



STATE OF NEW YORK DEPARTMENT OF HEALTH

161 Delaware Avenue Delmar, NY 12054-1393

January 4, 2007

DQS-DAL: 07-01
Subject: Resident Advance Directives
and Basic Life Support

Dear Administrator:

This letter is intended to communicate the Department of Health's current policy and guidance regarding advance directives and basic life support, such as cardiopulmonary resuscitation (CPR) in nursing homes.

The Department issued guidance in August 1999, which stated that nursing facility staff must provide CPR to a resident whose heart is not beating, unless a resident's advance directive indicates it is not desired (see DAL 99-3). The Department believes that clarification of current policy and expectations can better protect residents' health and safety, as well as their right to self-determination.

The goals of emergency cardiovascular care (ECC) are to preserve life, restore health, relieve suffering, limit disability, and reverse clinical death (American Heart Association (AHA) Guidelines for CPR and ECC, 2005). Sudden cardiac arrest is a leading cause of death in the United States. As nursing homes continue to admit and care for increasingly clinically complex individuals, the potential for a cardiac arrest in nursing homes has also risen. According to the AHA, the provision of CPR, when performed immediately after a cardiac arrest, can greatly increase the victim's chance of survival. Therefore, it is critically important that nursing homes have coordinated, effective processes to appropriately respond to cardiac arrests.

State regulations (10 NYCRR § 400.21) and, where applicable, federal regulations (42 CFR § 483.10; Part 489, Subpart I) require nursing homes to maintain written policies and procedures addressing advance directives, such as health care proxies, orders not to resuscitate, Medical Orders for Life Sustaining Treatment (MOLST) forms and living wills. Also, under 10 NYCRR §§ 415.13, 415.26(c)(1)(iii)(a)(4) and 415.26(f)(3), nursing homes must have sufficient personnel to provide services, including CPR, to all residents on a 24-hour basis and must train all staff regarding resident emergency procedures and carry out staff drills.

The Department expects that nursing facilities will have in place systems, policies and procedures that ensure that resident advance directives regarding basic life support will be identified, known, and honored. Specifically, the Department requires the following:

Resident Advance Directives and Basic Life Support

- Nursing facilities will have in place policies and procedures that govern the identification, documentation, and implementation of resident advance directives. Staff should be knowledgeable about these policies and procedures.
- The policies and procedures will be communicated to prospective residents and their representatives prior to and upon admission to the facility.
- The receipt of the policy by residents and their representatives will be acknowledged in writing by the receiver and documented in the resident chart.
- Resident advance directives will be identified on the day of admission. They should be communicated to direct care staff who are responsible for caring for the resident, immediately upon admission. Delays in identifying the resident's resuscitative wishes are not acceptable.
- Any changes in the resident's wishes will be communicated to staff.
- Each nursing facility will have in place a system of identifying resident resuscitative status. The system may include more than one method, e.g., list at the nurses' station, DNR written on a wristband, wristband identifier, etc. However, the system must be consistent throughout the facility, and at least one identifier will be in the resident's room.
- The resuscitative status information will be reviewed frequently, to ensure that it is up to date. If more than one identification method is used, the information must be reviewed frequently to ensure that the information from each method is consistent.
- The resident's resuscitative status information will accompany the resident when the resident is transported from one location to another. For example, if the resident attends a physical therapy session in the therapy room, the resuscitative status must be available to therapy staff in the room. If the resident has a Do Not Resuscitate (DNR) order, a non-hospital DNR order must accompany the resident when the resident leaves the facility, for any reason.
- Staff with direct care responsibilities will be aware of the location of resident resuscitative status information, throughout the facility.
- All facility staff, including non-direct care employees and non-employees (e.g., temporary agency staff) will be aware of what to do if they encounter a resident arrest.
- The facility will maintain a record of any staff who are trained and capable of providing CPR and will be able to demonstrate current competency.
- Each facility's policy will include the administration of drills intended to evaluate and demonstrate compliance with facility policy and acceptable standards of practice as they

relate to identification of resuscitative status, response to resident event, and administration of all levels of CPR used in the facility.

The Department expects that each nursing facility will have at least one person with documented training who is capable of providing CPR, on each unit, on every shift, every day. The facility may use CPR educational materials and/or CPR courses from the American Heart Association, American Red Cross, National Safety Council or other equivalent educational material which meets the AHA Guidelines 2005.

The AHA recommends a response to a witnessed event within three to five minutes. To the extent possible, providers should maintain adequate numbers of trained staff such that the AHA recommendation can be achieved. Any staff can be trained to provide CPR.

In addition, consistent with AHA guidelines and to ensure ongoing quality, providers should consider implementing policies that require a review of all incidents and the timeliness and quality of the staff response.

In the absence of a DNR order, based on AHA guidelines, there are a limited number of patient situations where CPR does not need to be initiated. Nursing homes wishing to develop a policy that would apply these guidelines should review the AHA guidelines. As a reminder, a RN is the only nurse who can assess a resident and choose NOT to initiate CPR. If such a decision is made, the RN must document those findings and that decision in the resident's chart.

The Department continues its research to determine the appropriateness of implementing a uniform resuscitative status identifier. As this work progresses, we encourage nursing facilities to discuss with other nursing homes and hospitals in their communities the possibility of establishing a uniform DNR identifier that would be consistent across those care settings. This will likely reduce the potential for confusion on the part of individuals who work in multiple facilities as to how to accurately identify the resuscitative status of the patient/resident.

This guidance should be reviewed with the facility Medical Director, Director of Nursing Services, and all organizational leaders to ensure that expectations are met and appropriate systems and processes are in place. In addition, please ensure that staff are trained and knowledgeable about your facility's policies. Their knowledge, training, and ability to respond appropriately could very well save a life.

Please contact Denise Breli-Hyland, Division of Quality and Surveillance for Nursing Homes and ICFs/MR, at (518) 408-1267 if you have any questions regarding this guidance. Our thanks to our provider associations for their assistance in discussing and researching this issue.

Thank you for your prompt attention to this very important issue, and your continued commitment to high-quality care, resident safety, and respectful, dignified quality of life for our residents.

Sincerely,

A handwritten signature in black ink that reads "Keith W. Servis". The signature is written in a cursive style with a large, prominent 'K' and 'S'.

Keith W. Servis, Director
Division of Quality & Surveillance
for Nursing Homes and ICFs/MR