WHAT’S THE REALITY?
433,985 patients (1992-2005) -- 18.3% survived
Survival decreased with greater age or if from nursing home
Figure 1. Survival to Hospital Discharge after In-Hospital CPR, According to Year and Race.

Survival is poorer for black and other nonwhite patients (P<0.001). There is no significant change in overall survival from 1992 to 2005 (P=0.57 with the use of the likelihood-ratio test).
Outcome of CPR in those > 70 yrs old

- 503 patients - 3.8 % survived to discharge

- Poorest outcome?
  - Unwitnessed arrest 0.9%
  - Asystole or EMD 0.4%
  - CPR > 15 minutes 0.3%

*Murphy et al. Ann Intern Med 1989*
OUTCOMES OF CARDIAC ARREST IN THE NURSING HOME: DESTINY OR FUTILITY?

Robert Benkendorf, MD, Robert A. Swor, DO, Raymond Jackson, MD, Edgardo J. Rivera-Rivera, MD, Andrea Demrick, BS

ABSTRACT

Objective. To compare EMS system characteristics and outcomes between nursing home (NH) patients and out-of-hospital cardiac arrest (OHCA) patients whose arrests occurred in a residence (home). Design. Prospective cohort study reviewing OHCA from July 1989 to December 1993. Variables were age, witnessed arrest, response intervals, automated external defibrillator (AED) use, and arrest rhythms. Outcomes

The initiation of resuscitation is a topic that has received a tremendous amount of scrutiny in the medical literature. Some authors have suggested that rescuers not initiate, or that they limit, cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) in skilled nursing facilities because these attempts are futile1-8. The poor underlying health status of this population makes this a unique population of

PREHOSPITAL EMERGENCY CARE 1997;1:68-72
Outcome from cardiac arrest in community versus nursing home

• 2348 cardiac arrests over 4.5 years in Michigan

• Average age: NH patients 73.1 vs 67.5

• 50% of arrests were witnessed

• NH patients received BLS and ALS faster

• Survival: NH patients 0.0% vs 5.6%

Benkendorf et al. Prehosp Emerg Care 1997
Medical futility in asystolic out-of-hospital cardiac arrest

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Objectives: To study the factors associated with short- and long-term survival after asystolic out-of-hospital cardiac arrest, with a reference to medical futility.

Methods: This is a retrospective observational study conducted in Helsinki, Finland during 1 January 1997 to 31 December 2005. All out-of-hospital cardiac arrests were prospectively registered in the cardiac arrest database. Of 3291 arrests, 1455 had asystole as the first registered rhythm. These patients represent the study population.

Results: A short time interval to the initiation of advanced life support (ALS) was associated with a long-term benefit, but a short first responding unit (FRU) response time had only a short-term benefit. Conversion of asystole into a shockable rhythm provided only a short-term benefit. The prognosis was poor if the FRU response time was over 10 min or the ALS response time was over 11 min in bystander-witnessed arrests, and if the duration of resuscitation was over 8 min in emergency medical services (EMS)-witnessed arrests. Bystander-CPR was associated with increased 30-day mortality. The 30-day survival rate after an unwitnessed arrest (n = 548) was 0.5%. All survivors in this group were either hypothermic or were victims of near-drowning.

Conclusions: Resuscitation should be withheld in cases of unwitnessed asystole, excluding cases of hypothermia and near-drowning. The prognosis is poor if the FRU response time is over 10 min or the ALS response time is over 10–15 min in bystander-witnessed arrests. The decision of whether or not to attempt resuscitation should not be influenced by the presence of bystander-CPR. Early initiation of ALS should be prioritised in the treatment of out-of-hospital asystole.

Accepted for publication 10 July 2007

Key words: out-of-hospital cardiac arrest; asystole; outcome; bystander CPR; do not attempt resuscitation (DNAR).
CPR Outcome: What’s the bottom line?

- In-hospital: 14-18% survival to discharge
  1/2 survivors: mod - severe neurological deficit

- Public place: 7% survival to discharge
  2/3 survivors: mod - severe neurological deficit

- Aged care: 0 – 2% survival to discharge
  >3/4 survivors: mod - severe neurological deficit

The median age in RACFs is 85 ………
What do the public think?
SPECIAL ARTICLE

CARDIOPULMONARY RESUSCITATION ON TELEVISION

Miracles and Misinformation

SUSAN J. DIEM, M.D., M.P.H., JOHN D. LANTOS, M.D., AND JAMES A. TULSKY, M.D.

