MEMORANDUM

TO: WHCA Nursing Home Members
FROM: Brian R. Purtell, Director of Legal Services
RE: CPR in Nursing Homes- DQA memo 13-022/CMS S&C 14-01

In a Memorandum issued October 24, 2013, the Wisconsin Division of Quality Assurance (“DQA”) released DQA Memo 13-022 entitled CMS Clarification on Nursing Home Cardiopulmonary Resuscitation Policies. This Memorandum described the applicability and adjustments necessary in Wisconsin nursing homes following the recent release of CMS S&C Memo 14-01. The CMS memo contained several pronouncements regarding the expectation of the provision of CPR in federally certified nursing homes.

The CMS memo can be summarized as indicating that (a) all nursing homes are expected to have staff certified in CPR on duty every shift; and (b) these individuals must provide CPR for any resident who becomes pulseless or non-breathing unless one of the following conditions exists:

1. The resident has a valid do not resuscitate order;
2. The resident has obvious signs of clinical death; or
3. The initiation of CPR could cause injury or peril to the rescuer.

Most notably for Wisconsin providers, the CMS memo is explicit in prohibiting facilities from adopting a facility-wide DNR policy, as “facilities must not implement policies that prevent full implementation of advance directives and do not promote person-centered.” Wisconsin has previously accepted that nursing homes could implement facility-wide DNR policies, provided that certain conditions were met, including that the nursing home adequately communicated this policy to prospective residents prior to admission to allow them to make an informed decision about placement. The CMS directive on this issue however clearly and explicitly prohibits such policies.

The DQA memo communicating the release of the CMS memo further added that the S&C prohibits a facility from having a policy in which resuscitation would only be provided in the event the arrest was witnessed. The DQA memo states “this is also no longer acceptable.” While
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the CMS memo did not specifically address the “witnessed versus unwitnessed” issue, the statement identifying the only situations when resuscitation efforts can be withheld has the practical effect of precluding an “unwitnessed” exception.

Impact on Members:

Advance care planning, including CPR/DNR issues, in nursing homes and other long term care settings have received significant attention recently. The release of the CMS memo will likely not be the last on this subject, as providers, policymakers, ethicist and researches continue to discuss the appropriateness of resuscitation efforts, particularly on a population of individuals who are likely to not benefit from such efforts. While there will likely be ongoing debate and discussion, members should review their current policies and procedures to assure clarity and compliance with the recent issuance and applicable standards of practice.

WHCA is aware that several members have historically had a facility-wide no CPR policy in place. Such policies are now inconsistent with the expectations articulated in the CMS memo. Facilities with such policies will have to take prompt action to modify such policies and conform them to the directives in the CMS and DQA memos. Efforts should include the development of policy as to when and who shall provide resuscitation in the event of a resident arrest, as well as assuring that sufficient personnel are CPR certified and available in the facility.

Slightly more complicated will be for those facilities that while offering CPR, have included in their policies that resuscitation will not or should not be provided if an arrest is unwitnessed, regardless of a resident’s previously expressed wishes. Based on the DQA memorandum interpreting the CMS memo, those facilities that have an “unwitnessed” exception provision will require modification to policies. While there are authoritative studies on the success rate of resuscitation for unwitnessed arrests in a nursing home to support such a policy, the regulatory dictates and interpretations of resident rights prevail currently on this issue.

While the success rate for unwitnessed nursing home residents might justify such a policy for the frail elderly population, there are also practical issues/challenges in addition to the prohibition in the interpretations just released. These include the increasing presences of “younger” rehab residents who may not be reflected in studies on the efficacy of CPR in unwitnessed situations, as well as the ability of a policy to capture what constitutes an unwitnessed arrest. In recent years there have been several instances in which a facility with an “unwitnessed” policy have been cited or criticized for events in which it was not possible to establish exactly how long had passed since a resident had been seen before being found pulseless and not breathing.

