



Center for Clinical Standards and Quality/Survey & Certification Group

DATE: October 18, 2013
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Cardiopulmonary Resuscitation (CPR) in Nursing Homes

Ref: S&C: 14-01-NH
REVISED 01.23.15

*****Revised to include information on CPR certification and Appendix PP draft guidance revisions at F155*****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

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal-ADVANCE
COPY

Date:

SUBJECT: Revisions to the State Operations Manual (SOM) - Appendix PP – “Interpretive Guidelines for Long-Term Care Facilities F tag 155, Advance Directives

I. SUMMARY OF CHANGES: This instruction revises interpretive guidance at F155 to provide additional information to surveyors about facility policies on cardiopulmonary resuscitation.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Upon issuance

IMPLEMENTATION DATE: Upon issuance

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)

(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	PP/F155/§483.10 (b)(4) and (8) Advance Directives

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

*Unless otherwise specified, the effective date is the date of service.

ADVANCE COPY

F155

(Rev.)

§483.10(b)(4) and (8)

§ 483.10(b)(4) – The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and

§483.10(b)(8) – The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual’s option, formulate an advance directive. This includes a written description of the facility’s policies to implement advance directives and applicable State law.

INTENT: (F155) §483.10(b)(4) and (8) Rights Regarding Refusal of Treatment and Participation in Experimental Research and Advance Directives

The intent of this requirement is that the facility promotes these rights by:

- Establishing and maintaining policies and procedures regarding these rights;
- Informing and educating the resident about these rights and the facility’s policies regarding exercising these rights;
- Helping the resident to exercise these rights; and
- Incorporating the resident’s choices regarding these rights into treatment, care and services.

NOTE: While the language of 42 C.F.R §**483.10(b)(8)** applies only to adults, states may have laws that govern the rights of parents or legal guardians of children to formulate an advance directive. The CMS believes that this is an important issue for the parents/guardians of terminally ill or severely disabled children. Therefore surveyors are encouraged to refer to state law in cases where concerns arise regarding advance directives in non-adult populations. The regulatory language found under 42 C.F.R. § **483.10(b)(4)** applies to all residents, regardless of age.

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.¹

“Advance directive” means, according to 42 C.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 to an agent to make health care decisions in case the individual delegating that authority subsequently becomes incapacitated.

“Experimental research” refers to the development, testing and use of a clinical treatment, such as an investigational drug or therapy that has not yet been approved by the FDA or medical community as effective and conforming to accepted medical practice.

“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.

“Investigational or experimental drugs” refer to new drugs that have not yet been approved by the FDA or approved drugs that have not yet been approved for a new use, and are in the process of being tested for safety and effectiveness.

“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 medications 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.

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“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.

OVERVIEW

Traditionally, questions of care were resolved at the bedside through decision-making by an individual, his or her family and health care practitioner. As technological advances have increased the ability of medicine to prolong life, questions have arisen concerning the use, withholding, or withdrawing of increasingly sophisticated medical interventions.

The Federal Patient Self - Determination Act contained in Public Law 101-508 is the authority on an individual's rights and facility responsibilities related to Advance Directives. The right of an individual to direct his or her own medical treatment, including withholding or withdrawing life-sustaining treatment, is grounded in common law (judge-made law), constitutional law, statutory law (law made by legislatures) and regulatory mandates governing care provided by facilities. Several landmark legal decisions have established an enduring judicial precedence for the legal principles of advance directives and the right to refuse or withhold treatment³⁴⁵⁶.

These legal developments have influenced standards of professional practice in the care and treatment of individuals in health care facilities. Several decades of professional debate and discussion have simultaneously advanced the thinking on these matters and promoted implementation of pertinent approaches to obtaining and acting on patient/resident wishes.⁷⁸

ESTABLISHING AND MAINTAINING POLICIES AND PROCEDURES REGARDING THESE RIGHTS

The facility is required to establish, maintain, and implement written policies and procedures regarding the residents' right to formulate an advance directive, refuse medical or surgical treatment and right to refuse to participate in experimental research. In addition, the facility is responsible for ensuring that staff follow policies and procedures.

