Cardiopulmonary resuscitation is a potentially life saving, but invasive and traumatic, medical intervention to restart the heart and breathing in a person in cardiac and/or respiratory arrest. Average survival rates from hospital to discharge after CPR range from 5-20%, although individual chances of survival after CPR can range from zero to nearly 100% depending on the cause and the circumstances of the arrest (British Medical Association et al, 2014).

CPR usually involves chest compressions, attempted defibrillation, injection of drugs and ventilation of the lungs. It is commonly followed by prolonged treatment in an intensive care unit, which often includes artificial ventilation. As well as the risk of broken bones and internal injuries arising from the procedure itself, the person may be left with brain damage and resulting disability, especially if CPR is delayed.

For a person in cardiorespiratory arrest for whom no advance decision regarding the implementation of CPR has been recorded, CPR is performed unless staff are as sure as they can be that the procedure will not be successful.

Updated guidance, Decisions Relating to Cardiopulmonary Resuscitation, by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (BMA et al, 2014) states that making advanced decisions on CPR for people who are nearing the end of life or at risk of cardiorespiratory arrest should be part of good clinical practice. This avoids leaving people in the "default" position of receiving invasive and traumatic treatment that they may not want or from which they may not benefit. The guidance states that every advance CPR decision should be made on a patient-specific basis, based on the person's circumstances at that time, to assess whether the benefit of attempting CPR will outweigh the risks and burdens of treatment.

Nurses and other health professionals should include patients and/or people who are close to them in the decision regarding whether CPR should be attempted. These discussions should be conducted in a timely and sensitive way, and the issues carefully explained so patients have effective communication and documentation is vital to ensure CPR decisions are well made and clearly understood.

Keywords: End-of-life care/Resuscitation/Communication

In this article...

- Who should make advance decisions on cardiopulmonary resuscitation
- What to consider when deciding whether CPR should be undertaken
- How best to discuss the decision-making process with patients and families

5 key points

1. Making advance decisions about cardiopulmonary resuscitation for people nearing the end of life or at risk of cardiorespiratory arrest is good clinical practice
2. Decisions should be based on individual circumstances to assess whether the benefits outweigh the risks
3. Staff should ensure patients and/or those close to them are part of the decision-making process
4. Discussions are best carried out by trained practitioners who know the patient
5. Effective communication and documentation is vital to ensure CPR decisions are well made and clearly understood
Making advance CPR decisions

Advance CPR decisions are needed only for patients who are approaching the end of life and/or at risk of cardiorespiratory arrest; they are not needed for patients for whom cardiorespiratory arrest is not predicted or reasonably foreseen. Responsibility for an advance CPR decision rests with the most senior health professional caring for a patient, who could be a consultant, a GP or a senior or specialist nurse. Where possible, agreement should be reached with the entire multidisciplinary team.

CPR decisions should always be made on an individual basis; they should not be based on blanket policies. Where there is no possibility of CPR being successful, it should not be offered or attempted. However, if CPR could be successful in restarting a person’s heart and breathing for a sustained period, the benefits of prolonging life must be balanced against the potential harms and burdens of the procedure (Box 1).

When making CPR decisions there should be “open dialogue and shared decision-making between the patient and health professionals wherever possible” (BMA et al, 2014). CPR decisions must be free from discrimination – for example, in respect of a disability – and must be guided by the future quality of life that is acceptable to each individual.

Staff should ensure that regular reviews of CPR decisions are undertaken. A review may be triggered by:

» A request from the patient or those close to them;
» A significant change in the patient’s clinical condition or prognosis;
» The patient being moved to a different location, including within a healthcare establishment.

Consulting with patients

CPR decisions should be discussed well in advance, when patients are fit enough and also have time to consult with people and consider the options fully. For many patients, this is best done as part of a broader consideration of the type of care or treatments a person would wish to receive should their health deteriorate and they are unable to decide for themselves. This is often best done by health professionals who know the patient well and should be conducted in the patient’s home or usual care environment.

Where CPR has no realistic chance of success, staff should consider carefully whether to tell the patient of a Do Not Attempt CPR (DNACPR) decision. In most cases, people should be informed, but there are exceptions, such as patients who know they are close to the end of their life who may be so distressed by the information that it harms them.

If CPR could be successful, staff should help the patient to make an informed decision about whether they would wish to receive CPR, unless the patient lacks capacity to make their own decisions, declines any such discussion or there is evidence that such a conversation might be harmful to the patient. Staff should offer as much information as is wanted and make sure they clarify the patient’s wishes on CPR, taking care not to be guided by their own or others’ views on what is best for the person.

