Decisions Relating to Cardiopulmonary Resuscitation Policy

Originator: **Consultant in Palliative Medicine**

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Name of Chair: **Sue Hayter**

Approved by: **Board of Trustees**

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Name of Chair: **Charles Simpson**

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1. Introduction and Definitions

The purpose of this policy is to outline how advance decisions are made at St Nicholas Hospice Care regarding whether a patient will or will not receive cardiopulmonary resuscitation.

1.1 Hospice Context

St Nicholas Hospice Care is an independent charity that supports people living with dying, death and grief. The Hospice works mainly with the communities of West Suffolk and Thetford. The Hospice equips people with the knowledge and skills to ensure everyone matters in life and death and provides direct care, support and advice.

The work of the hospice is carried out by paid colleagues supported by a large team of volunteers and includes an Income Generation Department that manages a range of fundraising and retail activities.

1.2 Definitions

Colleagues – include paid staff and volunteers
Paid colleagues – employees, people on rotation or placement, consultants, people on temporary or part time contracts
Volunteers – people who offer time but are not paid / students
Patient – a person receiving care from SNHC
Family / Carers
Parents / Guardians – use when describing the legal responsibility to a child
Supporter – an individual or an organisation who makes a contribution to SNHC

2. Policy Statement

Cardiopulmonary Resuscitation (CPR) is a technique designed to maintain the body's circulation after the heart has stopped, whilst attempting to restore normal heart function. It can be used to save the life of someone who has a sudden medical event which causes the heart to stop (cardiac arrest), which would otherwise be fatal. It is most likely to be successful in those a.) with good health immediately prior to the cardiac arrest, and b.) those who suffer a large myocardial infarction (heart attack). This does not describe the population of patients cared for by St Nicholas Hospice Care; CPR is very unlikely to be successful in the majority of our patients. This policy is therefore intended to prevent inappropriate, futile or unwanted attempts at CPR.

This policy does not refer to other aspects of care e.g. analgesia, 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, The Orchard Centre and the Haverhill Hub.

When people other than patients collapse and require 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.

2.1 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.

DNACPR: do not attempt cardiopulmonary resuscitation

EoE: East of England

LPA: Lasting Power of Attorney

SNHC: St Nicholas Hospice Care

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 Managers

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

3.3 Colleagues

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

3.4 Representatives of the Clinical Committee

This policy was developed by the Medical Consultant. The Clinical Services Director is responsible for the review of the policy prior to approval by the Clinical Committee.

3.5 Other relevant staff

St Nicholas Hospice Care is fully committed to this policy and requires all staff to comply with it. However the policy is not intended to be contractual and may be changed subject to approval by the Board of Trustees and consultation with the staff representative group (staff forum).

4. Procedures and Implementation

CPR is a medical treatment, and as with any medical treatment, if the treating medical team does not think, on the balance of probabilities, that it will be beneficial, then they will not offer this treatment to a patient. If a treatment is offered to a patient deemed to have mental capacity, they may choose whether or not to accept it. The same applies to decisions made in advance about a treatment which may be used in an emergency. This means that if the hospice medical team do not feel CPR would be effective for a particular patient, in the event of a cardiac arrest, they may make a decision in advance that CPR would not be performed. Neither the patient nor the family can demand that CPR be given. If the medical team feel that CPR may be effective, they may offer it to the patient, who can then decide whether they would wish to be "for CPR in the event of cardiac arrest" or "DNACPR" (Do Not Attempt CPR).

The Court of Appeal ruled in 2014 that the patient and/or family (depending on the patient's permission to discuss being given, or their mental capacity status) must be offered the chance to be part of the decision-making process, and the outcome of the decision must be communicated to them. A fear of causing the patient distress should not prevent these conversations from being offered. The only grounds for withholding discussions are if staff feel there is actual risk of psychological or physical harm being caused by discussing CPR status.

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 Haverhill Hub. 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/Haverhill Hub, 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. ReSPECT forms are also in use in neighbouring counties as an alternative place to document CPR status (see Appendix). These forms are not currently initiated in Suffolk, but if initiated elsewhere they are considered to be valid, are recognised by all healthcare staff, and an EoE DNACPR form does not need to be completed in addition.

Patients who are assessed as being suitable for CPR will be informed of this, and offered CPR. If they agree, 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' who then suffer a cardiac arrest will be given basic CPR while awaiting paramedic transfer to hospital.

The resuscitation status of patients who are 'For Resuscitation' will be reassessed weekly for inpatients, and 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, as described above, 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 a 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 only be involved in resuscitation discussions with the patient's consent.

If a patient has made an Advance Decision to Refuse Treatment which requests DNACPR, this is a legally-binding document, and 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, though they 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 or ReSPECT 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 or ReSPECT form accompanies the patient and is to be brought to the attention of the ambulance staff.

For patients who are potentially close to death who are 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, if the procedure puts the patient at risk of a reversible cardiac arrest. 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 or ReSPECT form remain valid. The original form should accompany the patient (usually held in 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 St Nicholas Hospice Policies / Guidelines

- Consent Policy
- OCG6 Patient Transport guideline
- OCG44 Assessment of Capacity and Best Interests guideline
- T6 The Deactivation of Implantable Cardioverter Defibrillators guideline

6. Monitoring and Review

The Consultant in Palliative Medicine is responsible for review of this policy on a three-yearly basis, or when changes to relevant national guidelines or legislation are made, reporting to the Clinical Committee.

7. Statutory Compliance and Evidence Referenced

- 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 C1/2013/0045Tracey v Cambridge University Hospitals NSHFT [2014] EWCA Civ 822
  GMC Treatment and care towards the end of life: good practice in decision making, 2010

8. Appendices

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 within the headings of Clinical / Human Resources / Organisational

S:Organisational/ Policies – current/ CURRENT policies / CLINICAL

If you have problems accessing appendices please speak to your line manager or speak to the PA's office

Appendix 1 Patient Information leaflet "Decisions about CPR" (SNHC)
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
Appendix 8 Sample ReSPECT form