### Planning care in advance

9: Issues around resuscitation

<table>
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<tr>
<th>Produced by</th>
<th>Aim of this worksheet</th>
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<tbody>
<tr>
<td>St. Oswald’s Hospice</td>
<td>To review the issues around resuscitation and consider when not to attempt resuscitation</td>
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<tr>
<td>Regent Avenue, Gosforth, Newcastle-upon-Tyne, NE3 1EE</td>
<td>How to use this worksheet</td>
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<tr>
<td>Tel: 0191 285 0063, Fax: 0191 284 8004</td>
<td>• You can work through this worksheet by yourself, or with a tutor.</td>
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<tr>
<td>This version written and edited by:</td>
<td>• Read the case study below, and then turn to the Work page overleaf.</td>
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<tr>
<td>Claud Regnard, Honorary consultant in Palliative Care Medicine at St. Oswald’s Hospice</td>
<td>• 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.</td>
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<tr>
<td>Paul McNamara, Consultant in Palliative Medicine, St. Oswald’s Hospice and Northumbria Hospitals Trust</td>
<td>• 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.</td>
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<tr>
<td>Madeline Bass, Day Therapies Manager &amp; Clinical Lead, St. Nicholas’ Hospice, Bury</td>
<td>• If you think any information is wrong or out of date let us know.</td>
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<td>• Take this learning into your workplace using the activity on the back page.</td>
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#### 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.
INFORMATION PAGE: Issues around resuscitation

Principles of making resuscitation decisions (from BMA/RC/RCN Decisions Relating to CPR 2014)
- DNA CPR 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 DNA CPR 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 an 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.

DNA CPRs forms are changing....
DNA CPR 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.
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:

<table>
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<th>Exceptions</th>
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<tr>
<td>All patients should be consented for CPR</td>
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<tr>
<td>All patients should have a CPR decision made</td>
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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

Think about what could be done in these situations

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

References

Available online on www.clip.org.uk