DECISIONS RELATING TO CPR – George Jones

- George Jones
- 80 year old, retired farmer. Widowed.
- Lives alone in small cottage on the farm that his grandson (30) and his wife run as tenants
- Up until his recent episode of a chest infection that developed into pneumonia, George had no specific health problems and enjoyed living quite independently.

He ate a main cooked meal, with his family up in the farmhouse about 4 times a week, which he felt was enough for him. His daughter-in-law took him shopping with her once a week. He paid a cleaner for 3 hours a week.

He kept himself busy with his model railway and enjoyed watching sports on his television.

George's didn't recover from his chest infection as well as the medical team had hoped and ended up being hospitalised for treatment of pneumonia. After a difficult time, George did recover. When George came home he told his GP that he had hated being cooped up in "the stuffy hot hospital ward, full of nosey and noisy people…..my life's here at home" he said.

2 months later, whilst you are reviewing George he suffers a cardiac arrest

- What do you feel the action should be in relation to CPR? What influences your decision?

- Stepping back now and considering the *bigger picture* context of George's current health, his advanced age and potential risks, can you say you are not wholly surprised that he had a cardiac arrest?

- Is there a likelihood CPR could be successful in his case?

- If CPR were successful, what are the potential associated risks of surviving CPR for George? *Consider these broadly, in relation to impact for him physically, functionally, cognitively, in relation to his independence, where he might spend the rest of his life?*

- In relation to the *bigger picture* context of George's current health, potential risks and what you know about him, should he be asked whether he would want CPR should he have a cardiac arrest? Should he have opportunity to explore the burdens of CPR in order to help him with that decision?

- Would you routinely know this information about a patient?

- What could you proactively do 'as a team' to help ensure you have the information you need, should George arrest, to ensure *the right* decision is made for him?

FACILITATOR NOTES/CONSIDERATIONS: GEORGE JONES

What do you feel the action should be in relation to CPR? What influences your decision?

- Act in favour of CPR with no information or obvious circumstances re: health related appropriateness or patient preference decisions that determine otherwise.

Stepping back now and considering the *bigger picture* context of George's current health, his advanced age and potential risks, can you say you are not wholly surprised that he had a cardiac arrest?

- No. Advancing age and frailty – make him a risk

Is there a likelihood CPR could be successful in his case?

If CPR were successful, what are the potential associated risks of surviving CPR for George?

In relation to the *bigger picture* context of George's current health, potential risks and what you know about him, should he be asked whether he would want CPR should he have a cardiac arrest? Should he have opportunity to explore the burdens of CPR in order to help him with that decision?

- Yes, he could survive, although with statistics relating to success of CPR and associated burdens – he could survive but with significant burdens that change his level of independence, comprehension or where he is cared for – he would need to have opportunity to determine the acceptability of these risks for himself. He's already given a hint of his preference for home and not being around noisy/nosey people – is this important to him? Only he can determine what the 'quality of life' determination of what is potentially acceptable risk v burden.

Would you routinely know this information about a patient?

- Individual to the service/group/professional this question is posed to.

What could you proactively do 'as a team' to help ensure you have the information you need, should George arrest, to ensure *the right* decision is made for him?

- Usual links to how they proactively engage with significant information to support decision making and planning in terms of prognostication – identifying those at risk; picking up on clues to peoples preferences/concerns; having confidence and skills to engage with honest, open conversations - providing opportunity for ACP & supporting appropriate and timely communication of those decisions.
- How this is achieved depends on the role/involvement of the individual/service...

DECISIONS RELATING TO CPR – Dina Smith

- Dina Smith
- 58 year old. Lives with her husband and twin sons (aged 17) in their bungalow in the centre of town.
- Dina was diagnosed 3 years ago with motor neurone disease.

Her condition had slowly deteriorated. She had lost the use of her legs, much of her arm use and some of her head/neck muscle control. Her swallow had become progressively affected, but had refused a PEG tube earlier on in her disease as "….didn't want to prolong her disease into more distressing symptoms". She managed on thickened liquids and use of a suction machine at home.

Dina's husband (Dan) would normally be her main carer; but following a RTA in his works van, Dan was recently wheelchair bound and waiting for further surgery before any rehab for him could continue to get him back on his feet.

Dina told her brother that she wanted to stay at home for as long as possible, but felt that depending on her husband's recovery stage, he (and the boys) may not cope as she required more nursing need. Both Dina and Dan were currently receiving home care support through a private agency. She wanted to look at care home situations as a 2nd option. Her brother had promised to help her look at those options.