The facility's policies and procedures delineate the various steps necessary to promote and implement these rights, including, for example:

- Determining on admission whether the resident has an advance directive and, if not, determining whether the resident wishes to formulate an advance directive;
- Determining if the facility periodically assesses the resident for decision-making capacity and invokes the health care agent or legal representative if the resident is determined not to have decision-making capacity;
- Identifying the primary decision-maker (e.g., assessing the resident's decision-making capacity and identifying or arranging for an appropriate legal representative for the resident assessed as unable to make relevant health care decisions);
- Defining and clarifying medical issues and presenting the information regarding relevant health care issues to the resident or his/her legal representative, as appropriate;

- Identifying, clarifying, and periodically reviewing, as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions;
- Identifying situations where health care decision-making is needed, such as a significant decline or improvement in the resident's condition;
- Reviewing the resident's condition and existing choices and continuing or modifying approaches, as appropriate;
- Establishing mechanisms for documenting and communicating the resident's choices to the interdisciplinary team; and
- Identifying the process (as provided by State law) for handling situations in which the facility and/or physician do not believe that they can provide care in accordance with the resident's advance directives or other wishes on the basis of conscience.

INFORMING AND EDUCATING THE RESIDENT ABOUT THESE RIGHTS

The facility is required (by 42 C.F.R. § 489.102 Requirements for Providers) to provide, at the time of a resident's admission, written information concerning the resident's rights to make decisions concerning medical care, including the right to refuse medical or surgical treatment, decline to participate in experimental research and the right to formulate advance directives. The resident must also receive a written description of the facility's policies that govern the exercise of these rights.

ESTABLISHING ADVANCE DIRECTIVES

The facility must ensure compliance with Federal and State requirements regarding advance directives. At the time the resident is admitted to a nursing home, staff must determine whether the resident has executed an advance directive or has given other instructions to indicate what care he or she desires in case of subsequent incapacity. Such a directive or instructions could be a living will, a directive to the attending physician, a durable power of attorney for health care, a medical power of attorney, a pre-existing medical order for "do not resuscitate (DNR)," or another document that directs the resident's health care. Several States have also adopted the use of a portable and enduring order form that documents the resident's choices related to life-sustaining treatments.⁹

If the resident or the resident's legal representative has executed one or more advance directive(s), or executes one upon admission, it is important that copies of these documents be obtained, incorporated and consistently maintained in the same section of the resident's medical record readily retrievable by any facility staff, and that the facility communicate the resident's wishes to the resident's direct care staff and physician. If the resident has not executed an advance directive, the facility is required to advise the resident and family of the right to establish an advance directive as set forth in the laws of the State; to offer assistance if the resident wishes to execute one or more directive(s); and to document in the resident's medical

record these discussions and any advance directive(s) that the resident executes. The resident has the option to execute advance directives, but cannot be required to do so. As required by 42 C.F.R. §489.102(a)(3), the facility may not condition the provision of medical care or discriminate against a resident based on whether he or she has executed an advance directive.

Advance Care Planning

In order for a resident to exercise his or her right to make knowledgeable choices about care and treatment or to decline treatment, the primary care provider and facility staff should provide information (in a language and terminology that the resident understands) to the resident and/or his/her legal representative regarding the resident's health status, treatment options, and expected outcomes. Whether or not the resident chooses to execute an advance directive, discussion and documentation of the resident's choices regarding future health care should take place during the development of the initial comprehensive assessment and care plan and periodically thereafter. The process of having such discussions, regardless of when they occur, is sometimes referred to as "advance care planning."

The process of advance care planning is ongoing and affords the resident, family and others on the resident's interdisciplinary health care team an opportunity to reassess the resident's goals and wishes as the resident's medical condition changes. Advance care planning is an integral aspect of the facility's comprehensive care planning process and assures re-evaluation of the resident's desires on a routine basis and when there is a significant change in the resident's condition. The process can help the resident, family and interdisciplinary team prepare for the time when a resident becomes unable to make decisions or is actively dying.

