CPR – Cardiopulmonary Resuscitation Policy

**CPR-CARDIOPULMONARY RESUSCITATION POLICY**

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**POLICY**

It is the policy of this facility will provide basic life support, including CPR – Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident’s advance directives.

Nurses and other care staff are educated to initiate CPR, as recommended by the American Heart Association (AHA) unless:

* A valid Do Not Resuscitate order is in place
* Resident presents with obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection or decomposition) are present
* Initiating CPR could cause injury or peril to the rescuer

CPR certified staff will be available at all times. Staff will maintain current CPR certification for healthcare providers including hands-on skills practice and in-person assessment and demonstration of skills.

**CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - DEFINITIONS**

* **Advance Care Planning** – is a process used to identify and update the resident’s preferences regarding care and treatment at a future time including a situation in which the resident subsequently lacks capacity to do so. For example, when life-sustaining treatments are a potential option for care and the resident is unable to make his or her choices known
* **Advance Directive** – means according to 42C.F.R. 489.100, a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Some States also recognize a documented oral instruction.
* **Cardiopulmonary Resuscitation (CPR**) – refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased
* **Durable Power of Attorney for Health Care** (a.k.a. “Medical Power of Attorney”) is a document delegating authority for an agent to make health care decisions in the case the individual delegating that authority subsequently becomes incapacitated
* **Health Care Decision – Making** – refers to consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual’s physical or mental condition
* **Health Care Decision-Making Capacity** – refers to possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choices.
* **Life-Sustaining Treatment** – is treatment that, based on reasonable medical judgment, sustains an individual’s life and without it the individual will die. The term includes both life-sustaining medication and interventions (e.g., mechanical ventilation, kidney dialysis, and artificial hydration and nutrition). The term does not include the administration of pain medication or other pain management interventions, the performance of a medical procedure related to enhancing comfort, or any other medical care provided to alleviate a resident’s pain.
* **Legal Representative** (e.g., “Agent”, “Attorney in Fact”, “Proxy”, “Substitute Decision-Maker”, “Surrogate Decision-Maker”) – is a person designated and authorized by an advance directive or State law to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions
* **Treatment** – refers to interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms

**OBJECTIVE OF THE CPR-CARDIOPULMONARY RESUSCITATION POLICY**

The objective of the CPR policy is to provide basic life support based until emergency medical services arrives, consistent with the resident advance directives, in the absence of an advance directive or Do Not Resuscitate Order and if the resident does not show signs of clinical death. Prompt initiation of CPR is essential as brain death begins four to six minutes following cardiac arrest if CPR is not initiated within that time.

**OVERVIEW OF COMPONENTS OF THE POLICY**

1.  Requirements for CPR-Cardiopulmonary Resuscitation:

1) Personnel must provide basic life support, including CPR, to a resident who requires such emergency care prior to arrival of emergency medical personnel:

a. Subject to related physician orders

b. Consistent with the resident’s Advance Directive

2) CPR certified staff must be available at all times

a. Staff must maintain current CPR certification for healthcare providers through a CPR provider with training that includes hands-on skills practice and in-person assessment and demonstration of skills

b. Online-only certification is not acceptable

**PROCEDURE FOR CPR-CARDIOPULMONARY RESUSCITATION**

**PURPOSE**

The facility shall provide basic life support, including CPR to a resident who requires such emergency care prior to the arrival of emergency medical services, consistent with the resident’s advance directives and physician orders.

**SUPPLIES**

* Backboard
* Face mask or Resuscitator Bag
* Automated External Defibrillator (AED)
* Crash Cart
  + Basic airway equipment
  + Oxygen masks, tubing, cannulas, etc.
  + Suction Machine and equipment

**PROCEDURE**

1. Employee to verify safety of the scene/environment

2. Check for resident response. Tap or shake shoulder of resident asking, “Are you okay”.

3. Simultaneously assess the resident for breathing and pulse for 10 seconds.

* If necessary, open the airway:
  + Head-tilt/chin-lift technique
  + If a head, neck or spinal injury is suspected, utilize the modified jaw-thrust maneuver

4. Shout for nearby help or pull the call button for assistance. Activate emergency response system. Staff immediately instructed to retrieve AED and emergency equipment. If collapse was witnessed and staff member alone, leave resident to activate the emergency response system and retrieve AED (unless another staff member is able to retrieve device) before beginning CPR.