Agreement must be sought from any patient with capacity before sharing information with others, including family and
friends. It can also be helpful to ask people who they want or do not want to be involved in the decision-making process should they become incapacitated. Where a patient with capacity requests confidentiality, their wishes must be respected and explained to loved ones, even if it makes discussing the patient’s care difficult. The same duty of confidentiality applies to children and young people, although staff should make every “reasonable effort” to persuade children who are reluctant to involve their parents to do so (BMA et al, 2014). Where patients lack capacity, staff should ask those close to them about the their wishes, feelings, beliefs and values, unless they have already expressed a wish for confidentiality. Staff should explain to patients and their loved ones that the role of friends and family is not to take decisions on behalf of the patient, but to help the healthcare team make a CPR decision that is in the patient’s best interests.

If a patient or their loved ones disagrees with a DNACPR decision, they should be offered a second opinion, but this may be avoided if the decision is endorsed by all members of a multidisciplinary team.

Patients who refuse CPR should not be pressurised into treatment they do not wish to have and, if a patient lacking capacity has a valid and applicable advance decision referring treatment (ADRT) specifically refusing CPR, this must be respected. If a patient wishes CPR to be attempted, and it has a reasonable chance of success, the patient’s wishes should be respected, even if medical opinion is that the harm may outweigh the benefits. Staff should ensure that patients are given a realistic assessment of the quality of life that they might reasonably expect and that this is acceptable to them.

Communicating effectively
Nurses and other health professionals should ensure “clear, accurate and honest communication” (BMA et al, 2014) with the patient and/or those close to the patient. The guidance acknowledges that these conversations can be difficult, stating they should be conducted by staff who have expertise and undertaken training.

Staff should offer people clear verbal and written information and check their understanding of what has been explained to them. Information should be given on:

- CPR;
- The local resuscitation policy and services;
- People’s role in decision-making to decide whether the benefits of CPR are likely to outweigh the harms and burdens, and whether the level of recovery is acceptable to the patient. However, “information and discussion should not be forced on unwilling patients” (BMA et al, 2014). If people do not wish to discuss CPR, staff should respect this and document it.

Recording and communicating decisions
All CPR decisions should be communicated to other health professionals in primary and secondary care, including ambulance clinicians and residential care home staff. Staff must ensure clear and full documentation of CPR decisions, the reasons for them and the discussions that informed those decisions. This often requires more detail being entered in the health record than on the CPR decision form. Recorded decisions about CPR should be kept up to date and accompany a patient when they move from one setting to another.

If a trust has separate nursing records, the senior nurse is responsible for ensuring that:

- Every CPR decision is recorded in the nursing records;
- Records are kept up to date;
- All those nursing the patient are aware of the current decision.

It should be made clear to health professionals, patients and those close to them that a DNACPR decision does not apply to any other part of the patient’s care or treatment and must not compromise any other aspect of care.

Acting on advance CPR decisions
A CPR decision form is not legally binding but should guide clinical decision making if a person goes into cardiorespiratory arrest. The final decision about whether to attempt CPR rests with the health professionals responsible for the patient’s immediate care who, in particular circumstances that must always be justified, may sometimes make a different decision from the one on the CPR decision form. These can include:

- Overriding an advance decision to attempt CPR because CPR has no realistic prospect of success;
- Attempting CPR where cardiorespiratory arrest is caused by an unforeseen and reversible event, such as a blocked airway, that was not envisaged when a DNA decision was made;
- Suspending a DNACPR decision temporarily during a medical procedure that could cause cardiorespiratory arrest, especially where prompt treatment of the arrest could be effective.

BOX 1: CPR ATTEMPTS: WHAT TO CONSIDER

Staff should bear in mind the following when deciding whether to attempt CPR:

- The likelihood that CPR will restart the person’s heart and breathing for a sustained time
- The level of recovery from CPR that is realistically expected
- The person’s known or ascertainable wishes
- The person’s human rights, such as the right to life and freedom from degrading treatment, including the right to a dignified death
- The likelihood of continuing pain and distress that is intolerable or unacceptable to the person
- The person’s level of awareness of their existence and surroundings

Deciding not to attempt CPR because it has no realistic prospect of success does not need patient consent and should not be delayed because patients are not well enough to have it explained to them, or family or other representatives are not available. Staff should explain and discuss this decision with patients/or their representatives as early as possible.

Conclusion
For many people nearing the end of life or at known risk of cardiorespiratory failure, “failure to make timely and appropriate decisions about CPR will leave people at risk of inappropriate or unwanted attempts at CPR as they die.

“The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored” (BMA et al, 2014).

It is therefore essential that health professionals take all necessary steps, where possible, to ensure that patients and/or those close to them can contribute to an informed decision on whether CPR should be attempted, and that they understand the circumstances in which the decision may not be adhered to.

References

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- Anticipatory prescribing in end-of-life care
- Bit.ly/NTAnticipatoryPrescribing