In her most recent discussion with her neurological consultant, Dina was aware that her prognosis now was unlikely to be more than a few months or so.

Over the next few weeks, her respiratory muscles were notably more affected, in that she was relying progressively more on her ancillary and abdominal muscles to support her breathing and experiencing more episodes of chest infections and associated pyrexia. Dina was generally looking very frail. Following discussion of her advancing illness, a DNACPR decision was put in place.

As you approach Dina, you notice her go into respiratory arrest.

- What do you feel the action should be in relation to responding to her respiratory arrest? What influences your decision?

- Stepping back now and considering the *bigger picture* context of Dina's progressive respiratory problems, with her advancing neurological disease, are surprised that she had a respiratory arrest?

- If she were to go on to have a cardiac arrest, is there likelihood that CPR would be successful in her case?

- In relation to the *bigger picture* context of Dina's current health, potential risks and circumstances and what you know about her, should she be asked whether she would want CPR should she have a cardiac arrest? What about respiratory arrest – could this have been predicted as a risk with someone with advancing neurological disease and having respiratory problems?

- Would you routinely know this information about a patient?

- What could you proactively do 'as a team' to help ensure you have the information you need to ensure the right decision is made for her?

FACILITATOR NOTES/CONSIDERATIONS: DINA SMITH

What do you feel the action should be in relation to responding to her respiratory arrest? What influences your decision?

- Act in favour of aiming to support respiratory needs with no information or obvious circumstances re: health related appropriateness or patient preference decisions that determine otherwise. Even decisions that indicate DNACPR do not officially relate to respiratory arrest, that if left could cause cardiac arrest.

Stepping back now and considering the *bigger picture* context of Dina's progressive respiratory problems, with her advancing neurological disease, are surprised that she had a respiratory arrest?

- Those with advancing neurological conditions that affect bulbar area/respiratory function are potentially at risk of respiratory arrest, such as through choking/blocked airways, infection or other reason that the respiratory drive may be affected. Addressing these: unblocking airway, treating infection, supporting respiratory effort until normal drive returns can potentially reverse this situation. Part of our proactive discussion about future symptom risks for patients are part of processes such as our GSF meetings. What should be determined within this, is what the patients wishes/concerns are around this etc.

If she were to go on to have a cardiac arrest, is there likelihood that CPR would be successful in her case?

In relation to the *bigger picture* context of Dina's current health, potential risks and circumstances and what you know about her, should she be asked whether she would want CPR should she have a cardiac arrest? What about respiratory arrest – could this have been predicted as a risk with someone with advancing neurological disease and having respiratory problems?

- The challenge here is whether she has a cardiac arrest because her respiratory arrest is not addressed – is there a slight chance, with age and a relatively healthy heart, she could survive CPR (although still be significantly burdened by her failing respiratory effort with potential burdens of requiring hospital admission and breathing support? Or if her heart stops as a result of advanced stage of her disease. Consider the statistics relating to cardiac arrest survival outside hospital intensive support situations.

Would you routinely know this information about a patient?

- Individual to the service/group/professional this question is posed to.

What could you proactively do 'as a team' to help ensure you have the information you need to ensure the right decision is made for her?

- How this is achieved depends on the role/involvement of the individual/service...
- Usual links to how they proactively engage with significant information to support decision making and planning in terms of prognostication – identifying those at risk; picking up on clues to peoples preferences/concerns; having confidence and skills to engage with honest, open conversations - providing opportunity for ACP & supporting appropriate and timely communication of those decisions.
- Also consider, the relevance of Advance Directives to Refuse Treatment (ADRT) – Dina had already refused a PEG feed option as didn't want her MND prolonged. What was her understanding around the intentions of 'enabling a natural death' when the DNACPR decision was made in relation to the risks/burdens of other problems that could arise?

