CPR
Is Our System in Order?

Presented by:
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Objectives
Upon completion of this program, attendees will be able to:
• Review the American Heart Association and Emergency Cardiovascular Guidelines on CPR
• Identify the risk of non-compliance including Immediate Jeopardy
• Examine the steps to ensure that your organization is in compliance

American Heart Association
“ECC=Emergency Cardiovascular Care:
• Immediate Recognition and activation of emergency response system
• Early CPR with emphasis on chest compressions
• Rapid defibrillation
• Effective advanced life support
• Integrated post-cardiac arrest care”

American Heart Association
Change in Sequence:
No longer A-B-C
Is now:  C-B-A:
Chest Compressions-Airway-Breathing

American Heart Association
• For complete recommendations and resources for CPR, please see:
http://www.heart.org/HEARTORG/CPRAndECC/HealthcareProviders/Healthcare-Providers_UCM_001121_SubHomePage.jsp

LAWS, REGULATIONS AND RECOMMENDATIONS
CMS Memorandum

Ref: S&C: 14-01-NH
Cardiopulmonary Resuscitation (CPR) in Nursing Home.


Effective implementation 10/18/2013

CMS Memorandum

- Addresses the American Heart Association guidelines and recommendations
  “According to the AHA, reversal of clinical death is among the goals of ECC (Emergency Cardiovascular Care) since brain death begins four to six minutes following cardiac arrest if CPR is not administered during that time.”

CMS Memorandum

The American Heath Association “urges all potential rescuers to initiate CPR unless:
1. A valid DNR order is in place
2. Obvious signs of clinical death
3. Initiating CPR could cause injury or peril to the rescuer”

Obvious Signs of Clinical Death

- Obvious signs of clinical death:
  - Rigor mortis
  - Dependent lividity
  - Decapitation
  - Transection
  - Decomposition

Background

Federal regulations 42 C.F.R. 483.10
Provide that a resident of a skilled nursing facility or nursing facility has the right

- To a dignified existence
- Self determination
- Formulate an advanced directive

Background

Federal regulations 42 C.F.R. 483.20 and 483.25:
- Services provided by the facility must meet the professional standards of quality
- Provide the necessary care and services to attain the highest practical mental, physical and psychosocial well-being
Memorandum Summary

• Initiation of CPR- Prior to the arrival of (EMS) nursing home must provide basic life support
• Facility CPR- Facilities must not establish system wide no CPR policy
• Surveyor Implication-Review
  – Facility Policies
  – Practice where CPR was not consistent with resident request
  – Formulation of Advance Directives

Wisconsin

October 24, 2013
DQA Memo 13-022

CMS Clarification on Nursing Home Cardiopulmonary Resuscitation Policies


Wisconsin DQA Memo 13-022

(October 24, 2013) Prior to DHS guidance, facilities were allowed to have policies that staff would not provide CPR, rather call 911 or have witnessed code policies—

No longer acceptable

Wisconsin DQA Memo 13-022

• Policies should have been revised
• Residents, families, guardians, etc. should have been notified of the changes
• Discussion with residents/families, etc., should indicate whether a change in advance directives in light of the policy changes
• Facilities must have CPR certified staff on duty at all times

System Evaluation

• Do you have a system in place for quick identification of the code status of each resident?
• How often do you audit this system?
• What is your system for new admissions?
• What is your system for resident choice changes?

Nursing Home Survival

Survival rates are affected with:
• Unwitnessed arrest
• Poor staff response
• Lack of willingness to honor code request
• Lack of training
• Unaware of code status
Statistics

CMS Memo addresses a 2006 JAMDA research study:

- "post survival rates among nursing home residents ranged from 2 to 11 percent"
- "Survival rate was 2 percent"
- "33 percent of residents who wanted CPR did not receive it"

Times are Changing

- 2012 CMS Nursing Home Data Compendium:
  1 in 7 nursing home residents were under the age of 65 in 2001

CPR Ready

- How often does you staff receive training
- Who is trained
- Policy for performing CPR
- How long does it take EMS to arrive
- Is our crash cart in order
- Personal Pocket mask
- Automatic defibrillator

Examples of Responses

- Refused to do CPR on a resident
- Stopped CPR - "She is dead anyway"
- "It’s to late to start CPR"
- "I didn’t even think about starting CPR" (even though she was a full code).

Practice – Practice – Practice

Is every two years enough???

