CPR Challenges in Aging Services: Untrained Staff, Unclear Resident Wishes, Unmanaged Risks

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ECRI Institute and* Annals of Long-Term Care: Clinical Care and Aging (ALTC) *have joined in collaboration to bring* ALTC *readers periodic articles on topics in risk management, quality assurance and performance improvement (QAPI), and safety for persons served throughout the aging services continuum. ECRI Institute is an independent nonprofit that researches the best approaches to improving health care.

ECRI Institute frequently receives questions from aging services providers regarding aspects of staff providing cardiopulmonary resuscitation (CPR) to residents in respiratory or cardiac distress. In some settings, staff who are untrained in performing CPR may find a resident in distress, call 911, and be directed by the dispatcher to perform CPR despite their lack of training. In other cases, a resident's wishes regarding resuscitation may not be documented or such documentation may not be available.

In each of these situations, indecision on the part of staff can jeopardize resident safety and raise the risk that resident's wishes will not be honored, in turn raising the risk for legal liability. ECRI Institute advises organizations to take an approach that combines setting realistic expectations, encouraging use of advance directives, and training staff to reduce all of these risks.

Untrained Staff

If untrained staff are directed by a 911 dispatcher to perform CPR, how should they respond? Should the staff inform the dispatcher that they are not trained? What are the risks if an untrained individual performs CPR anyway?

Lawsuits can arise with almost any response in this situation—against the individuals as well as the organization—if CPR is performed negligently or against the organization if CPR is not performed. The latter situation arose in 2013 and made national news when a resident died after staff refused to perform CPR despite a 911 operator's instructions.[1]

ECRI Institute recommends that organizations establish emergency response practices that do not depend on state Good Samaritan laws to protect employees. While there is no imperative to train all employees in CPR, organizations should consider requiring training for staff who respond to call bells or other emergencies as "first responders."

In instances where performing CPR is part of someone's assigned duties—whether formally or informally, as part of the person's job description, or by request in an emergency—ECRI Institute suggests that the organization provide training and certification the person will need in the course of his or her duties. This may include providing training in CPR and first aid so that the person can handle an emergency until paramedics or other emergency responders arrive. Determining that CPR is medically indicated can be both difficult and stressful. Providing training and certification beforehand can give employees the needed skills and can help to engender confidence in others at the scene (eg, a spouse).

If a 911 dispatcher provides instructions on performing CPR and the person being instructed to act does not have the knowledge or ability to perform CPR or is not certified, the individual should convey this information to the operator. The operator may ask if anyone else is present who knows CPR and work with that person until more help arrives. In situations where an employee is certified to perform CPR but emergency medical response is not part of his or her assigned duties, the organization is still likely to face greater risk for not responding than if the staff member performs CPR effectively in a medically indicated situation. Risk may be greater in higher-acuity-level settings, but, even in independent living settings for older adults, residents certainly are at risk for cardiac events.

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Setting expectations for residents that CPR will be attempted if indicated in a medical emergency is a key risk management step. Because do-not-resuscitate (DNR) orders may not be immediately available in such situations, organizations should focus on setting realistic expectations for residents and their families about emergency medical incidents. If staff are instructed to begin CPR when a trained person is present, this policy should be communicated to residents. Town hall meetings for independent living residents can be one opportunity to reinforce this policy and answer questions regarding appropriate use of the call bell, CPR administration, and even refusal of transportation to the hospital.

Advance Directives

Encouraging residents to have an advance directive, living will, or durable power of attorney for health care is an important first step in defining expectations. The first two mentioned are written or oral communications about the wishes of individuals in advance of the need for resuscitation and are based on the Patient Self-Determination Act of 1990.[2] These advance instructions must be initiated while the person is able to cognitively understand the implications of the directive and, while they may be either written or oral, written communications are more desirable. These communications may be revoked at any time. Hospitals and assisted-living/skilled-nursing organizations ask at admission whether the person has an advance directive. Physicians in practice settings may also ask whether their patients have advance directives.

Communication and Setting Realistic Expectations

Communication is key. Setting realistic expectations with potential clients begins within marketing materials that provide information about the services that are—and are not—provided within each level of care or service line. Giving information to prospective clients about the benefits of written advance directives is a great way to begin a conversation about the individual's wishes regarding treatment during long periods of incapacity or at the end of life.

Continuing care retirement communities (CCRCs) might talk about advance directives at resident council or town hall meetings if residents raise concerns about such incidents. Leaders of the organization might talk about the resuscitation policies of the different levels of care and service lines within the organization. This is an opportune time to listen and respond to concerns of residents about end-of-life issues.

It is critical that policies and procedures stay up-to-date and address the approach to advance directives and emergency response in all levels of care and service. Many CCRCs address advance directives of clients entering assisted living or skilled nursing, and a majority of long-term care residents may have a DNR or do-not-attempt-resuscitation (DNAR) order. However, short-term care patients may not have a DNR order, expecting to get better and leave the skilled-nursing organization. Organizations must clearly distinguish DNR or DNAR status through policies and procedures, in the resident record, and through a fail-proof notification system. Underscoring the need for the most up-to-date processes is the introduction of automated external defibrillators into the environment and perhaps into clinical equipment.

