



Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 14-01-NH

REVISED 01.23.15

DATE: October 18, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Cardiopulmonary Resuscitation (CPR) in Nursing Homes

*****Revised to include information on CPR certification and
Appendix PP draft guidance revisions at F155*****

Memorandum Summary

- **Revisions to Guidance** - The Centers for Medicare & Medicaid Services (CMS) have revised the guidance to surveyors in Appendix PP under F155 to clarify a facility's obligation to provide CPR.
- **Initiation of CPR** - Prior to the arrival of emergency medical services (EMS), nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with that resident's advance directives or in the absence of advance directives or a Do Not Resuscitate (DNR) order. CPR-certified staff must be available at all times.
- **Facility CPR Policy** - Some nursing homes have implemented facility-wide no CPR policies. Facilities must not establish and implement facility-wide no CPR policies.
- **Surveyor Implications** - Surveyors should ascertain that facility policies related to emergency response require staff to initiate CPR as appropriate and that records do not reflect instances where CPR was not initiated by staff even though the resident requested CPR or had not formulated advance directives.
- **CPR Certification** - Staff must maintain current CPR certification for healthcare providers through CPR training that includes hands-on practice and in-person skills assessment. Online-only certification is not acceptable.

The CMS has revised surveyor guidance in Appendix PP of the State Operations Manual (SOM) under F155 to clarify CPR policies for nursing homes. The regulatory language remains unchanged.

A. Background

Federal regulations at 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” and “self-determination” including the right “to formulate an advance directive.” The provisions of §§1819(b)(2) and (b)(4)(A) of the Social Security Act (the Act) and the regulations at 42 C.F.R. §483.20(k)(3)(i) and §483.25 further stipulate that the services provided by the facility “must meet professional standards of quality” and “the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident.”

The American Heart Association (AHA) publishes guidelines every five years for CPR and Emergency Cardiovascular Care (ECC). These guidelines reflect global resuscitation science and treatment recommendations from the 2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care with Treatment Recommendations. According to the AHA, reversal of clinical death is among the goals of ECC since brain damage begins four to six minutes following cardiac arrest if CPR is not administered during that time.¹ In the guidelines, AHA has established evidenced-based decision-making guidelines for initiating CPR when cardiac arrest occurs in or out of the hospital. AHA urges all potential rescuers to initiate CPR unless: 1) a valid DNR order is in place; 2) obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or 3) initiating CPR could cause injury or peril to the rescuer.² AHA guidelines for CPR provide the standard for the American Red Cross, state EMS agencies, healthcare providers, and the general public.

B. Facility CPR Policy

One of the central tenets of person-centered, individualized care is the right to formulate an advance directive. Along with Federal regulations at 42 C.F.R. §483.10, regulations at 42 C.F.R. §489.102 require providers, including skilled nursing facilities (SNFs) and nursing facilities (NFs), to provide written information to residents about their rights to make decisions about medical care, including the right to formulate advance directives. An individual’s choice to forego CPR in a medical emergency is an important aspect of advance directive decision making.

Research generally shows that CPR is ineffective in the elderly nursing home population. A 2006 research study from the Journal of the American Medical Directors Association (JAMDA) described post-CPR survival rates among nursing home residents ranged from 2 to 11 percent. This study found the survival rate was 2 percent with only 67 percent of residents receiving CPR while awaiting arrival of EMS while 33 percent of residents who wanted CPR did not receive it prior to EMS. However, the population in nursing homes is increasingly comprised of younger residents requiring medical care, residents needing short-term rehabilitation, and residents from different cultural backgrounds. The JAMDA study authors concluded that “with the increasing numbers of patients in SNF/NF for short-term rehabilitation, policymakers and nursing home administrators will need to consider the effect of limited resuscitation on these potentially more viable and younger patients.”³ The 2012 edition of the CMS Nursing Home Data Compendium

shows approximately 1 in 7 nursing home residents were under age 65 in 2011, which likely reflects the increased number of short-stay residents. The Compendium also shows nursing home residents have become more ethnically diverse.⁴ Cultural differences may have a significant impact on a resident's beliefs surrounding illness and their willingness to discuss end-of-life issues. The increased diversity of nursing home residents calls for decision-making regarding advance directives to be individualized, documented, and effectively implemented throughout the facility. Any limits on how a facility may implement advance directives should be applied on a case by case basis, taking into consideration a resident's preferences, medical conditions, and cultural beliefs. While some nursing homes have implemented facility-wide no CPR policies, facilities must not implement policies that prevent full implementation of advance directives and do not promote person-centered care.

C. CPR certification

Staff must maintain current CPR certification for healthcare providers through a CPR provider whose training includes hands-on practice and in-person skills assessment; online-only certification is not acceptable. Other government agencies, such as the Occupational Safety and Health Agency (OSHA),⁵ institutions, and States, have also determined that online-only certification is not acceptable. Resuscitation science stresses the importance of properly delivered chest compressions to create blood flow to the heart and brain. Effective chest compressions consist of using the correct rate and depth of compression and allowing for complete recoil of the chest.^{6,7} Proper technique should be evaluated by an instructor through in-person demonstration of skills. CPR certification that includes an online knowledge component, yet still requires an in-person demonstration and skills assessment to obtain certification or recertification, is acceptable.

D. Survey Implications

When reviewing facility policies and procedures related to emergency response, surveyors should ascertain that facility policy, at a minimum, directs staff to initiate CPR as appropriate. Facility policy should specifically direct staff to initiate CPR when cardiac arrest occurs for residents who have requested CPR in their advance directives, who have not formulated an advance directive, who do not have a valid DNR order, or who do not show AHA signs of clinical death as defined in the AHA Guidelines for CPR and Emergency Cardiovascular Care (ECC). Additionally, facility policy should not limit staff to only calling 911 when cardiac arrest occurs. Prior to the arrival of EMS, nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest in accordance with that resident's advance directives or in the absence of advance directives or a DNR order. CPR-certified staff must be available at all times to provide CPR when needed. Facilities must not establish and implement facility-wide no CPR policies for their residents as this does not comply with the resident's right to formulate an advance directive under F155. The right to formulate an advance directive applies to each and every individual resident and facilities must inform residents of their option to formulate advance directives. Therefore, a facility-wide no CPR policy violates the right of residents to formulate an advance directive.

For survey process questions on this memorandum, please contact the CMS Regional Office. Please send policy questions related to this memorandum to dnh_triageteam@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

References:

1. <http://www.nlm.nih.gov/medlineplus/ency/article/000013.htm>.
2. http://circ.ahajournals.org/content/122/18_suppl_3/S665.full.pdf+html
3. Shah MN, Fairbanks, RJ, Lerner, EB. Cardiac Arrests in Skilled Nursing Facilities: Continuing Room for Improvement? J Am Med Dir Assoc 2007 March; 8(3): e27-e31.
4. http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/nursinghomedatacompendium_508.pdf
5. https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=28541.
6. http://circ.ahajournals.org/content/122/18_suppl_3/S685.full.
7. <http://circ.ahajournals.org/content/early/2013/06/25/CIR.0b013e31829d8654.full.pdf+html>.

/s/

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Attachment: Advance Copy of Revised F155

cc: Survey and Certification Regional Office Management