CLiP

15 minute Worksheet

Planning care in advance

9: 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- If you think any information is wrong or out of date let us know.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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INFORMATION PAGE: Issues around resuscitation

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 <u>not</u> 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 <u>AND</u> 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.

DNACPRs forms are changing....

DNCPR forms will eventually be replaced by a single UK ReSPECT form. For more information see www.respectprocess.org.uk and CLiP worksheets 7 and 8 in this module.

WORK PAGE: Issues around resuscitation

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 *not* be asked to make a decision about whether to have CPR	True	False
3.	Estimates about a patient's quality of life should *not* 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 *does* 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

ReSPECT website and resources: www.respectprocess.org.uk
Mental Capacity Act: *https://www.legislation.gov.uk/id/ukpga/2005/9*
MCA Code of Practice: *https://assets.publishing.service.gov.uk/.../Mental-capacity-act-code-of-practice.pdf*
Capacity, care planning and advance care planning in life limiting illness: a guide for health and social care staff. NHS End of Life Care Programme, 2011: http://www.ncpc.org.uk/publication/advance-care-planning-guide-health-and-social-care-staff

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