Personal communication about advance directives or DNR or DNAR status is tricky at best. Many residents may not wish to openly advertise their DNR or DNAR status with a bracelet and refuse to wear one. Thus, identification may depend on other forms of notification. In independent living and in home- and community-based residences, refrigerator kits, yellow packets, or other identification kits for emergency medical services (EMS) providers may be used. Organizations may help independent-living and home- and community-based residents display their advance directives in the appropriate location according to state law.

Records Management

Another critical element of a comprehensive emergency response program is records management. Several documents are associated with treatment decisions, such as physician orders, advance directives, designation of a health care proxy, and DNR paperwork. The American Heart Association (AHA) defines an advance directive as[3]:

> [A] legal binding document that in the United States is based on the Patient Self-Determination Act of 1990. It communicates the thoughts, wishes, or preferences for healthcare decisions that might need to be made during periods of incapacity. . . . The legal validity of various forms of advance directives varies from jurisdiction to jurisdiction. Courts consider written advance directives to be more trustworthy than recollections of conversations.

The AHA goes on to define a DNR or DNAR order as an order that[3]:

> [I]s given by a licensed physician or alternative authority as per local regulation and it must be signed and dated to be valid. The DNAR order should explicitly describe the resuscitation interventions to be performed in the event of a life-threatening emergency. In most cases, a DNAR order is preceded by a documented discussion with the patient, family, or surrogate decision maker addressing the patient's wishes about resuscitation interventions. In addition, some jurisdictions may require confirmation by a witness or a second treating physician.

It is important to note that an advance directive does not have to contain a DNR or DNAR order. Further, according to the AHA, a DNR or DNAR order is valid without an accompanying advance directive. Documentation of a DNR or DNAR order "can take many forms (eg, written bedside orders, wallet identification cards, identification bracelets, or predefined paper documents approved by the local emergency medical services authority). The ideal DNAR documentation is portable and can be carried on the person."[3]

ECRI Institute recommends that an organization develop specific policies and procedures that address where the advance directive will be maintained. The same holds true for any DNR or DNAR order. The speed and ease of locating such information are critical to its usefulness. Further, the information must be up-to-date.

Some organizations have placed dot stickers on the outside of records to symbolize a "no code" status. This system is not foolproof in that dots may fall off, become loose and stick to another record, be accidentally left on if the person changes his or her mind, or be left on the record on discharge, providing erroneous information about the next person.

Staff Education

Staff training and education play an important role in effective emergency response. The many considerations include the following:

Knowledge of emergency response policies and procedures. Since timing is a critical factor in effective emergency response, it is vital to educate staff about the organization's scope of and procedures for emergency response. Awareness of the organization's published practices allows staff to respond in a professional, confident, and calming manner—all important elements when responding to medical emergencies. These policies and procedures should include emergency notification practices (ie, who gets notified and how), the care to be delivered, and the steps that should be taken to facilitate EMS arrival, depending on the event.

Emergency care certifications. Given the likelihood that most aging services providers will experience emergency care events at one time or another, a predetermined approach allows the organization to create care and response systems to address medical emergencies. Assigning responder responsibilities to specific positions allows the organization to address consistent staffing patterns and provide the emergency care training and certifications that may be indicated, such as first aid or CPR.

Event response evaluation. Assessing organizational response after emergency care events can help identify education and training needs, improve organizational response, and prompt needed revisions to policies and procedures.

Resident education and training. As vested stakeholders in this process, organizations should take every opportunity to educate residents on available emergency services and response procedures. Discussions about emergency services, whom to contact when, and what to expect in response to emergency notification should be held before and during admission and regularly at resident council or town hall meetings.

Process Management

A last consideration is the processes that will be followed when a resident experiencing a medical emergency has a known advance directive or DNR or DNAR order and those that will be followed when it is not known whether the resident has an advance directive or DNR or DNAR order. Policies and procedures must clearly delineate how staff immediately identify the code status of an individual who is "down" and should state that if the code status cannot be determined immediately, CPR will be initiated. The issue here is that delay in CPR may result in brain death or death, whereas CPR can be performed until code status is known. Organizations must educate residents and families that it is the policy of the organization to begin CPR if the DNR or DNAR status or advance directive is not immediately obvious. Residents and families can be brought into the discussion by talking about the policy to begin CPR if status is unknown in cases such as when a resident is out walking on the grounds or in another common area that is far away from the DNR or advance directive. Policies and procedures must also outline whether and when 911 calls will be made—particularly when the individual is known to have a DNR or DNAR order.

Conclusion

Each organization must ensure understanding of local and state regulations concerning resuscitation and adherence to advance directives and DNR or DNAR orders. ECRI Institute recommends that policies, procedures, and education closely mirror local, state, and federal regulations regarding when, where, how, and by whom to perform—or not to perform—CPR.◆

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