TO CODE OR NOT TO CODE: THAT'S NOT REALLY THE QUESTION

Emily Park
Husch Blackwell LLP
235 East High Street
P.O. Box 1251
Jefferson City, MO 65102-1251
(573) 761-1120
emily.park@huschblackwell.com

OVERVIEW

• No-CPR policy or not: that is the question
• A No-CPR policy is a policy under which staff is prohibited from or limited in attempting CPR on ALF residents
• We will cover why this is a hot topic
• What the law requires
• The policy options
• Justifications and issues with having a No-CPR policy
• What should be done regardless of the policy chosen

Why is this a topic of conversation?

• California ILF Situation – Brookdale Senior Living
California ILF Situation

- An employee was asked by a 911 dispatcher to begin CPR on an 87-year-old resident, but the employee refused.
- The 911 dispatcher pleaded with the employee: “I understand if your boss is telling you, you can’t do it, but as a human being…you know, is there anybody that’s willing to help this lady and not let her die? …Is there a gardener? Any staff, anyone who doesn’t work for you?”
- The employee was allegedly following a facility policy that, in the event of a health emergency, the staff is to immediately call EMS for assistance.
- The residents are informed of and agree to this policy on admission.
- The resident ultimately passed away at the hospital.
- The resident’s family expressed their satisfaction with the facility’s actions, but the media accounts of the situation caused great alarm.

Why did the California case cause such great alarm?

- Death denying culture
- Presentation of CPR in television and movies has led to high expectations about its use and success in everyday life.
- CPR has “symbolic importance” – it is the “last action we can take to try to keep people from dying.”

Whether an ALF can have a “No-CPR” policy depends on state law

- At least 18 states – CPR-trained staff members are required
- Oregon – recommends CPR training, but does not require it
- Montana – CPR trained staff need only be on duty if the facility offers CPR
- Kentucky – must train staff on CPR “unless the policies of the [ALF] state that this procedure is not initiated by its staff, and that clients and prospective clients are informed of the policies.”
- In many states, the law is unclear. Missouri, for example, has no requirement that staff be CPR-trained, but ALFs are required to provide 24-hour “protective oversight.” At least one Missouri ALF has been cited for failure to provide protective oversight by failing to attempt CPR. BUT, this facility also had a policy stating that it would have CPR-trained staff and provide CPR in emergencies.
What is the relevant law for ALFs in Kansas?

- Staffing requirements – “sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident's functional capacity screening, health care service plan, and negotiated service agreement.” K.A.R. 26-41-102.

- Staff training and education regulation DOES NOT explicitly require CPR training. K.A.R. 26-41-103.

- In its April 2013 newsletter, KDADS confirmed that there is NO requirement that adult care homes in Kansas have CPR-trained staff.

- KDADS instructed that, because residents may have an expectation that CPR will be performed, each adult care home should disclose, prior to admission, its process for responding to individuals who desire CPR.
Kansas law does require informing residents of the facility policies and procedures and Kansas statutes related to advance directives. K.A.R. 26-39-102(b) and (c).

- Durable Power of Attorney for Health Care Decisions (K.S.A. § 58-625 et seq.)
- Do Not Resuscitate Orders and Directives (K.S.A. § 65-4941 et seq.)
- Living Wills (K.S.A. § 65-28,101 et seq.)
- Under the Living Wills statutes, a physician may refuse to comply with a valid declaration (i.e., moral objection), but must transfer the patient to another physician. Likewise, some facilities may have moral objections to following a living will. This is partly the reason facilities must disclose their policies and procedures regarding advance directives.

To have a No-CPR Policy or Not

Policy Options

- "No-CPR" – Staff is to immediately call EMS and wait with the resident. The policy can provide that staff is not permitted to perform CPR or add caveats:
  - Only trained staff are permitted to perform CPR (this may require the facility to staff employees who are CPR-trained); or
  - Any staff member may follow instructions from 911 for CPR until paramedics arrive
- CPR Not Routine – CPR will not be performed unless the resident has been fully informed of the risks and benefits and an order has been put into the resident’s record that CPR is desired (or in certain other situations, such as a medical professional has decided CPR is appropriate and the resident does not have a DNR)
- CPR (Unless DNR) – Staff will perform CPR pursuant to the American Heart Association’s guidelines unless the resident has a valid DNR or other advance directive.
Justifications for having a “No-CPR” policy or policy where CPR is not routine

- Attempted CPR has low success rates in nursing home residents and the elderly
  - Studies on attempted CPR on nursing home residents show survival rates from 0-5%
  - These studies led one author to conclude that no-CPR should be the default policy in SNFs, with orders to attempt CPR being put on record for residents who wish to have CPR attempted (if needed) after explanation of the risks and benefits and outcomes of attempted CPR in the SNF. See Steven Zweig, Cardiopulmonary Resuscitation and Do-Not-Resuscitate Orders in the Nursing Home, 6 Arch. Fam. Med. 424, 426 (1997).
  - Data collected on out of hospital cardiac arrests under the CDC Cardiac Arrest Registry to Enhance Survival (CARES) show that 10/01/05 to 12/31/10:
    - 13.5% occurred at nursing homes and ALFs with a survival rate of 3.7%.
    - For age groups (regardless of the location), the survival rate of those aged 65-79 was 9.3% and those aged 80+ was 4.4%.
    - Residents of ALFs generally are in better health than those in SNFs. The facility should look at its own resident population and staffing when deciding on a CPR policy.

