Introduction

Cardiopulmonary resuscitation (CPR), provided via advanced cardiac life support (ACLS, 1) can be a life-saving intervention for some patients who suffer cardiopulmonary arrest. Survival to hospital discharge following cardiopulmonary resuscitation is under 20%, even lower when cancer, renal failure, sepsis, or dementia is present (2). This document offers guidance to help with decision-making in this circumstance.

Definitions

**Code team:** Multi-disciplinary group of individuals including the following roles: physician code leader, nurse, respiratory therapist, recorder, additional clinical support. All are ACLS-certified. May be a formal team (cardiopulmonary arrest team or rapid response team), or may be made up of individuals on the patient care unit, critical care or acute care.

**DNAR:** Do not attempt resuscitation. Person has no pulse and/or is not breathing. An order not to attempt resuscitation in the event of cardiopulmonary arrest (same as a DNR order).

**DNI:** Do not intubate. Person is in respiratory distress with a pulse. Order to forgo intubation in the setting of respiratory distress (does not apply in arrest situations).

**Surrogate decision maker:** Any person authorized to make decisions on behalf of a patient who lacks capacity to make the decision at hand.

Assessing and addressing patients’ understanding of and preferences about resuscitation efforts

Resuscitation preferences and patients’ understanding about DNAR orders should be discussed with as many patients as possible, particularly those unlikely to survive a cardiac arrest. Encourage patients who have capacity to include family members and significant others in the discussion, so that they are aware of the patient’s preferences. When the patient lacks capacity to make decisions about resuscitation, the conversation should be held primarily with the authorized surrogate decision-maker; other family members and significant others may be included.

Discussion with primary care physician in the ambulatory setting prior to admission is encouraged, particularly for patients with serious chronic illness, and serves as a jumping-off point for inpatient discussions. When ambulatory patients choose to limit resuscitative efforts or other life-sustaining treatment, complete a POLST form so that those medical orders are portable.

Discussion is especially high priority for patients who:

- May lose decision-making and/or communication capacity, so that their understanding and preferences can be addressed while they are able to make decisions and communicate those decisions.
- Are seriously ill, either chronically or acutely, such that a cardiopulmonary arrest would not come as a surprise.
- Have documentation of an advance directive that limits life-sustaining treatment in particular circumstances, in order to clarify whether current situation corresponds with pre-specified circumstances.
- Have in place a completed POLST (practitioner order for life-sustaining treatment, 4) form. POLST orders must be followed, in any care setting.

Discussion should include:

- Patient’s medical prognosis, based on acute and chronic conditions present at the time of the discussion.
- Likely outcome of cardiopulmonary resuscitation, considering current acute and chronic conditions.
- Emphasize that “DNAR” does not mean limitations on other treatments.
Why some patients/families choose a DNAR order. For example, to honor patient’s preferences, to respect a natural dying process, and because even if the patient did survive the arrest, it would not add to/restore quality of life, it would merely prolong an inevitable dying process.

Medical record documentation about patients’ preferences should be entered via the advance care planning (ACP) navigator tab, available in all care venues, and needs to include:

- Who participated in the conversation, including care team member(s), patient, significant others, and, if legal surrogate, who that is.
- Resuscitation choice(s) decided upon.
- Reasons for choices made (DNAR, full code, other preferences (for example, no tracheostomy, no feeding tube, etc.).
- It is helpful to document possible impact of resuscitation choices on other potential treatment decisions, including transfer to critical care; invasive procedures; chemotherapy; etc.

Consultation is available to help with advance care planning, please see appendix.

Usual procedure for cardiopulmonary resuscitation

Patients with no previous documentation of resuscitation orders undergo full cardiopulmonary resuscitation. Duration of CPR is a clinical decision made by the resuscitation team during CPR, based on their clinical evaluation of the patient, considering all aspects of the patient’s condition, including outcomes of previous resuscitation and therapeutic efforts (see below).

- Follow usual standard of care (advanced cardiac life support protocol) for patient suffers a cardiopulmonary arrest, and who does not have DNAR order in place. Initiate resuscitative efforts while code team assembles.
- Thoroughly evaluate the patient’s clinical status, before and during the course of the resuscitation.
- Make a transparent, team-based decision about the duration of resuscitative efforts.
- The code leader performs a debrief with members of the clinical team at the end of the code, including a synopsis of the event, as well as an analysis of what went well and opportunities for improvement. This discussion helps drive system improvement. The debrief also provides an opportunity to discuss and support team members emotional response to the code.

References

(4) NJ POLST. August 2019 version. POLST-Fillable-Form-Green.pdf (njha.com)

Appendix: consultation services

Geriatrics consultation is available throughout HMH to help with advance care planning discussions, diagnosis and management of symptoms associated with serious illness in elderly patients, and to help with hospice referrals. Palliative care consultation is available for patients who have serious illness and would benefit from symptom management, goals of care discussions, and/or have end of life care needs. In the acute hospital setting a palliative consult can be requested via EPIC. Palliative ambulatory appointments and palliative skilled nursing facility consults are also available throughout the HMH system. Bioethics consultation is available when ethical questions arise, please reach out to local bioethics colleagues. Reasons for consultation may include interpretation of advance directives or patient’s previously expressed preferences, conflict about the plan of care, or questions about potentially inappropriate treatment, among others.