The ability of a dying person to control decisions about medical care and daily routines has been identified as one of the key elements of quality care at the end of life. Advance care planning is a method to further a resident's control over his or her own medical treatment and choices.¹⁰ It also allows the decision-maker (whether it is the resident, family or other legal representative) to be better informed about the treatment alternatives available in a variety of circumstances.

RIGHT TO REFUSE MEDICAL OR SURGICAL TREATMENT

If a resident (directly or through an advance directive) declines treatment (e.g., refuses artificial nutrition or IV hydration, despite having lost considerable weight), the resident may not be treated against his/her wishes. If a resident is unable to make a health care decision, a decision by the resident's legal representative to forego treatment may, subject to State requirements, be equally binding on the facility. A facility may not transfer or discharge a resident for refusing treatment unless the criteria for transfer or discharge are otherwise met.

If a resident's refusal of treatment results in a significant change in condition, the facility should reassess the resident and modify the care plan as appropriate. The facility is expected to assess the resident for decision-making capacity and invoke the health care agent or legal representative if the resident is determined not to have decision-making capacity. Once the decision-making capacity is assessed, the facility is expected to determine and document what the resident is refusing, to assess the reasons for the resident's refusal, to advise the resident about the consequences of refusal, to offer pertinent alternative treatments, and to continue to provide all

other appropriate services. The resident's refusal of treatment does not absolve a facility from providing other care that allows him/her to attain or maintain his/her highest practicable physical, mental and psychosocial well-being. For example, a facility would still be expected to provide appropriate measures for pressure ulcer prevention, even if a resident has refused food and fluids and is expected to die.

CARDIOPULMONARY RESUSCITATION (CPR)

Facilities must not implement a facility-wide "no CPR" policy as this policy may prevent implementation of a resident's advance directives and does not meet professional standards of quality as required in §483.20(k). 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. 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.¹¹ AHA guidelines for CPR provide the standard for the American Red Cross, state Emergency Medical Services, healthcare providers, and the general public.

If a resident experiences a cardiac arrest, facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services, and:

- in accordance with the resident's advance directives, or*
- in the absence of advance directives or a Do Not Resuscitate order; and*
- if the resident does not show obvious 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.¹²

Additionally, CPR certified staff must be available at all times. Staff must maintain current CPR certification for healthcare providers through a CPR provider whose training includes hands-on skills practice and in-person assessment and demonstration of skills; 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 chest¹³. Proper technique should be evaluated by an instructor through in-person demonstration of skills. CPR certification which includes an online knowledge component yet still requires in-person skills demonstration to obtain certification or recertification is also acceptable.

Presence of a facility-wide "no CPR" policy interferes with a resident's right to formulate an advance directive and should be cited at §483.10(b)(4) and (8), Rights Regarding Treatment and Advance Directives, F155. For concerns related to provision of CPR and CPR certification of staff, the survey team should also consider §483.20(k)(3), Services Provided Meet Professional Standards, F281 and §483.75, Effective Administration for Resident Well-Being, F490.

RIGHT TO DECLINE TO PARTICIPATE IN EXPERIMENTAL RESEARCH

The resident has the right to refuse to participate in experimental research. A resident being considered for participation in experimental research must be fully informed of the nature of the experimental research (e.g., medication, other treatment) and the possible consequences of participating. The resident must give informed consent in order to participate. If the resident is incapable of understanding the situation and of realizing the risks and benefits of the proposed research, but a legal representative gives proxy consent, the facility has a responsibility to ensure that the proxy consent is properly obtained and that essential measures are taken to protect the individual from harm or mistreatment. The resident (or his/her legal representative if the resident lacks health care decision-making capacity) must have the opportunity to refuse to participate both before and during the experimental research activity.

A facility participating in any experimental research involving residents must have a process for committee (e.g., an Institutional Review Board) approval of this research and mechanisms in place for its oversight. In this regard, §483.75(c), Relationship to Other HHS Regulations, applies (i.e., research conducted at a facility must adhere to 45 CFR Part 46, Protection of Human Subjects of Research).

