Saint Francis Hospice

Caring for you

Frequently asked questions about cardiopulmonary resuscitation (CPR)

This leaflet gives information about cardiopulmonary resuscitation (CPR)

It explains:

- what cardiopulmonary resuscitation (CPR) is
- what Saint Francis Hospice staff can and what staff cannot provide at the hospice in the event of a cardiac or respiratory arrest in terms of CPR
- when CPR may be an effective intervention, and when it will not be an effective intervention
- when and why we ask your views about attempt at resuscitation
- how you can effectively share your views if you do not want to be for resuscitation attempt
- what we do when someone is not able to give their views (if they lack capacity).

You and people close to you may find it helpful to go through this leaflet with a doctor or nurse. Please approach any of the medical or nursing team with any questions concerning CPR, or with any questions after reading this leaflet.

What is CPR?

CPR is an advanced emergency treatment which attempts to restart the heart and breathing if a person suffers a cardiac and/or respiratory arrest – i.e. the heart or breathing suddenly stops. The start point is recognition, followed by rapid instigation of rigorous chest compressions and assisted breathing, defibrillation as soon as possible, and rapid transfer to hospital for sophisticated monitoring, where drugs and continued physical treatments will be tried in an effort to stabilise the situation.

What facilities for CPR are available at Saint Francis Hospice?

CPR can be started in any setting, but it can only be maintained with intensive and ongoing specialist medical, nursing, and equipment support if it is to have any realistic chance of success.

All of our medical and nursing staff are trained to recognise and respond to a cardiopulmonary arrest but there are no facilities at the hospice to sustain CPR. Continued care of the casualty would require rapid transfer to hospital via 999 for the ongoing intensive management any CPR attempt requires, most usually in an intensive care or coronary care ward.

When can CPR be an effective intervention?

When the heart and lungs are robust enough to respond to vigorous treatment, and when CPR is started as soon as possible after the heart stops.

People are most likely to respond to CPR if they were previously well, and have a sudden, witnessed cardiac arrest where immediate CPR attempts are started and followed up quickly by intensive care. With more people trained to start CPR, and improvements in intensive care, outcomes have improved over time[1]. However, heart stoppage is a huge health event. Even with the best care, the majority will not recover.

Our staff would initiate CPR on any visitor, staff member or volunteer found collapsed with no heartbeat/breathing effort, since in the absence of knowing the medical history of the individual we have to try.

If a patient is relatively robust, has limited disease (as opposed to widespread disease) and a good performance status they may have a reasonable (20%+) chance of success from CPR. If we know that the individual is keen for all efforts to be made to restart the heart should it stop, then, in the event of a witnessed collapse we would attempt CPR.

When would CPR not be an effective intervention?

The likelihood of success is hugely reduced if the collapse is not witnessed. If an individual has known underlying serious health conditions and is found collapsed with no breathing/heartbeat, a CPR attempt will be extremely unlikely to be successful.

When there is known advanced, progressive disease, a CPR attempt is unlikely to have any realistic chance of success. This situation applies to many needing hospice care.

Can everyone receive CPR?

No.

There are three situations when CPR should not be attempted.

1. People who have a serious and advanced illness (for example advanced cancer, or severe heart or lung disease), including people with advanced frailty (e.g. who need to spend more than 50% of their day in bed) have a very poor chance of any recovery from a CPR attempt. Only 2 - 3% who receive CPR in hospital will recover enough to be able to leave hospital: less if they have other medical conditions. In those who do leave hospital, the likelihood of serious permanent damage as a result of the arrest or treatment is very high[2,3,4]. Sadly even with improvements in CPR over time, for people whose start point is that they have a serious and advanced illness, recovery statistics have not improved. If a CPR attempt is unlikely to have any realistic chance of success it should not be offered.

2. People who have a serious illness, and have the capacity to decide on treatments and interventions, may decide that they would not want anyone to attempt CPR should their heart stop. If they make that decision, it should be respected. The important thing is that all those around them, and all involved in their care should know their wishes.

3. For people who have a serious illness, who do not have capacity to decide on treatments and interventions, a Best Interest meeting should be convened within which the hopes and harms of any proposed or crisis treatment can be fully discussed. The Best Interest meeting would need to include people able to advocate for the individual. If the outcome of the Best Interest meeting is that CPR should not be attempted in the event of cardiopulmonary arrest, then that decision should be respected. The important thing is that all those around the person, and those involved in their care should know that decision.

Can CPR ever be harmful?

The person who has had a cardiopulmonary arrest will be unaware, as their heart will have stopped.

