright orange sheet summarising the nature of the CPR decision will be put at the very front of the medical notes, on top of any other sheet of paper in the folder. The decision must also be shared amongst the whole multidisciplinary team at the appropriate multidisciplinary team meetings. It is hoped that the need for legal review can always be avoided, but the hospice is aware that this may be necessary in very complex cases.
- Every patient who requests CPR in the event of a cardiac arrest should also be offered the possibility of admission to an acute hospital in preference to the hospice. This potentially offers real-time cardiac monitoring, a prompt CPR service provided by experienced staff that are equipped with a defibrillator and other important equipment, and intensive care facilities should the patient survive a CPR attempt. Specialist Palliative Care advice is still available in this setting, from the relevant Hospital Palliative Care Support Team.
- If the patient elects to be admitted to the hospice in preference to an acute hospital, the patient should be advised that we will do our very best to honour the request for CPR if it becomes clinically indicated subject to the limitations described in the policy above. However, no disciplinary action will be taken by the hospice against any staff member who refuses to perform CPR in the event of a cardiac arrest if such an action is contrary to their own clinical judgement at the moment CPR might be deemed to be required. If cardiopulmonary resuscitation is considered appropriate then it will be administered in accordance with the “Adult Basic Life Support” algorithm of the Resuscitation Council (UK) until such time as an ambulance arrives to take the patient to the nearest casualty department.
- Whenever CPR is attempted in the hospice and proves to be successful, the patient must be transported by emergency ambulance for appropriate follow up treatment at hospital.

Resuscitation Policy and Procedure for Patients at katharinen House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 7 of 12	Revision No.:1	
		Date of approval:01/02/07	
		Revision due by:01/02/10	

# KATHARINE HOUSE HOSPICE

- Any CPR activities must be documented accurately in the patient's clinical notes and the details of the circumstances of death must also be documented carefully.
- 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 an ambulance arrives to take the patient to the nearest casualty department.



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

Resuscitation Policy and Procedure for Patients at Katharine House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 8 of 12	Revision No.: 1	
		Date of approval: 01/02/07	
		Revision due by: 01/02/10	



# KATHARINE HOUSE HOSPICE

## Appendix One: A 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<sup>1 2 3 4 5</sup>. It has been demonstrated beyond doubt that, when predicting the likelihood of survival following cardiopulmonary resuscitation, the deliberations of doctors are no better than blind guesses<sup>6</sup>.

Cardiopulmonary resuscitation is a brutal act with 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<sup>7 8</sup>. Other serious complications include:

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

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

Analysis of hospital data has confirmed that the likelihood of successful cardiopulmonary resuscitation varies between different disease groups<sup>31 32 33</sup>. 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<sup>34</sup>. 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<sup>35</sup>. It is generally accepted that patients in the hospice almost never survive cardiopulmonary resuscitation<sup>36</sup>.

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<sup>37</sup>. 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<sup>38</sup>.

There is evidence that the presence or absence of “do not resuscitate” instructions in medical notes do not influence what happens at the moment of natural death. In one study, only 39%

Resuscitation Policy and Procedure for Patients at katharinen House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 9 of 12	Revision No.:	1
		Date of approval:	01/02/07
		Revision due by:	01/02/10

# KATHARINE HOUSE HOSPICE

of 171 consecutive patients who did not receive cardiopulmonary resuscitation had written instructions not to resuscitate in their notes<sup>39</sup>.

Bearing in mind that:

- Hospice patients with advanced cancer almost always die of exhaustion and that death from cardiac arrest is likely to be exceedingly rare.
- There has not been a single recognised cardiac arrest in the first 15 years of patient care at Katharine House Hospice and therefore the staff has had no need or opportunity to maintain skills in the art of cardiopulmonary resuscitation.
- In the unlikely situation of a patient with advanced cancer having a cardiac arrest in the hospice, the event has a high chance of being unwitnessed and the likelihood of successful resuscitation is vanishingly small.
- Successful cardiopulmonary resuscitation almost always results in very serious injury to the patient.
- Palliative care professionals cherish and affirm life but consider death from advanced incurable disease to be a natural process

it is the policy of this hospice to adopt a default position of “no cardiopulmonary resuscitation” for our patients, although we are keen to point out that a default position is not the same as a “blanket decision”. As evidence of the fact that we individualise decisions regarding CPR, we would like to point out that:

- We are very happy to discuss CPR issues with any worried parties.
- Occasionally patients attending Katharine House do not have an advanced life – threatening illness. If it is anticipated that there is a fair risk of an acute event requiring cardiopulmonary resuscitation, then one of the medical staff will discuss with the patient the fact that there are limited resources for resuscitation in Katharine House and offer transfer if appropriate.
- Sometimes patients may request to be in a location where they will receive cardiopulmonary resuscitation in the event of a cardiac arrest even after medical staff have suggested that such a measure may not be in their best interests. In such a situation the patient’s choice must be paramount and transfer to hospital arranged at the earliest opportunity.
- Sometimes patients will continue to request CPR in the event of a cardiac arrest whilst receiving inpatient or day centre care at the hospice. As a hospice, we will do our best to honour such requests, subject to the legitimate limitations described in our cardiopulmonary policy and procedure.
- In the event that a patient suffers an acute collapse that is not a cardiac arrest (e.g. anaphylactic reaction) appropriate resuscitative measures will be taken.
- The nursing staff have an annual update in cardiopulmonary resuscitation as a first aid measure and would use this skill while awaiting an ambulance should a member of staff, volunteer or visitor (or indeed a patient who has opted to accept our limited resources) collapse.

Resuscitation Policy and Procedure for Patients at Katharine House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 10 of 12	Revision No.:	1
		Date of approval:	01/02/07
		Revision due by:	01/02/10

# KATHARINE HOUSE HOSPICE

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Resuscitation Policy and Procedure for Patients at katharinen House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 11 of 12	Revision No.:	1
		Date of approval:	01/02/07
		Revision due by:	01/02/10

# KATHARINE HOUSE HOSPICE

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Resuscitation Policy and Procedure for Patients at katharinen House Hospice			
No: Ref: BR/Resuscitation Policy and Procedure	Page 12 of 12	Revision No.:	1
		Date of approval:	01/02/07
		Revision due by:	01/02/10