

# CLiP

15 minute Worksheet



## Planning care in advance

### 8: Issues around resuscitation

Intermediate level

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#### Aim of this worksheet

To review the issues around resuscitation and consider when not to attempt resuscitation

#### How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, and then turn to the Work page overleaf.
- Work any way you want. You can start with the exercises on the Work page using your own knowledge. The answers are on the Information page - this is not cheating since you learn as you find the information. Alternatively you may prefer to start by reading the Information page before moving to the exercises on the Work page.
- This CLiP worksheet should take about 15 minutes to complete, but will take longer if you are working with colleagues or in a group. If anything is unclear, discuss it with a colleague..
- If you think any information is wrong or out of date let us know.
- Take this learning into your workplace using the activity on the back page.

#### Case study

**Bill is a 54 year old man who had surgery for a carcinoma of the colon. He has been deteriorating steadily and is now reaching the end stages of his disease. He has become increasingly disorientated, chesty and sleepy over the past week. The clinical team agree that he is within days of death as a result of his cancer.**

**The doctor on the team feels that Bill is not for resuscitation and is adamant that Bill's wife must be asked for permission not to resuscitate Bill. On this basis the doctor has stopped Bill's antibiotics that were started for his chest.**

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## Principles of making resuscitation decisions (from BMA/RC/RCN Decisions Relating to CPR 2014)

- DNACPR decisions apply only to CPR (ie. cardiac massage and artificial respiration).
- Patient involvement in the decision is the default if they have capacity for this decision. If they do not have capacity it must be made using the MCA best interests process (see CLiP worksheet *Best interests*).
- Where no explicit decision has been made in advance there should be an *initial* presumption in favour of CPR.
- It is for the patient with capacity to weigh the risks and benefits of CPR, not the professional.
- A DNACPR decision does not override clinical judgement at the time of the arrest.
- Communication and the provision of information are essential parts of good quality care.

If an individual with capacity refuses CPR, or an individual lacking capacity has a valid and applicable ADRT or MCA best interests decision refusing CPR, this must be respected.

## Deciding about CPR

*Should all individuals be consented?* Only one group of individuals should be asked to consent to CPR- those in whom an arrest is anticipated *and* CPR could be successful.

*Should all individuals have the opportunity to discuss CPR?* For other individuals, consent is not possible since either a choice does not exist (because they are dying) or an arrest is not anticipated. However, discussion about future care should occur with everyone but must be led with their permission and at their pace.

*Should all patients have a CPR decision?* It is not possible to make decisions in individuals in whom an arrest is not anticipated in the current circumstances. Ask yourself the following: “*If the individual arrested now and could not be resuscitated, could I put the cause of death on the death certificate?*” If the answer is ‘Yes’ you can anticipate an arrest, if the answer is ‘No’ then you cannot anticipate an arrest and cannot make a CPR decision.

## True or false answers:

1. **F** Common sense rules. If it is clear that the circumstances are different to what was anticipated in the original decisions *and* CPR could succeed, then it would be expected to go ahead and carry out CPR.
2. **T** CPR is not an option) and there is no duty on healthcare staff to provide a treatment they are as certain as they can be cannot succeed. Good communication means that the individual (and family if the individual agrees) should be made aware of what is happening, but only if the individual wants to discuss this.
3. **T** Evidence shows that health professionals are notoriously inaccurate when judging a individual's quality of life.
4. **F** If no decision is in place, there is an *initial* presumption in favour of CPR. If it is clear that CPR could never work (eg. massive bleed or already dead) then you are not expected to carry out CPR.
5. **F** If CPR could be successful, Bill agrees to CPR, and he fully understands the potential burdens/benefits of carrying out CPR, then Bill's decision must be respected and doctors must carry out CPR..

## Three groups of individuals

*First group- No reason to believe the individual will arrest.* (Test: could you write a death certificate if they arrested and died now?): CPR should be attempted if an arrest occurs as there is no reason to believe it could not succeed. The only exception is a individual who has lost capacity but when they had capacity they arranged a valid & applicable ADRT refusing CPR. Be willing to discuss CPR if the individual wishes to do so.

*Second group- Those for whom there is no realistic chance that CPR could be successful:* Make a DNACPR decision. Do not offer CPR or ask the individual or family if they want it to be attempted. If the individual has capacity, consider explaining the decision to the individual (or to the family if they lack capacity) using the principles of breaking difficult news (see CLiP worksheet *Breaking difficult news*). There is no allowance in English law for treatment that cannot succeed to be demanded by the individual or family.

