# Cardiopulmonary Resuscitation Policy

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1. Policy Statement

St Nicholas Hospice Care is an independent charity delivering care, advice and support to people in the final chapters of their life, and their families, within the communities of West Suffolk and Thetford.

The work of the hospice is delivered by specially trained staff, supported by a large team of volunteers.

The organisation includes an Education Department that delivers education to the local community and an Income Generation Department that manages a range of fundraising and retail activities.

This policy is intended to prevent inappropriate, futile or unwanted attempts at Cardiopulmonary Resuscitation (CPR). It does not refer to other aspects of care e.g. analgesics, antibiotics, fluids, suction, treatment of choking, treatment of anaphylaxis, treatment of hypoglycaemia or other interventions which are sometimes loosely referred to as “resuscitation”.

This policy has specific reference to patient care which is delivered in Sylvan Ward and The Orchard Centre and the Burton Centre.

When people other than patients collapse and require basic CPR this will be given by first aiders whilst waiting for paramedic response.

In the community, the GP is responsible for deciding a patient’s resuscitation status.

Definitions & Abbreviations

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 staff training in order that they do not become deskilled.

Advanced CPR involves defibrillation (the delivery of electric shocks to try and stimulate the heart to return to its normal rhythm), intubation (a 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.

AND: Allow a Natural Death

AR: Attempt Resuscitation
DNACPR: do not attempt cardiopulmonary resuscitation

DNAR: Do Not Attempt Resuscitation

EoE: East of England

LPA: Lasting Power of Attorney

SCH: Suffolk Community Health

SNHC: St Nicholas Hospice Care

2. Statutory Compliance and Evidence

- Human Rights Act 1998
- Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. 3rd edition (1st revision) 2016
- Case C1/2013/0045 Tracey v Cambridge University Hospitals NHSFT [2014] EWCA Civ 822

3. Responsibilities and Accountability

3.1 Chief Executive Officer (CEO)

The CEO has ultimate responsibility for implementation of this policy. The CEO will ensure that this policy is approved by the Board of Trustees.

3.2 Directors and Managers

All clinical directors and managers must ensure the implementation of the policy and that procedures are adhered to and staff receive appropriate training.

3.3 Employees

All clinical employees (inclusive of volunteers) must ensure adherence to the policy and are responsible for attending annual training sessions and maintaining their skills and knowledge.

4. Procedures and Implementation

Staff will sensitively discern if it is beneficial to the patient to discuss issues of resuscitation prior to admission to the Sylvan Ward or attendance at The Orchard Centre and Burton Centre. They will support their discussion with the patient information booklet called ‘Decisions about Cardiopulmonary Resuscitation’ supplemented if needed by the EoE Patient Information leaflet (see Appendix). When assessed on Sylvan Ward or The Orchard Centre/Burton Centre the patient’s extent and stage of disease will be considered. See Appendix ‘Identification of patients suitable for CPR (SNHC)’. 
Due to the nature of hospice care, where many patients are dying of advanced disease, few are likely to be suitable 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).

The EoE DNACPR document will be completed by a doctor (see Appendix ‘EoE DNACPR Form’). The 'SNHC Decisions and Discussions on CPR' (see Appendix) guides as to when CPR may be appropriate.

Patients who are assessed as being suitable for CPR will be informed of this, and offered CPR. Their status will be classed as ‘For Resuscitation’. This is in line with the joint recommendations by the Resuscitation Council, BMA and RCN. Patients who choose to be 'For Resuscitation' will be given basic CPR (should the need arise) while awaiting paramedic transfer to hospital.

The resuscitation status of patients who are ‘For Resuscitation’ will be reassessed weekly for inpatients, at least 6 weekly for Orchard Centre/Burton Centre patients.

**Communication with patients or their representative that a DNACPR decision has been made**

Decisions about DNACPR form just part of Advance Care Planning discussions, and this should be the context for communication with a patient regarding a DNACPR decision. Assumptions should not be made about a patient’s wishes: it should be explored in a sensitive way how willing they might be to know about a DNACPR decision. While some patients may want to be told, others may find discussion about interventions that would not be clinically appropriate burdensome and of little or no value. However, information should not be withheld simply because conveying it is difficult or uncomfortable for the healthcare team, nor because it may cause a patient distress. The Court of Appeal has ruled that a discussion should not be held if the distress caused is likely to cause the patient psychological or physical harm. It is good practice to explain the aims of treatment, i.e. comfort, and to discuss preferred care options. Discussions around DNACPR should be clearly documented in the healthcare record and on the DNACPR form, including, if it was decided that the discussion would not be held with the patient, the reasons for this decision.

