11.1 GENERAL PRINCIPLES

- Cardiopulmonary resuscitation (CPR) includes all life support measures which are applied in the event of a cardiac arrest in the endeavour to restart circulation and breathing. It is comprised of basic life support and advanced life support.\(^1,2,3,4\)

- Basic Life Support aims to maintain adequate circulation and oxygenation until action can be taken to reverse the underlying cause of the cardiopulmonary arrest. It includes external cardiac massage and rescue breathing, via mouth to mouth or by use of a pocket mask or bag valve and mask.\(^4,5\)

- Advanced Life Support represents a continuation of basic life support and involves the use of a defibrillator, venous cannulation, intubation, advanced airway management, appropriate intravenous drugs and other advanced therapies to provide definitive treatment for reversible causes of cardiac arrest.\(^1,4\)

- Basic and advanced life support was originally intended to be administered to otherwise healthy people with reversible pathology, which left untreated would lead to cardio-respiratory arrest and sudden death.\(^2,6,7\)

- CPR is not indicated in certain circumstances including:
  - If CPR is not predicted to restart the heart and breathing.
  - Where successful resuscitation would probably result in a quality of life previously deemed unacceptable by the patient, recognising that the focal point of any such decision would be the views of that patient.
  - If it is contrary to the wishes of the patient with capacity for that decision, as previously expressed in a written, valid and applicable Advance Decision to Refuse Treatment (ADRT).\(^7,9,11,12\)

- Decisions about CPR must be made on an individual basis. Advance care planning, including decisions about CPR, is an important part of good clinical care for those at risk of cardio-respiratory arrest.\(^2,10,12\)

- The purpose of Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR) orders is to allow dying patients to die peacefully without undergoing futile attempts at resuscitation prior to death.\(^11\) If the patient is in the dying phase and has a prognosis of days to weeks, CPR would not be appropriate and a DNACPR order should be considered.\(^13\)

- A DNACPR decision only applies to CPR and not to any other aspects of treatment.\(^2,7,8\)

- A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the patient’s respiratory or cardiac arrest that does not match the circumstances envisaged.

- A patient with capacity has the right to be involved in decisions that affect and involve them.\(^10,14\) A patient with capacity for that decision has the right to refuse treatment including CPR, but
Not to demand treatment that is clinically inappropriate. If a patient lacks capacity, those close to the patient should be involved in discussions to explore the patient’s wishes, feelings, beliefs and values. ^2

- Any CPR decision must depend on the individual circumstances of the patient. A blanket do-not-attempt-cardiopulmonary resuscitation policy on the basis of a particular patient group, such as the elderly, disabled or residents of a nursing home or hospice, is not permissible. ^2, 9, 12, 13, 15

- Wherever possible, discussions about CPR should be carried out by an experienced senior clinician. ^2

- The BMA / RCN Joint Statement outlines three patient scenarios relating to CPR decisions and the actions that should be taken i.e.
  - An arrest cannot be anticipated in the current circumstances.
  - An arrest can be anticipated but there is no realistic chance that CPR could be successful.
  - An arrest can be anticipated and there is a realistic chance that CPR could be successful.

The Joint Statement should be reviewed for guidance in the three scenarios. ^2

- Hospitals and hospices should have a CPR policy which all staff are aware of, and appropriate information for patients and relatives about resuscitation policies and facilities available within the establishment. ^2, 5, 10, 16, 17, 18

- Policies and decisions about CPR need to be compatible with the Human Rights Act 1998, implemented in 2000, and with the Mental Capacity Act 2005. ^10, 12, 14, 20

- CPR is rarely appropriate for patients with a terminal illness. ^3, 7 However, palliative care units now treat patients earlier in their disease and also patients with non-cancer diagnoses whose prognosis may be less clear. In some units, procedures are performed such as interventional pain techniques where cardiac arrest may be a rare but recognised complication. Prompt intervention may be successful in reversing the underlying cause. Therefore there may be a small subgroup of hospice patients for whom consideration of CPR may be appropriate. ^9

- It has been suggested that palliative care units may need to consider whether they should have automated external defibrillators (AEDs) which could also be brought into use should staff or visitors suffer cardiac arrest. However cardiac arrest is such a rare event in this setting that it is not feasible to expect that hospices could be providers of comprehensive advanced life support over and above appropriate use of AEDs as it would be impossible to maintain the necessary skills. Speedy transfer of these patients to hospital for intensive treatment and monitoring should be of paramount importance in the event of an arrest. The focus of training should be on maintaining skills in Basic Life Support so this can be implemented until paramedics arrive to transfer the patient to hospital. ^15, 21

### 11.2 GUIDELINES

- The BMA / RCN Joint Statement provides comprehensive guidance on decisions relating to CPR. Practitioners are advised to consult this document for further information. ^2 [Level 4]

- All hospices are governed by NHS or Care Quality Commission (CQC) regulations. The latter clearly states that health establishments must base their CPR policy on Resuscitation Council policy. This includes inpatients, outpatients and patients attending day therapy. ^2, 23, 24 [Level 4]

- Decisions regarding CPR must involve the multi-professional team alongside the patient, relatives and carers where appropriate. The most senior clinician in charge of the patient’s care will have ultimate overall responsibility for the decision, and for ensuring adequate documentation of that decision. Documentation should include: how the decision was reached;
the date of the decision; reasons for the decision and the name and position of the person responsible for making the decision.2,8,17,19 [Level 4].