*Third group- those for whom an arrest can be anticipated AND in whom CPR might be successful:* you must consent the individual with capacity by informing them of the risks/benefits of CPR and the probability of these outcomes. If they refuse CPR, write a DNACPR and offer the opportunity to complete an ADRT (see CLiP worksheets on ADRT). They can choose CPR, even if the risks and burdens appear to outweigh the benefits. If the individual lacks capacity, use the MCA best interests process (see CLiP worksheet *Best interests*).

## Bill's situations

*Bill's wife makes it clear she does want CPR:* this is about breaking difficult news that CPR is not an option now.

*Bill improves and becomes mentally clear:* Bill can now make decisions for himself. If an arrest is anticipated *and* CPR could be successful, then he must be asked. However if CPR could not work, then a DNACPR decision must be documented and an explanation given to Bill if he wants to discuss this.

*Bill suddenly chokes on some food and stops breathing:* this is unexpected and therefore any previous CPR decisions do not apply. Since clearing his airway and CPR would be likely to succeed, the right action would be to carry out CPR.

# Reflect

Think briefly about the doctor's wish to ask Bill's wife for permission not to offer cardiopulmonary resuscitation. Do you agree, disagree or are you unsure?

# Write

down the exceptions to the two statements below:

## Exceptions

All patients should be consented for CPR	
All patients should have a CPR decision made	

True  
or  
false

- |    |  |      |       |
|----|--|------|-------|
| 1. | A 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision must always be respected                        | True | False |
| 2. | Bill's partner or family should <i>not</i> be asked to make a decision about whether to have CPR                   | True | False |
| 3. | Estimates about a patient's quality of life should <i>not</i> be used when deciding about CPR                      | True | False |
| 4. | If no decision has been made, CPR must always be carried out   | True | False |
| 5. | If the doctors feel that CPR could succeed but the burdens outweigh the benefits, a DNACPR decision should be made | True | False |

# Reflect

Think about what could be done in these situations

Situation	Possible solution(s)
Bill's wife makes it clear she <i>does</i> want resuscitation	
Bill briefly regains capacity but remains very ill	
Bill suddenly chokes on some food and stops breathing	

What do you think about Bill's situation now?

## FURTHER ACTIVITY: Issues around resuscitation

Find out what your resuscitation policy says in your clinical setting.

Does it follow the principles of the 2007 BMA/RC/RCN Joint Statement?

## FURTHER READING: Issues around resuscitation

### Key documentation

*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, 2014.

Mental Capacity Act, Code of Practice. See <http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf>

*Mencap.* Considerations of 'quality of life' in cases of medical decision making for individuals with severe learning disabilities. *Mencap*, 2001

Regnard C, Randall F. A framework for making advance decisions on resuscitation. *Clinical Medicine*, 2005; **5**(4): 354- 60.

Regnard C, Randall F. Head to Head- Should hospices be exempt from following national cardiopulmonary resuscitation guideline? *British Medical Journal*, 2009; **338**: 986.

### Other sources

Ackroyd R, Russon L, Newell R. Views of oncology patients, their relatives and oncologists on cardiopulmonary resuscitation (CPR): questionnaire-based study. *Palliative Medicine*.2007; **21**(2): 139-44.

Deep KS, Griffith CH, Wilson JF. Discussing preferences for cardiopulmonary resuscitation: what do resident physicians and their hospitalized patients think was decided? *Patient Education & Counseling*. 72(1):20-5, 2008

Elwell L. The no-CPR decision: the ideal and the reality. *Journal of Palliative Care* 2000; **16**: 53 – 56.

Horsted TI, Rasmussen LS, Meyhoff CS, Nielsen SL. Long-term prognosis after out-of-hospital cardiac arrest. *Resuscitation*. 2007; **72**(2): 214-8.

Iwami T, Nichol G, Hiraide A, et al. Continuous improvements in "chain of survival" increased survival after out-of-hospital cardiac arrests: a large-scale population-based study. *Circulation* 2009; **119**: 728–34.

Meaney PA, Nadkarni VM, Kern KB, Indik JH, Halperin HR, Berg RA. Rhythms and outcomes of adult in-hospital cardiac arrest. *Crit Care Med* 2010; **38**: 101–8.

Schindler MB, Bohn D, Cox PN, McCrindle BW, Jarvis A, Edmonds J, Barker G. Outcome of out-of-hospital cardiac or respiratory arrest in children. *New England Journal of Medicine*. 1996; **335**(20): 1473-9.

Wiese CH, Bartels UE, Zausig YA, Pfstinger J, Graf BM, Hanekop GG. Prehospital emergency treatment of palliative care patients with cardiac arrest: a retrospective investigation. *Supportive Care in Cancer*. 2010; **18**(10): 1287-92.

Willard C. Cardiopulmonary resuscitation for palliative care patients: a discussion of ethical issues. *Palliative Medicine*, 2000 **14**: 308 – 312.



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- The last hours and days
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