Justifications (continued)

- Attempted CPR can cause harm to elderly residents.
  - One physician has referred to attempting CPR on fragile elderly individuals as “violent.”
  - Rib and sternum fractures are possible in such cases.
  - Dislodging pacemaker electrodes is another possibility.
  - Staffing
    - Untrained staff may be more likely to cause injury by improperly performing CPR.
    - If you implement a policy that you WILL provide CPR in emergencies, you will be required to follow your own policy and provide trained staff.

Justifications (continued)

- The facility could face liability if CPR is attempted and the resident has a valid advance directive in place instructing against the use of life-prolonging procedures
  - Statutory
  - Negligence (although this claim is difficult in states that do not recognize “wrongful life” claims)
  - Battery
  - Intentional Infliction of Emotional Distress
Potential Problems with a No-CPR Policy

- Wrongful death action. See Kranson v. Valley Crest Nursing Home.
- Medical malpractice – breaching a standard of care, proximately causing injury (i.e., a claim that failure to initiate CPR immediately caused brain damage)
- Citations from regulatory agency for resident abuse or neglect related to the failure to provide adequate care.
  - Numerous nursing facility cases on failure to provide CPR – Legacy Health; Epsom Healthcare; Lakewood Villa Healthcare Ctr:
    - At least one Missouri ALF has been cited for its failure to attempt CPR on a resident
- Criminal prosecutions for resident abuse and neglect
- Professional disciplinary actions
- Bad publicity

What needs to happen regardless of the policy

- KDADS expects the facility's CPR policy to be disclosed (along with the facility's policies regarding advance directives)
- Disclosure means thoroughly and explicitly explaining the policy
- Disclosure to residents, their representatives, and their family members frames their expectations, which logically lowers the chances of a lawsuit
- Disclosure should occur prior to or at the time of admission
- Clear disclosure prior to admission may allow the facility to argue that the resident effectively made a choice about his or her care when the resident decided to live an ALF that clearly disclosed its no-CPR policy.
- If the policy is that CPR will not be attempted by staff or that staff will not routinely attempt CPR, the disclosure of this policy to the resident, legal representative, and family members should be documented by having these individuals sign the policy.

Disclosure is KEY
Education

- Educate your residents, their legal representatives and family members, and staff about how CPR is attempted, the risks and benefits of attempted CPR, and the survival rates
- Resident education on CPR should be done regardless of your policy
- In a survey, 41% of residents initially opted for CPR, but when told that the probability of survival was 10-17%, only 22% desired CPR. When told the probability of survival was 0-5%, only 5% desired CPR
- Be sure to use the proper language. Asking "would you want CPR if your heart and breathing stopped," should always elicit a "YES!!" You should ask "would you want us to attempt CPR?"

The Policy

- Should be concise and unambiguous
- Presented as a separate document at admission
- If it is a no-CPR or no-routine-CPR policy, it should cover what is done instead of CPR, i.e., immediately call 911 and wait with resident, comfort care, etc.
- If it has caveats, they should be clear and leave no room for employees to question what action should be taken
- CPR (unless DNR) policy – clearly and concisely address the appropriate circumstances for administering CPR (see Epsom case). The American Heart Association guidelines are a good starting point.
- Staff need to be regularly trained on the policy (see Kranson case – nurse testified he was unaware of the facility’s CPR policy)

Facilities are still required to gather advance directive documents from the resident (K.A.R. 26-39-102(b)) and should have procedures in place to ensure the transmittal of this information to EMS.

Just as with advance directives, the CPR policy should be reviewed with the resident, legal representative, and family members at least annually. Residents often change their position.

- Research on nursing home residents showed 40% of those who were admitted with full-code CPR orders had switched to DNR status within 5 years of admission.
If the facility chooses to have a CPR (Unless DNR) Policy

- Ensure CPR-trained staff are on duty at all times who can determine when CPR is appropriate and can perform CPR.
- Implement a process for identifying those with advance directives and who do not want CPR attempted.
  - It could be considered negligence or result in administrative sanctions if the facility offers CPR but does not have a quick method for determining code status of a resident.
  - Also, performing CPR on someone who does not want it can result in lawsuits based on negligence, battery, and intentional infliction of emotional distress, or possibly a citation from a regulatory agency for resident abuse.
  - Options: color coding or bracelets

CPR (Unless DNR) Policy (continued)

- If someone has an advance directive or DNR, the facility must train the staff on providing the resident forms of care not covered by the advance directive or DNR, including comfort care, in the event of a medical emergency.
- There is some concern that residents with DNRs and advance directives are having their care inappropriately limited because the DNR or advance directive lessens respect for the resident. Regular staff training on end-of-life care should alleviate these concerns and ensure residents are receiving appropriate care.

Conclusion

- Whether to have a No-CPR policy or not is clearly a decision that must be made looking to several factors at the facility (staff, resident population) and the potential justifications and issues discussed.
- Regardless of the policy, remember to:
  - Disclose it
  - Educate the resident, legal representatives, and family on CPR
  - Make the policy a separate document that is concise and unambiguous
  - Regularly train staff
  - Annually review the CPR and advance directive policies with residents
  - Gather advance directives and ensure transmittal to EMS
- If offering CPR, remember to:
  - Have CPR-trained staff on duty
  - Address in the policy the appropriate circumstances for CPR (AHA Guidelines)
  - Implement a process for identifying those with advance directives
  - Train staff on end-of-life care, including comfort care


KRS 194A.719(1)(d)

910 KAR 1:240

December 12, 2012 Statement of Deficiencies issued to Century Pines Assisted Living by Missouri Dept. of Health and Senior Services


KDADS, Sunflower Connection, Vol. 10, No. 2 (April 2013), pg. 7

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Tim Mullaney, Resident’s Often Change Position on CPR, Showing Need for Minimum Data Set Changes, Researchers Say, McKnights (July 29, 2013)