INVESTIGATIVE PROTOCOL

§483.101(b)(4) AND (8) RIGHTS REGARDING REFUSAL OF MEDICAL OR SURGICAL TREATMENT, PARTICIPATION IN EXPERIMENTAL RESEARCH AND ADVANCE DIRECTIVES

Objectives

To determine whether a facility promoted the resident's right to refuse medical or surgical treatment, to refuse to participate in experimental research, and to formulate an advance directive by:

- Establishing and maintaining policies and procedures regarding these rights;
- Informing and educating the resident about these rights and the facility's policies regarding these rights;
- Helping the resident exercise these rights; and
- Incorporating the resident's choices regarding these rights into treatment, care and services.

Use

Use this protocol for:

- Complaints from residents, family members or other resident representatives concerning services related to a resident's right to refuse medical or surgical treatment, participate in experimental research, formulate an advance directive, or provide written information, policies and procedures related to advance directives;

- All sampled residents identified with orders or a condition (e.g., neuromuscular diseases, exacerbation of COPD, temporary swallowing or gastrointestinal tract issues) potentially related to provision of life-sustaining treatments such as artificial nutrition/hydration, artificial ventilation, dialysis, blood transfusions, or cardiopulmonary resuscitation. (NOTE: For the Quality Indicator Survey (QIS) process this review would be conducted during Stage 2 of the survey);
- Residents who refused medical or surgical treatment; or
- Is participating in an experimental research activity or project.

Procedures

Briefly review the resident's record to determine if the resident has an advance directive, is participating in experimental research, refused medical or surgical treatment, received or is currently receiving life sustaining treatments. The surveyor(s) should conduct the following observations, interviews and record reviews.

Observations

Observe the selected resident care and treatments provided during various shifts. Note whether the care and services related to participation in experimental research, refusal of medical or surgical treatment, or provision of life-sustaining treatment are consistent with the care plan, progress notes and resident choices.

Interviews

Resident/Representative

Interview the resident and/or the resident's legal representative, as appropriate, regarding the following:

- What the facility has done to determine the resident's choices regarding care and treatment;
- What the staff and practitioner have done to inform the resident or the resident's legal representative about the resident's medical condition and relevant health care issues;
- What the staff and practitioner have done to inform the resident or the resident's legal representative about treatment options and the relevance of those options to the resident's goals, wishes, medical condition and prognosis;
- What the staff and practitioner have done to help the resident or the resident's legal representative document treatment choices (e.g., advance directives or another format consistent with State and Federal law and regulation); and
- If the resident is participating in research, did the resident or the resident's legal representative receive information prior to the start of the project that: sufficiently explained the research for which he/she was being asked to give consent; made clear the

risks and benefits of the research; and informed him/her of the right to refuse to participate?

Facility staff

Interview staff who are involved in informing residents about treatment options and documenting resident wishes to determine:

- How the facility determines whether the resident has an advance directive or other existing documentation related to life-sustaining treatment;
- What training staff receive regarding advance directives and their initiation;
- How the facility assessed the resident's capacity to make health care decisions and consent to participate in experimental research;
- How the practitioner and facility inform the resident or legal representative about his or her medical condition and relevant health care issues;
- How the practitioner and facility inform and educate the resident or legal representative about treatment options and the resident's right to refuse medical or surgical treatment, to formulate an advance directive and to refuse to participate in experimental research;
- How staff helps the resident or legal representative document treatment choices and formulate an advance directive;
- How documented choices and treatment decisions are communicated to the interdisciplinary team;
- How the practitioner and staff monitor and safeguarded the rights of the resident involved in experimental research;
- How staff know where to access the documented information on the resident's treatment choices and advance directives in the medical record, during both routine care and in an urgent or emergent situation; and
- How the facility ensures that practitioner orders and treatment decisions are consistent with the resident's documented choices and goals.