In light of the recent attention triggered by the CMS and DQA interpretations on the issue, all members, regardless of their past policies, should review and revise as necessary in light of the communications issued. In such review, it is recommended that as part of your review/development you rely upon recognized, evidence-based standards of practice, and that you assure involvement of your Medical Director. Given both the reference to and authority of
the American Heart Association’s (AHA) *Guidelines for CPR and Emergency Cardiovascular Care*, it is advisable that this be included in your research and policy development.

The AHA guidelines include the circumstances where it is identified that even in a situation where a resident has expressed a desire for resuscitation, that such efforts could be withheld, *e.g.* when there are obvious signs of irreversible death. The relevant section reads as follows:

| Withholding and Withdrawing CPR  
| (Termination of Resuscitative Efforts) Related to Out-of-Hospital Cardiac Arrest (OHCA) |

**Criteria for Not Starting CPR in All OHCA**

Basic life support (BLS) training urges all potential rescuers to immediately begin CPR without seeking consent, because any delay in care dramatically decreases the chances of survival. While the general rule is to provide emergency treatment to a victim of cardiac arrest, there are a few exceptions where withholding CPR might be appropriate, as follows:

- Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril
- Obvious clinical signs of irreversible death (*e.g.*, rigor mortis, dependent lividity, decapitation, transection, or decomposition)
- A valid, signed, and dated advance directive indicating that resuscitation is not desired, or a valid, signed, and dated DNAR order

In the nursing home setting the most applicable basis for withholding CPR, in the absence of a DNR order would be the obvious clinical signs irreversible death, most specifically the presence of rigor mortis or dependent lividity. A facility policy permitting the withholding of CPR in such instances does present the practical challenge of an RN’s training and expertise in making a definitive determination of the presence of either these conditions in order to appropriately withhold resuscitation for an individual who has previously expressed a desire for resuscitation. Consideration should also be made as to the likelihood of staff encountering an individual with clear and unmistakable rigor mortis or dependent lividity. With both taking several hours to clearly develop, and the rarity of a resident going multiple hours without any staff interaction, the situations where an RN will be presented with such clear indications of irreversible death is few.

As the withholding of resuscitation efforts in the absence of clear basis for doing so has and likely will result in a serious allegation of non-compliance, policies that include the exception for obvious signs of irreversible death should instruct personnel to err on the side of providing resuscitation efforts if there is any question as to the presence rigor mortis or dependent lividity.
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Given the minefield associated with the non-provision of resuscitation efforts for an individual who has expressed the desire for such, the most conservative and cautious approach may be to instruct personnel to provide resuscitation for such individuals except in the most obvious and extreme circumstances of signs of irreversible death. Many providers, recognizing the practical issues have simply provided expectations that staff are to begin CPR in the absence of a DNR order, and await EMS personnel.

While the majority of nursing home residents elect a Do Not Attempt Resuscitation order, there remain individuals who either express a desire for all resuscitation efforts, or a decision is not affirmatively made. While this is certainly an individual’s right, often is the case that clinicians question, based on the resident’s age, condition and other factors, that such is a request for futile treatment. Narrowing the circumstances in which individuals who will likely not benefit from the provision of CPR involves proper and ongoing advance care planning dialogs. Such dialog begins at the admission process through educating the resident and their legal decision makers of the facts and efficacy of resuscitation. This is hopefully a continuation of prior discussions with acute and primary providers. Reducing the number of who elect to have a “full code” status who would not benefit from this will lessen the circumstances in which personnel are expected to provide such efforts, often times knowing that it is contrary to any likely positive results.

The advanced care planning discussion should not end at the admission process and should be revisited regularly, and at a minimum, at a significant change of condition. Members should review the recently revised F155 guidance that enhances the expectations on this process as one that is an ongoing discussion, rather than a one-time presentation of a CPR/Hospitalization form. Revisiting treatment choices, particularly at a change of condition, should be incorporated into the care planning process.

Members with questions regarding the above are encouraged to contact me (brian@whca.com).

Resources:

2010 American Heart Association Guidelines for CPR and ECC

AMDA White Paper on Surrogate Decision-Making and Advance Care Planning in Long-Term Care

Revised F155 Guidance