If it is concluded that the patient does not wish to know about or discuss a DNACPR decision, their agreement to share this with those close to them should be sought. Family/carers of a patient who has capacity should not be involved in resuscitation discussions without the patient’s consent.

A patient’s Advance Decision requesting DNACPR will be respected.

For those where CPR has a realistic chance of success the aim of treatment will be discussed with the patient and their view on resuscitation sought when appropriate, although people have the right to decline to have these discussions. (See Appendix ‘Decisions and Discussion on CPR’.)

A competent patient (or their legally appointed LPA) can:

-...
• Make an advance refusal of CPR
• Accept (consent to) CPR if offered
• Decline to discuss

A patient with mental capacity (or the LPA for a patient without mental capacity) has no legal right to demand CPR if the responsible senior clinician and multi-professional healthcare team judge that it would not be successful.

When a patient lacks capacity for involvement in advance decisions and has no legally appointed LPA, the responsibility for deciding if resuscitation is in the patient’s best interest lies with the lead medical clinician with responsibility for the patient. Family/carers do not have decision-making rights or responsibilities and should be consulted to clarify the patient’s views as part of the best interest process.

**Communication with ambulance staff**
When a DNACPR decision is in place, the EoE DNACPR form remains with the patient, wherever their place of care. For those patients transferred by ambulance to the community or to a hospital for outpatient treatment or investigation, the EoE DNACPR form accompanies the patient and is to be brought to the attention of the ambulance staff.

For sick patients being transported by ambulance to home, or transfer to hospital or nursing home, guidance needs to be given by the hospice medical team. The risk of death in transit, and the wishes as to destination in the event of death will be discussed with the patient and his/her relatives/carers and ambulance staff.

**Communication between doctors or nurses**
Suspension of a DNACPR decision may be appropriate during interventions – e.g. nerve blocks and insertion of drainage tubes. In such situations cross through the DNACPR form and write “suspended” with date and signature. Write a new form when the suspension ends.

Following transfer between healthcare settings, DNACPR decisions documented on the EoE DNACPR form remain valid. The original form should accompany the patient (usually held in their Yellow ‘My Care Wishes’ Folder) If they were not previously aware of the DNACPR form, the existence of the form and the decision recorded will usually need to be brought to the attention of the patient and their carer prior to discharge from Sylvan Ward.

The patient’s GP, district nurse, hospital consultants, care home staff, out of hours medical services, ambulance services and other relevant healthcare professionals across all settings will be informed of the individual’s resuscitation status.

**5. Related policies / guidelines / documentation**

• Consent Policy
• OCG6 Instructions to Ambulance Crew (see below)
• OCG29 Assessment of Capacity Document
• T6 Implantable Cardioverter Defibrillators: The Deactivation of

6. Monitoring and Review
The Consultant in Palliative Medicine is responsible for review, reporting to the Clinical Committee.

7. References / Bibliography
Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. 3rd edition (1st revision) 2016
GMC Treatment and Care Towards the end of life: good practice in decision making 2010
Royal College of Physicians (2009) Advance Care Planning
Case C1/2013/0045 Tracey v Cambridge University Hospitals NSHFT [2014]
EWCA Civ 822

8. Appendices
Appendix 1 Patient Information leaflet
Appendix 2 Identification of patients suitable for CPR (SNHC)
Appendix 3 Decisions and Discussions on CPR (SNHC)
Appendix 4 NHS East of England Integrated DNACPR Policy for Adults
Appendix 5 EoE DNACPR Form
Appendix 6 EoE DNACPR Patient Information Leaflet
Appendix 7 EoE DNACPR Frequently Asked Questions

Appendices are for guidance and may be altered as they do not form part of the policy. All appendices can be found within the St Nicholas Hospice Care shared drive.