Health care practitioners and professionals

Interview one or more health care practitioners and professionals as necessary (e.g., physician, nurse practitioners, physician assistants, charge nurse, director of nursing, social worker) who, by virtue of training and knowledge of the resident, should be able to provide information regarding:

- How the facility seeks, identifies, and documents the resident's wishes regarding advance care planning and life-sustaining treatments;
- How the facility ensures that medical orders and treatments reflect the resident's choices and goals;
- The process by which the staff and practitioners are involved in advising the resident and the resident's legal representative about the right to refuse treatment (including life-sustaining treatments);
- How documented choices and treatment decisions are communicated to the interdisciplinary team;
- How the staff and practitioner obtain and document informed consent of the resident who is participating in experimental research;
- How the staff and practitioners proceed if the resident who is involved in experimental research is suspected of, or identified as, suffering adverse consequences related to his/her participation;
- How staff know where to access the documented information on the resident's treatment choices and advance directives in the medical record, during both routine care and in an urgent or emergent situation; and
- How the staff and practitioner periodically reassess the resident's condition and prognosis to identify whether existing advance directives remain pertinent and/or whether there is a need to review or possibly modify them.

During the course of the review, the surveyor should consider contacting the attending physician or health care practitioner regarding questions related to the treatment regimen. It is recommended that the facility's staff have the opportunity to provide the necessary information about the resident and the concerns to the physician or health care practitioner for his/her review prior to responding to the surveyor's inquiries. If the attending physician or health care practitioner is unavailable, interview the medical director as appropriate.

Record Review

Depending on the issue of concern, review the resident's records for evidence of whether and how the facility determines the resident's capacity to understand and make decisions regarding the right to refuse treatment, to formulate an advance directive and/or refuse to participate in experimental research. Review whether information was provided in writing regarding these rights. Review whether the facility determined at admission if the resident had an existing advance directive and, if the resident did not have one, whether the facility offered the resident the option to formulate an

advance directive. Review for any information regarding initiating, continuing, withholding, or withdrawing treatment.

Note whether the care plan considers the resident's choices.

Depending on the issue of concern, review information such as medical orders and interdisciplinary progress notes to determine:

- Whether there is documentation of the rationale for recommendations and treatment decisions related to life-sustaining treatment options;
- Whether the practitioner's orders are consistent with the resident's documented choices and goals. Unless, in rare circumstances, where a physician needs more information about the residents decisional capacity, has a conscientious objection to the residents decision or other aspects of the case in order to be comfortable writing orders that are consistent with the resident's expressed wishes;
- The frequency and scope of monitoring the resident who is participating in experimental research activities for responses to and adverse consequences of any experimental treatments;
- Whether any treatments or interventions have been ordered (e.g., unplanned hospitalizations or placement of a feeding tube) that are inconsistent with the resident's documented treatment preferences or with any existing advance directives; and
- Whether the resident's advance directive, if formulated, has been incorporated into his or her active record, including in medical orders, progress notes, the resident care plan or other relevant means of communication to the interdisciplinary team.

Review of Facility Practices

Depending on the issue of concern, the assigned surveyor should review, as indicated, the facility's policies, procedures, records related to determining and documenting resident wishes regarding advance care planning and implementing medical orders that reflect a resident's wishes. Related concerns may have been identified that would suggest the need for further review of facility practices. Examples of such activities may include a review of policies, staffing, staff training and/or functional responsibilities.

DETERMINATION OF COMPLIANCE

Criteria for Compliance

The facility is in compliance with 42 §CFR 483.10 (b)(4) and (8), if the facility has:

- Established and implemented policies and procedures regarding the right to formulate advance directives, refuse medical and surgical treatment and other related interventions and to decline to participate in experimental research;

- Informed and educated the resident about these rights, including the facility's policies regarding exercising these rights;
- Determined whether the resident has an advance directive in place or has offered the resident the opportunity to develop an advance directive;
- Documented when the resident is determined not to have decision-making capacity and therefore decision-making is transferred to the health care agent or legal representative;
- Helped the resident to exercise these rights based on explaining risk and benefits of declining treatment;
- Incorporated the resident's choices into the medical record and orders related to treatment, care and services;
- Consistently maintained advance directives and resident goals and in the same section of the clinical record or other document filing system for all appropriate residents, where those documents are easily retrievable by staff during both routine and urgent or emergent situations; and
- Monitored the care and services given to the resident to ensure that they are consistent with the resident's documented choices and goals.