DECISIONS RELATING TO CPR – Emily Brown

- Emily Brown
- 59 year old lady, General Hospital Night Sister, Nurse, married to Jim. Daughter lives away.
- Over the past 8 years, Emily had a history of health problems relating to:
    - Heavy smoking; high alcohol intake, high blood pressure, and obesely overweight.
    - In the subsequent 3 years, Emily stopped drinking alcohol altogether, reduced her smoking to 5 cigarettes per day and gradually lost 8 stone in weight.
    - She has regular reviews with her GP Practice.
- 8 months ago, diagnosed with vascular dementia.
    - Independently mobile, but increasing episodes where memory, understanding and judgment were compromised.
    - Suffered from depression.
    - Carer support twice a week, to enable Jim to go out/do what he needed to do on his own.
- 2 months ago, Emily fell and broke her ankle.
    - The GP and DN team had since been involved in home visits treating a wound that had become infected and ulcerated on her lower leg and treating her for a chest infection.

Three weeks into this, Jim telephoned to ask for a home visit as he felt Emily likely had a chest infection again. She had been more 'out of sorts than usual' over the weekend and breathless.

As you attend to review Emily, she goes into cardiac arrest. Once Jim realises this, he becomes unsettled and tells you he's now Emily's *Lasting Power of Attorney* and knows Emily would not want to be resuscitated and have her dementia prolonged.

- What do you feel the action should be in relation to CPR? What influences your decision?

- Could CPR be successful in her case?

- Stepping back now and considering the *bigger picture* context of what you know about Emily's health history, are you wholly surprised that she has had a cardiac arrest?

- If CPR were successful, what are the potential associated risks of surviving CPR for Emily? *Consider these broadly, in relation to impact for her physically, functionally, cognitively, in relation to level of independence, where she might spend the rest of her life? Care needs?*

- As Emily's Lasting Power of Attorney for Health and Welfare, does Jim have a right to refuse potentially life sustaining treatment (such as CPR)? What would influence your decision?

- Would you routinely know this information about a patient?

- What could you proactively do 'as a team' to help ensure you have the information you need, should Emily arrest, to ensure the right decision is made for her?

FACILITATOR NOTES/CONSIDERATIONS: EMILY BROWN

What do you feel the action should be in relation to CPR? What influences your decision?

- Act in favour of CPR in the presence of no information or obvious circumstances re: health related appropriateness or patient preference decisions that determine otherwise.

Could CPR be successful in her case?

- In terms of statistics relating to her age, her health conditions not being significantly advanced and being a witnessed arrest, CPR could be successful.

Stepping back now and considering the *bigger picture* context of what you know about Emily's health history, would you be surprised that she has had a cardiac arrest?

- It would seem reasonable to say yes, that a cardiac arrest at this point would not have been predicted.

If CPR were successful, what are the potential associated risks of surviving CPR for Emily?

- The burdens of CPR will always have the risks of the potential of burdens associated with survival. More pertinent to Emily is that, should she survive even with no additional burdens to her current condition, she will survive to continue with the changes to her health associated with her vascular dementia. In these circumstances the determination of what is a 'burden' is subjective to the patient's perspective of what is acceptable.

As Emily's Lasting Power of Attorney for Health and Welfare, does Jim have a right to refuse potentially life sustaining treatment (such as CPR)? What would influence your decision?

Dependant factors:

- You know for definite that Jim is officially the LPA for Health (official documentation approved/stamped by the Office of Public Guardian seen by someone and recorded/scanned into the patient notes and communicated).
- In order for Jim to be able to refuse life-sustaining treatment (on behalf of Emily), Emily will have had to included permission for Jim to do so in the specific area of the LPA documentation, otherwise he has no other rights in refusing life-sustaining treatment than any other family member other than having their opinion/knowledge about the person heard in order to support a clinicians best interests decision.
- Opinions/decisions from the appointed LPA, only come into force if the patient lacks the capacity to make that specific decision for him/herself at that point in time.

Would you routinely know this information about a patient?

- Individual to the service/group/professional this question is posed to.

What could you proactively do 'as a team' to help ensure you have the information you need, should Emily arrest, to ensure the right decision is made for her?

- As you would not have expected Emily to be at risk of a cardiac arrest, there was no expectation for you/other professionals to 'ask the question' up front. However, consider people, such as Emily who by the time they get to the stage where there disease is advanced and their risk is more likely, we have 'missed the boat' in terms of supporting self- determination around decisions such as CPR, as with diseases such as dementia she will have already lost capacity.
- Initiating opportunity for ACP in a timely way is particularly important here. Emily and Jim had already had some sort of discussions relating to concerns and decisions for the future in that Jim identified he had been appointed an LPA by Emily; could this have been explored/identified earlier by the teams who supported them.
- At the points of life or death decisions, there is little time to get the person to pull out the documentation etc to prove they have the right to make decisions.