What is the Place of CPR in the Nursing Home?

Hartnett, T. (2004). CPR controversy: A review of cardiopulmonary resuscitation in LTC. *Caring Symposium Reporter. 6,* 1-21.

Since the use of cardiopulmonary resuscitation (CPR) for elders in nursing homes is widely debated, Dr. David L. Jackson, MD, PhD, national medical director of HCR Manor Care and adjunct professor of geriatric medicine, Johns Hopkins University School of Medicine, believes, "The better foundation you build from day one with each patient, the better response you will have when a crisis arises."

In a nursing home setting, understanding the initial goals of CPR, "to save lives of individuals who suffer sudden electrical cardiac disturbances – especially ventricular tachyarrhythmia and fibrillation in the face of a myocardial infarction, help discussions on its appropriateness. Historically these determinations were made in hospitals by emergency medical personnel on relatively healthy, younger individuals. Later CPR began being taught as an emergency response to near death events such as accidental electrocution and near drowning. Gradually CPR has moved to long term care settings.

It is important to distinguish between elders, who need sub-acute rehabilitation but who have few and low severity of co-morbidities, and those who have multiple co-morbidities, are chronically ill and/or are in the late stages of a progressive disease. Research on elders living in nursing homes consistently show very poor outcomes when CPR is performed (survival rate at best is less than 5% [this includes individuals who live but in a coma], and in most studies it has been 0%).

Key issues relate to ethical concerns and state regulations. One ethical dilemma involves these questions:

- Is the physician always required to follow the directions and wishes of the patient and/or family?
- Does the physician have an affirmative duty to provide treatment even when there is no benefit?

Dr. Jackson thinks, "family-control can't be absolute when there is not established benefit for an intervention." He states, "We use the technology simply because it is there. Thus it is the master of the patient and not the servant." He stresses that, "The decision regarding the use of CPR in the nursing home patient should be made based on good evidence-based medicine."

Dr. Jackson's advice is to initiate advance directive discussion within the first 24 hours after admission to a nursing home; when the family has expectations about communicating about the care plan. He suggests that staff return to the issue routinely – especially as clinical issues increase. He suggests involving clergy (of the same faith as the elder) if family members disagree on a decision. Don't wait until the last weeks of life to involve clergy in the advanced care plan. He thinks nursing homes should establish an Ethics Advisory Committee, made up of independent ethicists, clinical staff, social workers and others, if it does not have one.

IMPLICATIONS FOR PRACTICE: Culture change practices such as small groups of residents living in neighborhoods with permanent, consistent staff allows for closeness and more communication with, therefore a better understanding of individual elder's wishes in matters such as end of life desires. It is helpful if staff receives hospice training to be better equipped and more comfortable discussing death with elders.