Post-Acute and Long-Term Care Medical Association
Position Paper I93

"Cardiopulmonary Resuscitation in Long-Term Care Facilities"

The issue of whether to initiate cardiopulmonary resuscitation (CPR) in residents of long-term care facilities must acknowledge the right of residents to direct their course of treatment within the limits of recognized medical effectiveness. The policy of the Post-Acute and Long-Term Care Medical Association (PALTmed) is to provide the highest quality medical care to all long-term care residents and their families in conformity with contemporary ethical and medical standards. Decisions to order treatment limitations in the case of cardiopulmonary arrest in residents within a long-term care facility should be based on medical science, ethical considerations, resident value systems and patient autonomy.

It is PALTmed's position that CPR is most often a futile therapy in long-term care facilities and that attempted resuscitation is over-utilized in this setting. This position is based on current outcome research (see attached references). CPR is a medical treatment, and as such, should always have full disclosure of benefits, risks, and alternatives to the resident or surrogate decision maker under the doctrine of informed consent. The ultimate responsibility for conducting this discussion rests with the attending physician.

Residents and their families need to understand that CPR in the nursing home population is most often unsuccessful. In the hospital setting, where good data are available, only 15% of patients on general medical or surgical floors for whom CPR is attempted survive to discharge. This percentage decreases to two to five percent for the hospitalized patient who is chronically ill and elderly. Survival of the chronically ill, debilitated, elderly resident within the nursing facility following CPR is rare although survival outcomes for some short stay residents may approach that of the community elder. Such underlying chronic conditions as sepsis, neoplasm, neurologic disease and failure of one or more organ systems result in the poor outcomes. Other factors contributing to the poorest outcomes relate to the circumstances of the cardiopulmonary arrest itself such as an unwitnessed arrest, initial asystole, electromechanical dissociation or resuscitation efforts lasting greater than 15 minutes. In circumstances where death is expected, it is consistent with sound medical practice to forego CPR.

It should be clearly understood that treatment limitations regarding CPR do not preclude the delivery of customary urgent and emergent care to residents in serious or life threatening situations that are potentially reversible. Antibiotic treatments, hospitalization, and urgent surgical procedures should be used when indicated regardless of the resident's resuscitation status unless treatment limitation orders have been clearly specified. Comfort care should be given to all, without exception. It should be emphasized that nursing home residence by itself, is not thought to be a marker for the futility of other medical treatment.

The issue of whether to initiate CPR for residents in long-term care facilities must acknowledge the rights of residents to direct their course of treatment within the limits of recognized medical

effectiveness. Information regarding the policies of the long-term care facility as well as the State and Federal laws defining the rights of individuals and surrogates must be presented to all residents at the time of admission as required by the Federal Patient Self-Determination Act. In developing a CPR policy, each facility needs to consider the characteristics of its own population, its institutional philosophy, and available emergency services. PALTmed acknowledges that there may be facilities that elect an across-the-board no CPR policy. As long as this policy is declared to prospective residents prior to admission it will allow the selection of a facility that will be consistent with the resident's wishes.

It is also PALTmed's position that the decision to stop or withhold resuscitation when it is considered to be a futile therapy is appropriately a medical decision that should be made by the physician. Physicians have a duty to abstain from doing whatever in their judgment is deleterious to the patient. This rationale needs to be explained to the resident and/or surrogate and documented in the medical record. In case of conflict, physicians must not abandon residents and must assist in transferring their care to a physician who will be able to abide by their wishes.

In conclusion, developments in the knowledge base concerning CPR mandate new approaches to resuscitation, particularly regarding the lack of efficacy for nursing home residents who have significant and multiple illnesses. Policies that are developed to meet present needs will need continuing revision to remain current, especially balancing the principle of professional responsibility with patient autonomy.

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