Abstract Background. Responsible, shared decision making on the part of physicians and patients about the potential use of cardiopulmonary resuscitation (CPR) requires patients who are educated about the procedure’s risks and benefits. Television is an important source of information about CPR for patients. We analyzed how three popular television programs depict CPR.

Methods. We watched all the episodes of the television programs ER and Chicago Hope during the 1994–1995 viewing season and 50 consecutive episodes of Rescue 911 broadcast over a three-month period in 1995. We identified all occurrences of CPR in each episode and recorded the causes of cardiac arrest, the identifiable demographic characteristics of the patients, the underlying illnesses, and the outcomes.

Results. There were 60 occurrences of CPR in the 97 television episodes — 31 on ER, 11 on Chicago Hope, and 18 on Rescue 911. In the majority of cases, cardiac arrest was caused by trauma; only 28 percent were due to primary cardiac causes. Sixty-five percent of the cardiac arrests occurred in children, teenagers, or young adults. Seventy-five percent of the patients survived the immediate arrest, and 67 percent appeared to have survived to hospital discharge.

Conclusions. The survival rates in our study are significantly higher than the most optimistic survival rates in the medical literature, and the portrayal of CPR on television may lead the viewing public to have an unrealistic impression of CPR and its chances for success. Physicians discussing the use of CPR with patients and families should be aware of the images of CPR depicted on television and the misperceptions these images may foster. (N Engl J Med 1996;334:1578-82.)

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WHAT ARE THE ETHICS AND LEGALITIES?
A doctor’s common law duty:

To take reasonable steps
(as other reasonable doctors would)

to save or prolong life

or act in the patient’s best interests
Do no harm

Dignity

Beneficence & Non maleficence

Don’t offer something that won’t help and that is likely to do harm

Surgery?? Chemo??
WHAT DO WE DO?
Research Questions

• How many RACFs offer CPR and how frequently is it provided?
• How many RACFs have a CPR policy?
• What do RACF managers believe the success rate of CPR is?
• What are RACF manager’s opinions about CPR provision?
Survey Design and Distribution

• A national survey completed by one respondent per RACF (Manager, Site Manager or Director of Nursing)

• Distribution:
  Aged and Community Service Australia (ACSA)
  Leading Age Services Australia (LASA)
  DOHA contact list
Results - Demographic

- Over 500 RACF managers responded
Results – CPR knowledge

• ¾ believed that survival rate of CPR in RACFs is <10% and 1/3 (correctly) that survival is <2%

• < 50% correctly believed that >50% of residents who survive CPR will suffer from neurological impairment
Results – CPR provision

• 4/5 reported that their facility provide CPR
  But only 1/5 agreed that CPR should be initiated in a witnessed cardiac arrest
  And most agreed that there are situations when it is inappropriate to initiate CPR and more appropriate to allow a natural death

• No CPR was administered in 3/4 of the facilities in the last 12 months
Results – CPR policy

• More than $\frac{3}{4}$ believed a CPR policy is required in RACFs to meet legal and/or accreditation expectations around CPR provision
  – Many thought that their facility’s CPR policy was inadequate
  – 4/5 supported the introduction of standardised government CPR guidelines
Results – CPR documentation

• Half of the facilities use a formal CPR document for residents
  – Nearly all agreed that it is important to discuss resuscitation status with the resident or family and that a resident CPR plan would help to reduce staff uncertainty
M. Sellars,  
R. Sjanta,  
L. Jackson,  
D. Mawren,  
R. Mountjoy  

*Respecting Patient Choices, Austin Health, Melbourne*
Summary

• Most RACFs offer CPR, but it is rarely provided to residents

• CPR practices inconsistent between RACFs
  – Managers vary in beliefs about providing CPR

• Only half of the facilities use a CPR document
  – Managers believe a CPR document would reduce staff uncertainty

• CPR policy inconsistent between RACFs
  – Managers have little confidence in policy
  – Support introduction of government CPR guidelines
Conclusion

• Government guidelines for whether and when CPR should be provided
  – Consistent and appropriate CPR practices to residents
  – Avoid burdensome or insufficiently beneficial medical interventions at end of life
WHAT SHOULD WE DO?
Controversy

Cardiopulmonary resuscitation in continuing care settings: time for a rethink?