If not, cite at F155.

IV. DEFICIENCY CATEGORIZATION (Part IV, Appendix P)

Once the team has completed its investigation, analyzed the data, reviewed the regulatory requirements, and determined that noncompliance exists, the team must determine the severity of each deficiency, based on the harm or potential for harm to the resident.

The key elements for severity determination for F155 are as follows:

1. **Presence of harm/negative outcome(s) or potential for negative outcomes** because of lack of appropriate care and services or lack of implementation of resident's right to refuse medical or surgical treatment, refuse to participate in experimental research and/or formulate an advance directive. Actual or potential harm/negative outcomes for F155 may include, but are not limited to:

- Resident was resuscitated despite a DNR order included in the resident's record;
- Resident suffered a life-threatening complication related to involvement in research activity in the absence of adequate consent of the resident or his/her legal representative;
- Resident was hospitalized contrary to his/her wishes; and

- Resident received treatment based on the consent of an individual who was not the resident or his/her representative, in accordance with State Law.

2. **Degree of harm (actual or potential) related to the noncompliance.** Identify how the facility practices caused, resulted in, allowed, or contributed to the actual or potential for harm.

- If harm has occurred, determine if the harm is at the level of serious injury, impairment, death, compromise, or discomfort; and
- If harm has not yet occurred, determine how likely the potential is for serious injury, impairment, death, compromise or discomfort to occur to the resident.

3. **The immediacy of correction required.** Determine whether the noncompliance requires immediate correction in order to prevent serious injury, harm, impairment, or death to one or more residents.

The survey team must evaluate the harm or potential for harm based upon the following levels of severity. First, the team must rule out whether Severity Level 4 (immediate jeopardy to a resident's health or safety) exists by evaluating the deficient practice in relation to immediacy, culpability, and severity. (Follow the guidance in Appendix Q, Determining Immediate Jeopardy.)

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety

Immediate jeopardy is a situation in which the facility's noncompliance with one or more requirements of participation:

- Has allowed, caused, or resulted in (or is likely to allow, cause, or result in) serious injury, harm, impairment, or death to a resident; and
- Requires immediate correction as the facility either created the situation or allowed the situation to continue by failing to implement preventative or corrective measures.

NOTE: The death or transfer of a resident, who was harmed as a result of facility practices, does not remove a finding of immediate jeopardy. The facility is required to implement specific actions to correct the deficient practices which allowed or caused the immediate jeopardy.

Examples of avoidable actual or potential resident outcomes that demonstrate severity at Level 4 may include, but are not limited to:

- As a result of the facility's failure to obtain and implement medical orders related to life-sustaining treatments, after the resident had documented choices, the resident was transferred to the hospital for an acute change of condition against his wishes, where he

was resuscitated against his documented wishes, despite the facility's knowledge that the intervention was against the resident's wishes.

- *A facility has implemented a facility-wide "no CPR" policy, meaning staff do not initiate CPR on any resident.*
- If Severity Level 4 (immediate jeopardy) has been ruled out based upon the evidence, then evaluate whether actual harm that is not immediate jeopardy exists at Severity Level 3 or the potential for more than minimal harm at Severity Level 2 exists.

Severity Level 3 Considerations: Actual Harm that is Not Immediate Jeopardy

Severity Level 3 indicates noncompliance that resulted in actual harm that is not immediate jeopardy. The negative outcome can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being.

Examples of avoidable resident outcomes that demonstrate severity at Level 3 may include, but are not limited to:

- The facility failed to identify the medical orders that detailed the resident's wishes to forego lab work, IV antibiotic treatment and IV hydration for the resident's 7th episode of aspiration pneumonia. Furthermore, the nurses refused to allow the resident to attend his son's wedding, insisting that the resident remain in the nursing home so that a chest x-ray and blood work be done, which went against the resident's expressed wishes. The resident suffered emotional harm.