Good health before an arrest increases likelihood of success and full recovery. With improvements in CPR over time around 20% of people in good health who have a witnessed arrest and immediate CPR will recover. Anyone undergoing CPR will suffer bruising, and fractured ribs and punctured lungs are common due to the necessary vigour of CPR. These injuries will heal over time. However, sadly, likelihood of success/recovery

is much lower overall than most realise. Despite best efforts, most attempts at CPR fail. Where there is survival, a proportion of survivors will have ongoing cardiac or other health problems. Some survivors will never get back to the level of physical or mental health they previously enjoyed. Permanent brain damage is always a risk, and a proportion of the survivors will be left with permanent brain damage.

People with serious and advanced illness, people who are frail, and people with a number of significant medical conditions are most likely to suffer harm and least likely to survive; if they do survive they are most likely to be left with severe damage to their brain and their body[4].

Who is responsible for making a decision about CPR?

It is a clinician's duty to look at the likelihood of success of a CPR attempt vs the likelihood of failure or harm. This will involve looking at the overall clinical picture. If there is no realistic chance of survival from a CPR attempt (meaning that it is clear that an attempt at restarting the heart/lungs, should they stop, will fail), then such an attempt should not be made, and the clinician should share this, clearly and compassionately. The ultimate responsibility for the decision whether or not someone is medically fit enough for attempt at cardiopulmonary resuscitation will rest with the senior doctor caring for the individual. That doctor will make that decision in close consultation with the clinical team.

At home the senior doctor will usually be the GP, but may be a specialist senior nurse or other senior doctor. On hospice premises this will be the consultant responsible for care.

Most people under hospice care have serious and advanced illness, so that the decision would be a medical one, due to there being no realistic chance of success and great risk of harm/distress. In cases where there is uncertainty around likelihood of success and the patient would want CPR to be tried, our hospice clinical team will discuss CPR status with the hospital consultant who has been most involved to date with an individual's treatment and care, to determine whether CPR success would be medically feasible. If no likelihood of success then this would be conveyed honestly and compassionately; the person would not be for CPR attempt, as a medical decision.

The hospice does support people with less advanced disease, who are active and physically robust. In this situation, it is an individual's choice as to whether they would want to undergo an attempt at CPR in the event of cardiopulmonary arrest.

In the absence of any decision the default position is to attempt CPR.

Do I or my family have a say in this decision?

Yes.

When a medical best interest decision is made that you should not be for CPR attempt, and you disagree, or you are unsure about that decision, you do have the right to seek a second opinion. The hospital Consultant who has been most involved to date with your treatment and care would be contacted to provide this[5].

Where there is a chance that a CPR attempt might be successful, you will be asked whether you would want to be for CPR attempt in the event of cardiopulmonary arrest. In the unlikely event that you were to have a cardiopulmonary arrest, you would not be conscious and able to share your wishes with us. So that we need to know in advance – what would you want any person present to do? The medical and nursing team will answer questions and provide any information needed to help you to make your own decision. There are excellent resources to help people who find things harder to understand, for example easy read and picture format leaflets.

Where the individual concerned does not have the capacity to decide what they would want to happen should they have a cardiopulmonary arrest, a Best Interest meeting should be convened so that those important to the individual, and those involved in their care can together weigh up the hopes versus harms of CPR attempt towards a Best Interest decision.

In the absence of any decision the default position is to attempt CPR.

Who will talk to me about CPR?

We aim to talk to everyone under our care about what is important to them in their care. This will usually include a check as to whether they have ever discussed CPR, as we would not want to miss people who have been worried about CPR and not had the opportunity to ask questions.

We know that most people want to be kept informed of their situation with regard to health, and to understand and be part of treatment options and treatment decisions.

However, we appreciate that some people are too poorly to discuss, or they do not want to discuss, or want another to discuss on their behalf. If someone is not able to discuss (as too poorly, or without capacity), or shares that they do not want to discuss, we will discuss resuscitation

status with their key nominated family/friend representative. If the medical decision is that resuscitation would have no realistic likelihood of success we will share with the person or their key nominated friend/family representative to ensure shared understanding of what is and what is not possible.

How do I share my views if I do not want to be for resuscitation attempt?

In the absence of any decision the default position is to attempt CPR, so that if you do not want to be for CPR attempt, or if a medical 'Do Not Attempt CPR' (DNACPR) decision has been made, you/we need to ensure that people around you know your view and decision/the medical decision. You should have a physical form in the house that states DNACPR. Ideally this should also be stated on an electronic record; one which is shared between anyone who may be called upon in a crisis. In London this electronic record is called Universal Care Plan (or UCP) and in Essex this electronic record is called System One. It is vital that not only professionals realise that resuscitation attempt would not be wanted, or would not work for you, but also family, friends and carers. Do ensure they know that you have a DNACPR status and that they know where the form is.

You may want to record your wishes about wider aspects of your care. The following are ways you can do this:

If you want to refuse treatments in addition to CPR you can write an 'Advance Decision' document. Such a document will be your voice in a time of crisis if you cannot speak for yourself through being poorly. Do ask the medical or nursing team for advice as to how to do this.