Simon P Conroy, Tony Luxton, Robert Dingwall, Rowan H Harwood, John R F Gladman

Cardiopulmonary resuscitation is rarely successful in people who are old or frail, but current policy guidance fails to take this into account
“Decisions relating to No Cardio-Pulmonary Resuscitation (CPR) Orders”

• **Principles**

  • Informed and carefully considered decisions not to apply CPR are consistent with good ethics and with good medical practice.

  • Decisions to withhold CPR seek to avoid unwanted, excessively burdensome or insufficiently beneficial interventions for patients at the end of life.
• It is critical to avoid potentially inappropriate resuscitation where patients move between healthcare health care facilities, such as during transport from a hospital to a residential care setting or vice-versa.
Withholding CPR without explicit discussion with the patient or family:

• The patient (or family/’person responsible’) does not wish to discuss CPR.

• The patient is aware they are dying and has already expressed a desire for palliative care;

• The health care facility does not provide CPR as a matter of course, consistent with the values and practices relevant to their patient population,
Clinical ethics

“Allow natural death” versus “do not resuscitate”: three words that can change a life

S S Venneman,¹ P Narnor-Harris,² M Perish,³ M Hamilton⁴

• Test the hypothesis that changing the terminology from the negative “Do Not Resuscitate” to the positive “Allow Natural Death”

• J Med Ethics 2008
Figure 1  Participants receiving the scenario in which the order was titled AND were statistically more likely to endorse it than their counterpart receiving the scenario with DNR.
# Advance Care Plan
## (Aged Care)

### This Advance Care Plan applies to:
- **Title**: 
- **First Name**: 
- **Last Name**: 

### Address: 

### Has a Medical Enduring Power of Attorney (MEPOA) been appointed?  Yes / No
- **MEPOA Name**: 
- **Alternate MEPOA Name**: 
- **Contact Number(s)**: 
- **Contact Number(s)**: 

### COPY OF MEPOA (IF NOMINATED) ATTACHED:  Yes / No

If you are unable to answer the following questions for yourself, then it is assumed your MEPOA or trusted representative will answer on your behalf.

### Current state of health:
In your own words – please explain your current health problems:

### Values and beliefs:
What are the things that matter most to you? (Eg: family & friends, familiar activities, independence, spiritual beliefs, religious practices, cultural beliefs).

### Future health situations:
What health conditions would you find unacceptable:  
(Eg: can’t talk, can’t walk, can’t eat /drink normally).

### Specific treatments:
Please write any specific treatments that you would or would not want:
- **Wanted:**
- **Not wanted:**

### Goals for end-of-life care:
What do you hope for most when you are near the end of your life?  
(For example: presence of family or other persons; access to places or items of significance; music; any personal, religious or cultural practices to be followed):
My Requests: (Initial ONE box which best describes your wishes)

○ If I am acutely ill, and it is reasonably certain that I will not recover, I want to be allowed to die naturally in my familiar surroundings. I do not want my life prolonged by extraordinary or overly burdensome treatments. I wish to receive palliative care that includes treatments to keep me comfortable, pain relief, and be offered food and drink of my choice.

OR

○ In the event of sudden or significant deterioration in my health I request to be transferred to hospital for assessment and possible treatment. For example: 

OR

○ I would like all decisions about medical treatments to be made by my doctors and those I have listed below. I request that they consider my wishes as outlined in this Advance Care Plan.

Declaration by competent # person:

I ask that if possible my MEPOA or trusted representative(s) include the following people in discussions and decisions about my health care:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

I, (Print name) ___________________________ Witness ____________________________________________

Name ___________________________ Witness ____________________________________________

Signature ___________________________ Signature ___________________________

Relationship ___________________________ Date ___________________________

Date ___________________________

# For definition regarding competence please refer to the ACP Information Page

OR

Declaration by MEPOA / Trusted representative (on behalf of a non-competent person):

I, ___________________________ (Print name) declare that the information completed above is a true record of my wishes on this date.

Signature ___________________________ Phone no ___________________________

Relationship ___________________________ Address ___________________________

Date ___________________________

Doctor’s review of plan: Date: ___________________________

Name: ___________________________ Signature: ___________________________