NOTE: If Severity Level 3 (actual harm that is not immediate jeopardy) has been ruled out based upon the evidence, then evaluate as to whether Severity Level 2 (no actual harm with the potential for more than minimal harm) exists.

Severity Level 2 Considerations: No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy

Severity Level 2 indicates noncompliance that resulted in a resident outcome of no more than minimal discomfort and/or had the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well being. The potential exists for greater harm to occur if interventions are not provided.

Examples of avoidable outcomes at Severity Level 2 include, but are not limited to:

- As a result of the facility's failure to establish and implement policies and procedures regarding the rights to decline treatment and other related interventions, the resident and/or the resident's legal representative was unaware of the opportunities to decline medical treatment, although a situation involving the use of life-sustaining treatment options had not yet arisen in the resident's care; or

- As a result of the facility's failure to obtain medical orders that were consistent with the resident's documented wishes, the direct care staff was unaware of the resident's wishes, although a situation involving life-sustaining treatment options had not yet arisen in the resident's care.

Severity Level 1: No Actual Harm with Potential for Minimal Harm

The failure of the facility to recognize and facilitate the exercising of the resident's right to refuse medical or surgical treatment, to refuse to participate in experimental research and to formulate an advance directive; and to maintain written policies and procedures regarding these rights, places the resident at risk for more than minimal harm. Therefore, Severity Level does not apply for this regulatory requirement

ENDNOTES:

¹ Adapted from: Emanuel, L.L., Danis, M., Pearlman, R.A., Singer, P.A. (1995). Advance care planning as a process: structuring the discussions in practice. *Journal of the American Geriatric Society*, 43, 440-6.

² TX Health and Safety Code Title 2, §166.002: Definitions – Advance Directives Act. Available from: <http://www.statutes.legis.state.tx.us>; Accessed on December 3, 2010.

³ Thomas, K.R. (Updated September 19, 2005). The Right to Die: Constitutional and Statutory Analysis. Congressional Research Service Report for Congress, 907-244A. (<http://www.policyarchive.org/handle/10207/bitstreams/363.pdf>)

⁴ Quinlan. (1976). 70 N.J. 10, 355 A.2d 647. (<http://www.libraryindex.com/pages/582/Court-End-Life-RIGHT-PRIVACY-KAREN-ANN-QUINLAN.html>)>Court

⁵ Bartling v. Superior Court. (1984). Dec 27:209:220-7. (<http://www.ncbi.nlm.nih.gov/pubmed/11648164>)

⁶ Cruzan v. Director, Missouri Department of Health. (1990). 497 U.S. 261. (http://www.oyez.org/cases/1980-1989/1989/1989_88_1503)

⁷ Atmore, C. & Naksook, C. (2007). Respecting Patient Choices – Literature Review. Prepared by Health Issues Centre for the Respecting Patient Choices Project, Austin Health, La Trobe University, VIC, Australia. (<http://www.healthissuescentre.org.au/documents/items/2008/04/205853-upload-00001.pdf>)

⁸ Emanuel, L.L., von Gunten, C.F., Ferris, F.D. (1991). Education for Physicians at the End of Life (EPEC) Participant's Handbook -- Plenary 2, Legal Issues. Robert Wood Johnson Foundation. (http://endoflife.northwestern.edu/legal_issues/module15.pdf)

⁹ POLST Physician Orders for Life Sustaining Treatment Paradigm (<http://www.ohsu.edu/polst/>)

¹⁰ Teno, J.M., Casey, V.A., Welch, L.C., Edgman – Levitan, S. (2001). Patient-Focused,

Family-Centered End-of-Life Medical Care: Views of the Guidelines and Bereaved Family Members. *Journal of Pain and Symptom Management*, Vol. 22 No. 3.

¹¹ http://circ.ahajournals.org/content/122/18_suppl_3/S665.full.pdf+html.

¹² http://circ.ahajournals.org/content/122/18_suppl_3/S665.full.pdf+html.

¹³ http://circ.ahajournals.org/content/122/18_suppl_3/S685.full.