If you would like to nominate someone to speak for you on treatment decisions or to take over decision making on your behalf, you may want to appoint a Lasting Power of Attorney for Health and Welfare. This is useful if forgetfulness is a problem, or if there is concern that in the future you might lose capacity or the ability to speak for yourself. Do ask the medical or nursing team for advice as to how to do this.

Many people find it helpful to write down their preferences and wishes for the future. You can simply write and share your wishes, or you can use a formatted document.

- One in local use is called the Preferred Priorities for Care document. It is formatted to give a straightforward structure for thinking through, writing down and sharing with family the things that are important to you

- The Universal Care Plan (for London Boroughs) can record broader wishes – just ask your GP, district nurse or palliative care team to do so
- System One (for Essex Boroughs) can record broader wishes – again ask your GP, district nurse or palliative care team to do so
- Essex Boroughs also use a paper based plan called the PEACE plan (PEACE stands for ProactivE Advance CarE). It is a document mainly used for people who haven't capacity, to record best interest decisions. But it can also be used for people who find it hard to speak out in a crisis, or are more vulnerable to losing ability to speak for themselves (for example frailer care home residents). The PEACE document ensures that everyone understands what makes best care, and what to do in a crisis.

All of these documents cover much, much more than simply CPR decisions. We encourage everyone to share their decisions with important family/friends, and with the clinicians caring for them, so that all are aware and supportive.

Do let your medical or nursing team know if you would like to know more about recording your wishes.

Will I be disadvantaged if I opt for 'not for attempt at CPR'?

No.

Our efforts at all times will be on ensuring that you are supported and cared for in the way that is right for you, as much as is medically possible.

If CPR is not possible, or if you would not want a CPR attempt, even so you might well want active treatment for other medical crises such as infection or disease recurrence, and we would support you in achieving any such treatment that might be helpful for you.

Some people do decide 'not for' other treatments as well as 'not for attempt at CPR'. This may be because they no longer want hospitalisation, or because they feel they have had enough of such treatments. If this is the case for you, do share this with our medical or nursing team so that they can ensure that they understand your wishes, can help with information as needed, and that your wishes are noted and shared.

If I make a decision about CPR can I change my mind later?

Yes.

You can always re-visit a decision.

If you want to be for a CPR attempt in the event of a cardiopulmonary arrest, and your health situation worsens, you may change your mind, or 'for CPR' may become an intervention which is medically not supportable any more. Please do request a discussion with the medical or nursing team. If your health situation has changed, a member of the team will also revisit the discussion.

If you do not want a CPR attempt in the event of a cardiopulmonary arrest, or if CPR was deemed medically not supportable, and your health situation improves, the likelihood of success can certainly be re-discussed. Please do request a discussion with the medical or nursing team.

If the decision changes your team/your clinician will make sure that your healthcare record is updated with your decision and that others involved in your care are aware.

Natural dying

Many are worried about how they will die, and worry about cardiopulmonary arrest/CPR discussions. However, cardiopulmonary arrest i.e. sudden death is not a common cause of death in advanced disease. At end of life a person's heart does stop, but it does not 'arrest' or suddenly stop – it gently stops, as the final event, after many other changes in the body which slow the person, rendering them sleepier, with slower heart and breathing rhythms over a period of hours or days. When the heart stops, right at the end of life, it causes no pain, nor distress.

Please use this page to note down any worries or questions

References

1. www.londonambulance.nhs.uk/2020/01/29/we-release-new-stats-on-cardiac-arrests-showing-survival-rates-outside-of-hospital-reach-all-time-high/ Pub Jan 2020
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5. academic.oup.com/ageing/article/43/4/456/2812217

General articles of relevance:

- www.resus.org.uk/library/additional-guidance/ guidance-dnacpr-and-cpr-decisions
- www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-andcare-towards-the-end-of-life/cardiopulmonary-resuscitation-cpr
- www.bma.org.uk/advice-and-support/ethics/end-of-life/decisionsrelating-to-cpr-cardiopulmonary-resuscitation Last updated 2020

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About Saint Francis Hospice

Saint Francis Hospice provides care 24 hours a day, 7 days a week to local people affected by life-limiting illnesses. As a registered charity, we rely on the financial support of our community to keep providing world class care free of charge to individuals and their families. Every year, we provide treatment, care and support to more than 4,000 local people affected by a life-limiting illness.

Confidentiality

At Saint Francis Hospice we are committed to upholding your rights to confidentiality and protecting your privacy. We will treat your information with respect. Keep it secure and comply with the requirements of the Data Protection Act 2018 including GDPR. Our privacy notice is available on request or by visiting our website www.sfh.org.uk

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