- Retention of skills begin to decline within 10 months.
- Knowledge and psychomotor skill declined declines significantly at 10 weeks and 12 months

Maintaining and Retaining

- Yearly training
- On-site simulation lab
- Short practice session
- 3-6 minutes single CPR
- Practice skill independently
- Immediate feedback

Oermann, Edgren, Maryon, Roberts (2014)
Immediate Jeopardy

Harm
Actual - Has the provider’s non-compliance caused serious injury, harm, impairment, or death to an individual?
Potential - Is the provider’s non-compliance likely to cause serious injury, harm, impairment or death?

Immediate Jeopardy – Level 4
• In which the facility has non-compliance with one or more issues
• Allowed, caused or likely to cause serious impairment or death to a resident
• Requires immediate correction as the facility has allowed the situation to continue

Severity level 3
• Non-compliance that is not immediate
• Non-compliance that resulted in actual harm
• Clinical compromising or decline
• Inability to reach highest practicable well-being

Severity Level 2
• No actual harm, minimal harm, no immediate jeopardy
• Resident has minimal discomfort
• Compromised resident well-being
• Harm may occur if interventions not provided
Sub-Standard Quality of Care

- Substandard quality of care means one or more deficiencies related to participation requirements, resident behavior and facility practices, quality of life, or quality of care, that constitute either immediate jeopardy to resident health or safety (level J, K, or L);
- a pattern of or widespread actual harm that is not immediate jeopardy (level H or I);
- or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F).

Sub-Standard Quality of Care

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with participation requirements. (42 CFR 488.301)

Sub-Standard Quality of Care

Whenever a facility has deficiencies that constitute both immediate jeopardy to resident health or safety and substandard quality of care (as defined in 42 CFR 488.301), the survey agency must notify the attending physician of each resident found to have received substandard quality of care as well as the State board responsible for licensing the facility’s administrator. Notify physicians and the administrator licensing board in accordance with §7320.

Immediate Jeopardy

Examples:
- F309: The facility failed to ensure CPR was initiated on residents with full code status
- CPR initiated on a resident with a DNR status (facility failed to have a proper system in place for quick identification of code status)

Immediate Jeopardy

Immediacy

Is the harm or potential harm likely to occur in the very near future to this individual or others in the entity, if immediate action is not taken?

Immediate Jeopardy

Culpability

Did the facility know about the situation?

???
What Can We Do?

- Systems must be in place
  - Policies, Procedures consistent with regs and best practices
- Staff must be educated
- Staff MUST follow the policies and procedures
- Nurses cannot declare that a resident is “expired” or dead
- All departments will need training
- Ensure all equipment and supplies are in order
- Ongoing practice, audits and compliance monitoring

CPR

Ask Yourself…..

How would YOUR staff Respond in an EMERGENCY?

- Advance Directives
- Clear Documentation
- System to communicate wishes
- Care Planning
- Commitment to Person-Centered Care

Resident Wishes

F155 - Advance Directives

The Intent:
- To establish and maintain policies and procedures in the facility regarding these rights
- To inform and educate residents about your policies/procedures and about how they can exercise their rights
- To help/assist the resident in exercising their rights
- To ensure that the resident choices are incorporated in their treatment, plan, care and services

Tightening up Our Policies

1. Facilities are obligated to establish, maintain and implement written policies and procedures addressing
   a. The resident’s right to formulate an Advance Directive
   b. Right to refuse medical or surgical treatment
   c. The facility must ensure that the staff are following the policies and procedures
   d. Right to decline to participate in experimental research
Steps to Consider

1. On admission, is it determined that the resident has an Advance Directive or will choose to formulate one? Is this documented?
2. What formal system do you have identified in place to ensure that ongoing assessment of resident decision making ability is instituted in order to invoke decision making by a health care agent or legal representative if resident is unable to make their own decisions?

What MUST We Have in Place?

1. Written Policies and Procedures
2. Residents must receive written description of your Policies and Procedures.
3. On Admission, written information regarding the resident’s rights to refuse medical treatment and the right to formulate an Advance Directive.
4. If the resident has formulated/executed an Advance Directive, it should be placed in the same section of the medical record for staff retrieval and communication with staff and physician.

What MUST We Have in Place cont.?

5. If the resident does not have an Advance Directive in place, the facility must
   - Advise the resident/family of the right to establish an Advance Directive
   - Offer assistance in executing the Advance Directive if wishes and to document the process in the medical record
   - If the resident chooses to decline, they cannot be required to execute an Advance Directive
   - **The facility cannot discriminate or determine provision of care based on whether the resident has an Advance Directive

What MUST We Have in Place cont.?