5. Identify code status/advance directive preferences **(Include facility process for identification of code status/advance directive**).

* If the resident has a valid advance directive, a POLST (Physician Orders for Life-Sustaining Treatment Form that indicates that **resuscitation is not desired**) or MOLST (specify State specific documentation) or a “Do Not Resuscitate” (DNR) (Also known as DNAR -Do Not Attempt Resuscitation) order, **do not perform CPR**.

6. If no DNR order/advance directive exists or if advance directive does not indicate “Do Not Resuscitate”, **begin resuscitation efforts**:

7. If Resident does not exhibit normal breathing and has a pulse, **begin rescue breathing**, 1 breath every 5-6 seconds (10-12 per minute) using face mask or Resuscitator Bag.

* If resident is presenting with agonal breaths, continue as if resident is not breathing

8. Check pulse approximately every 2 minutes.

9. If no pulse, **begin CPR** (\*Please note: if AED is immediately available, use defibrillator as soon as possible when device is ready for use):

* + Place backboard under resident in bed or assist resident to a firm, flat surface if possible
  + Compress chest compressions at a rate of 100-200 per minute (place 2 hands on the lower half of the sternum)
  + Compress to a depth of at least 2” (inches)
  + Ensure full recoil following each compression
  + Minimize any pauses in compressions
  + Ventilate 2 breaths after 30 compressions, each breath to be delivered over 1 second, causing chest to rise (30:2 Ratio for both 1 or 2 rescuers). Use face mask or resuscitator bag.

10. AED: Follow manufacturer’s recommendations (See AED Policy and Procedure): Check rhythm.

* If AED indicates yes, shockable, give 1 shock. Resume CPR immediately for approximately 2 minutes until the AED prompts a rhythm check. Continue resuscitation efforts until one of the following occurs:
  + - Resident presents with effective, spontaneous circulation
    - Care is transferred to emergency responders to provide advanced life support
    - The rescuer is not able to continue due to exhaustion, dangerous environmental hazards or efforts to resuscitate places others in danger
    - Reliable and valid criteria that indicates irreversible death are met, criteria of obvious death are identified or criteria for termination of resuscitation is met.
  + If AED indicates no, non-shockable, Resume CPR immediately for approximately 2 minutes until the AED prompts a rhythm check. Continue resuscitation efforts until one of the following occurs:
    - Resident presents with effective, spontaneous circulation
    - Care is transferred to emergency responders to provide advanced life support
    - The rescuer is not able to continue due to exhaustion, dangerous environmental hazards or efforts to resuscitate places others in danger
    - Reliable and valid criteria that indicates irreversible death are met, criteria of obvious death are identified or criteria for termination of resuscitation is met.

11. Turn CPR over to emergency personnel upon arrival and prepared to take over

12. Perform hand hygiene.

13. Notify physician of resident status and obtain further orders.

14. Notify family/Resident Representative.

15. Prepare for transfer, including documentation information to be sent with emergency responders to hospital.

16. Document all appropriate information, including the transfer, in the medical record.

**AUTOMATED EXTERNAL DEFIBRILLATOR USE**

**POLICY**

It is the policy of this facility to use the automated external defibrillator (AED) when indicated in conjunction with CPR, based on resident wishes/advance directives

**EQUIPMENT/SUPPLIES**

1. Automated external defibrillator (AED) machine
2. 2 sets of electrode pads
3. Towel
4. Razor
5. Scissors
6. Gloves
7. Facemask/moth barrier device
8. Resuscitator Bag
9. Crash cart