- If a clinical decision is made that an arrest can be anticipated but there is no realistic chance that it could be successful, it is not appropriate offer CPR. Careful consideration should be given to whether to inform the patient of the decision. The situation should be reviewed regularly.2,10,11,13 [Level 4]

- When appropriate, patients and relatives should be given information, including written material, to supplement face-to-face discussions.2,5,10,17 [Level 4].

- Patients should be offered the opportunity to discuss CPR in more detail if they wish. Where discussions take place they must be approached with sensitivity and tact.2 [Level 4]

- If there is no Advance Decision to refuse Treatment or DNACPR order and the wishes of the patient are not known and cannot be identified, resuscitation should be the default position in the event of a cardiac or respiratory arrest, unless the patient is clearly dying or until further information is obtained that makes continued CPR inappropriate e.g. a DNACPR order or clinical information indicating that CPR will not be successful. [Level 4]

- If CPR might re-start the pulse and respiration, the benefits to the patient of prolonging life must be weighed against the potential burdens. This should incorporate consideration of the patient’s best interests and wishes in addition to clinical factors. Sensitive but realistic discussion with the patient of the facts, potential risks and adverse effects and their wishes should be undertaken unless they indicate that they do not want to discuss CPR.2,5,13 [Level 4]

- If a patient with capacity wishes to be a candidate for CPR in the event of cardiac arrest and CPR has a chance of restarting the pulse and respiration, their wishes should be clearly documented and the MDT must be aware of this decision. This wish should be reviewed with the patient at regular appropriate intervals as their condition advances.8,17 [Level 4] IF the patient wishes to have CPR, the team and patient may wish to consider whether they should be transferred to an appropriately equipped unit for ongoing acute medical care.9,12 [Level 4]

- Although patients or their advocates with Lasting Power of Attorney (LPA) can refuse treatment, they cannot demand treatment assessed by the healthcare team to be clinically inappropriate. If they do not accept a DNACPR decision and wish a second opinion, this should be arranged. Where possible, the clinician providing the second opinion should review the patient in their current place of care.2 [Level 4]

- A competent refusal of CPR must be respected, even if this will result in the patient’s death, without the need for the patient to justify their decision. Such a refusal may be documented in the form of a formal Advance Decision to Refuse Treatment and to be legally binding should be set out as described in the Mental Capacity Act i.e. it must be in writing, signed either by the patient, or by another person on his behalf, and signed by a witness. It must state that the advance decision is to apply even if the patient’s life is at risk. If an Advance Decision to Refuse Treatment is found to be not legally binding, it must still be taken into account when assessing the patient’s best interests.2,14 [Level 4]

- If a patient lacks capacity, CPR can be withheld if it would not be in the patient’s best interests as assessed by the MDT and those close to the patient.2,10,14,17 [Level 4]

- If a patient lacks capacity and has formally appointed an advocate with Lasting Power of Attorney to make welfare decisions and their authority includes making clinical decisions about life-sustaining treatment on the patient’s behalf, or if the court has appointed a deputy or guardian with similar authority, this person should be consulted about a decision concerning CPR. The Advocate with LPA or deputy cannot demand treatment that is clinically inappropriate. However, if it is thought that CPR may succeed in restarting the pulse and respiration for a prolonged period, a decision about the appropriateness of CPR should be made
in the patient’s best interests. This should be informed by the views of the MDT, those close to
the patient and advocates with LPA where those have been appointed. 2,14 [Level 4]

- If a patient lacking capacity has no family, friends / advocate and it is not clear whether or not
CPR would have a realistic chance of success, or if a DNACPR decision is being made on best
interests grounds, then an independent mental capacity advocate (IMCA) must be consulted at
the earliest opportunity. 2,14 [Level 4]

- DNACPR decisions should be recorded on a clearly identifiable document which should cross
care settings. 22 [Level 4]

- If a DNACPR document goes home with the patient, then the decision and the reason for it
should be discussed with the patient and those close to them. This should form part of
discussions about the patient’s awareness of their illness and facilitation of advanced care
planning. 22 [Level 4]

- Healthcare organisations should ensure that their clinical staff maintain knowledge and skills to
undertake discussions and decision making about CPR. 2 [Level 4]

11.3 STANDARDS

1. Hospitals and specialist palliative care units should have a resuscitation policy and all staff
should be aware of this policy. 2,5,10,16,21 [Grade D]

2. Designated staff should receive regular training to ensure that they maintain competency in
performing basic CPR. Clinical staff should update their skills on an annual basis. 2,9,10,12,21
[Grade D]

3. Any decisions about CPR must be clearly documented. This includes: how the decision was
reached; the date of the decision; reasons for the decision and the name and position of the
person responsible for making the decision. 2,17,19 [Grade D]

4. Decisions about CPR should be shared with all health care professionals who may need to
know e.g. hospitals, hospices, nursing homes, GPs, other community health care
professionals, out-of-hours medical services and ambulance staff. 13 [Grade D]

11.4 REFERENCES


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