6. The facility must provide education to the resident community on their rights to formulate an Advance Directive and the facilities policies and procedures.

Medical Director Involvement
Medical Director Involvement

Tips for the Medical Director Involvement:

• The Medical Director can help staff and practitioners identify clinical conditions and risks pertinent to the facility's population
• The Medical Director can provide guidance to nursing and other staff concerning when to contact him or her
• Review the medical and clinical appropriateness of the facility's direct-care practices

• The Medical Director can participate in administrative decision-making and the development of policies and procedures related to patient care (including CPR and Advance Directives)
• Monitoring and evaluating the quality and appropriateness of medical services as an integral part of the overall quality assessment and improvement program.

Medical Director Involvement

• A Medical Director can help review and analyze quality data and clinical topics presented at QA meetings and can help identify trends, root causes and pertinent interventions.
• The Medical Director can provide specific guidance for physician performance expectations

Organization Solutions

Immediate Solutions

1. Review current systems for each regulation to identify system updates necessary (i.e. policies/procedures, protocols, etc.) and develop an Action Plan
2. Update all Policies and Procedures to be consistent with the regulations (Quality Assurance, QAPI)
3. All Staff Education regarding each system/process with system to verify competence/understanding
4. Implement the System!
5. Implement a monitoring/audit component to verify compliance with the system.
6. Follow up for any opportunities for improvement!
Solutions

• Provide an opportunity for staff to practice CPR on a quarterly basis (3-6 minutes)
• Develop scenario’s for each shift
• Complete a table top exercise for each scenario
• Practice – Practice – Practice
• Promote training of all licensed and non-licensed nursing staff

Audit System

An effective Audit System will be one that is:
1. Formal
2. Organized
3. Completed as Planned
4. Data is utilized to improve/maintain quality and can be used to benchmark over time

<table>
<thead>
<tr>
<th>Area to Review</th>
<th>Compliance?</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nursing staff able to immediately identify code status of resident</td>
<td>Yes/No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Resident Advance Directive consistent with Code Status on Care Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. A review of 5 nurse personnel records include up-to-date CPR certification</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Audit Example

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Date of CPR Certification</th>
<th>Date of Mock CPR Drill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe</td>
<td>02/15/14</td>
<td></td>
</tr>
<tr>
<td>Susie Smith</td>
<td>02/15/14</td>
<td>10/16/14</td>
</tr>
<tr>
<td>Doris Jones</td>
<td>04/12/13</td>
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</tr>
<tr>
<td>John Williams</td>
<td>10/25/13</td>
<td>9/25/14</td>
</tr>
<tr>
<td>Lilly Andrews</td>
<td>02/15/14</td>
<td>10/16/14</td>
</tr>
<tr>
<td>Maggie Collins</td>
<td>02/15/14</td>
<td></td>
</tr>
</tbody>
</table>

**Fictitious Names

Audit Examples

• CPR Certification Dates
• Mock Drills
• Education Sign in
• Documentation following code:
  – Sequence of events
  – Consistent with Advance Directive/CP?
  – Notifications
  – EMS arrival
  – Follow up

Action Plan

<table>
<thead>
<tr>
<th>Area for Correction</th>
<th>Plan</th>
<th>Responsibility</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>1. 2 of 24 nurses with expired CPR certification</td>
<td>Immediate CPR certification for 2 nurses with expired CPR certification</td>
<td>DON to coordinate</td>
<td>Immediate</td>
</tr>
<tr>
<td></td>
<td>2. DON to ensure all shifts have nurse with current CPR Certification on duty</td>
<td>DON</td>
<td>Immediate</td>
</tr>
<tr>
<td></td>
<td>3. System calendar with alerts for notification 30 days prior to nurses CPR certification expiring</td>
<td>DON and in-service Coordinator</td>
<td>Beginning 11/1/14</td>
</tr>
<tr>
<td></td>
<td>4. Ongoing audits monthly to audit compliance with alerts</td>
<td>DON or designee</td>
<td>Beginning 11/1/14</td>
</tr>
<tr>
<td></td>
<td>5. Results of audits will be reported to quarterly QA Committee</td>
<td>DON</td>
<td>Next QA Committee Meeting</td>
</tr>
</tbody>
</table>
References and Websites


References and Websites


Questions?

Thank You!

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