**PROCEDURE**

**For Automated External Defibrillator, follow the manufacturer’s indications of use and instructions for application.**

* Manufacturer’s operating instructions may vary. Refer to the manufacturer’s instruction manual for specific guidance in the use and maintenance of the AED machine. It is recommended that a copy of the instructions and a copy of the policy and procedure be kept with the AED.
* **Check state regulations or requirements for use of an AED unit or training.**

**NOTE:** Only staff members who are CPR certified and trained in the use of AED may perform these procedures.

1. Confirm the resident’s individual Advance Directives.
2. CPR Certified staff are to assess the person for the following:
   1. Consciousness
   2. Open airway and check for breathing
   3. Check for signs of pulse (circulation)
3. Activate the Emergency Medical System (EMS)/Call 911.
4. Initiate CPR according to the facility’s guidelines, follow the CPR policy and procedure, and bring the AED to the location. The AED should be used as soon as possible.
5. Provide privacy, if possible. Ensure that the area around the person is safe and free on moisture. If resident is near water, move them to another location nearby.
6. Turn on the AED and follow prompts
7. Expose chest area and apply the electrode pads.
   1. Dry the chest if wet. (Note: if chest hair prevents contact with skin, shave the area if necessary and avoid cutting skin.)
   2. Do not apply alcohol, tincture of benzoin, antiperspirants or other products to the skin.
   3. Place electrode pads according to manufacturer’s instructions. Check the pads to make sure that the gel has not dried out.
8. Attach electrode connector to the AED if not already done.
9. Follow message prompts given by the AED. These will vary depending on the manufacturer.
10. If appropriate to your machine, push the Analyze button. NOTE: During the analyze process, the victim cannot be moving and announce to all staff to stand clear.
    1. If shock indicated:
       1. Assure everyone is clear
       2. Push shock button to reanalyze
       3. Repeat sequence up to three times
    2. If no conversion:
       1. Start CPR
       2. Follow AED prompts to stop CPR and clear for device to analyze rhythm and recommend to shock
       3. Repeat sequence until EMS arrives
    3. If shock not indicated:
       1. Reassess person for airway, breathing, and circulation
       2. Start CPR, if indicated
       3. Device will prompt to stop CPR and clear for device to analyze rhythm and recommend to shock. Follow directions until EMS arrives
    4. If cardiac conversion occurs, check for pulse. If pulse present, manage airway appropriately and assist ventilation as necessary. Leave the AED attached. Take vital signs as indicated.
11. Care of the person is to be transferred to the EMS personnel upon their arrival.
12. Notify resident’s physician and family/responsible party.
13. Document the episode, including notification to physician and family in the resident’s medical record. If it is a visitor or volunteer, complete and incident report. If it is staff, complete and employee occurrence report.
14. Clean the AED according to the manufacturer’s instructions, restock pads/other supplies and return AED to the storage area.
    1. Facility should monitor expiration dates of electrode pads.
15. AED battery life and operational status should be checked in accordance with the manufacturer’s recommendation (*identify here*)

**References**

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities 10/04/16:

* <https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

State Operations Manual Appendix PP – Guidance to Surveyors for Long-Term Care Facilities, 06/10/16:

* <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>

CMS Memo Ref:  S&C 17-07-NH:  Advance Copy – Revisions to State Operations Manual (SOM), Appendix PP- Revised Regulations and Tags, 11/09/16:

* <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf>

American Red Cross, Basic Life Support for Healthcare Providers, Provider Handbook, 2015:

* <http://www.redcross.org/images/MEDIA_CustomProductCatalog/m48040087_BLS_Handbook_(Final).pdf>

2015 American Heart Association Guidelines for CPR & ECC:

* <https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/>

Highlights of the 2015 American Heart Association Guidelines Update for CPR and ECC. American Heart Association:

* <http://eccguidelines.heart.org/wp-content/uploads/2015/10/2015-AHA-Guidelines-Highlights-English.pdf>

FDA: Strategies for clinical and Biomedical Engineers to Maintain Readiness of External Defibrillators:

* <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/CardiovascularDevices/ExternalDefibrillators/ucm233451.htm>