



Failures in Advance Care Planning: Content Analysis of CPR-Related Immediate Jeopardy Citations in Nursing Homes

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Disclosure

Drs. Dellefield (former) and Madrigal (current) are employees of the U.S. Department of Veterans Affairs (VA). The views expressed in this presentation do not reflect the position or policy of the VA or U.S. Government.

What to Expect

- Definition of terms/ brief video of CPR
- Review of CPR-related regulations/practices in nursing homes
- Brief description of study methods
- Findings
- Discussion/ my 2 cents
- Practice recommendations
- Opportunities for ombudsman advocacy
- Questions/discussion

Two terms that may be less familiar to some

Advance care planning

- Evolved from PSDA of 1990.
- Involves discussing & preparing for future decisions about healthcare if you become seriously ill or unable to communicate your wishes.
- Involves legal documents (advance directives).
- Advance Care Planning: A conversation Guide (NIA website (pdf))

Two terms that may be less familiar to some

Content Analysis

A systematic research method used to analyze written, spoken, visual communications (texts) to identify patterns, themes, or trends.

Used as qualitative method linked with quantitative findings.

The Importance of CPR – TIME sensitive



How to perform
CPR on adults
and infants



Cardiopulmonary Resuscitation (CPR)

- CPR is an **emergency life saving procedure** performed when someone's heart stops beating or someone stops breathing
- **CPR is:**
 - A unique clinical intervention because it is **evidence-based**, internationally recognized, and **time sensitive**
 - Driven by **advance directives**, formal or informal (i.e., preference for medical care when unable to communicate wishes)
 - Practiced in the context of **ethical principles** (i.e., respect for autonomy and the principle of futility), legal, and institutional cultural factors
 - **Standardized and certified** by the American Heart Association (AHA)

Regulation in Nursing Homes

- Long-standing history of '**No CPR**' guidelines in nursing homes
- 1990: **Patient Self-Determination Act (PSDA)**(mandated informed resident right to decision-making)
- 1994: American Heart Association initiated public **access to defibrillation**
- 2012: Centers for Medicare & Medicaid Services issued **F-tag 155** on resident right to advance directives
- 2015: Centers for Medicare & Medicaid Services issued **F-tag 678** on resident right to CPR
- 2024: States vary in requiring **presence of defibrillators** in nursing home

Interpretive Guideline (F-678)

- Provide **basic life support**, including **CPR**, to a resident requiring emergency care prior to the arrival of emergency medical personnel and in alignment with physician orders and residents' **advance directives**
- **Elements of compliance:**
 - Provide basic life support, including CPR
 - Ensure availability of staff to provide CPR
 - Have appropriate policies directing staff
 - Ensure staff is familiar with facility policies
 - Ensure staff know how to confirm residents' code status
 - Ensure staff maintain current CPR certification and training

Immediate Jeopardy

- **Immediate jeopardy (IJ)** describes a situation where a nursing home's noncompliance with regulations has resulted in, or poses a high risk of, serious harm, injury, impairment, or death to a resident
- Immediate jeopardy are **J, K, L citations**—J is an isolated event; K is a pattern; L is widespread

Study Purposes

- Identify **patterns of practice failures related to CPR** in the nursing home setting using statement of deficiencies issued due to non-compliance with F-tag 678 resulting in immediate jeopardy
- Determine **if content analysis of high-quality SODs is feasible and credible data source** for study of quality of nursing home practices

Methods: Design and Sample

- **Descriptive study** using demographics & content analysis
- 2019-2022 **Statement of Deficiencies** for SNFs on Nursing Home Compare (now CMS Care Compare)
 - <http://www.cms.gov>
- From CMS form 2567 and CMS Care Compare
- **Purposive sampling** IJ citation: F-678
- Used **Region V**
 - Includes: Michigan, Minnesota, Ohio, Wisconsin
 - n=93 SODs

Methods: Codebook

- **Codebook development**

- **Original development:** Prior research exploring nursing surveillance in VA nursing home immediate jeopardy citations
- **Modified:** AHA CPR guidelines and AHA certification training content
- Developed broad categories of practice failures
- Linked categories and subcategories with Donabedian's framework

Methods: Codebook

CONCEPT/CONSTRUCT	CATEGORIES	TEXT EXEMPLAR	(1)	(0)	(99)
Skill Mix: designation of staff who directly contributed to event response (before, during, and immediately after event)					
	DON	“Director of Nursing were notified on [DATE] at 4:00 PM of the Immediate jeopardy that began on [DATE] at 4:00 AM, due to the facility's failure to implement the use of the facility's Automatic External Defibrillator (AED), initiate compressions or ventilation, or documentation of the facility 'Code Blue Record' during a [CONDITION(S)] event for Resident #116 on [DATE] at 4:30.”			
	Nurse Manager	“LPN F called 911 at 4:45 AM on [DATE] after calling and receiving orders from the on-call nurse manager. LPN F was instructed to initiate CPR.”			
	Charge nurse	“Myself, care aide and charge nurse lowered patient to floor and began CPR.”			
	RN	“When asked if RN A left her alone in the room with Resident #2, CNA K stated, I think she did. I was with the Resident (#2) when she left to try to get the board.”			
	LVN/LPN	“LPN F summoned LPN E. LPN E assessed resident #100 and determined that he was unresponsive and not breathing.”			
	Nurse educator/DSD	“All nurses files were reviewed by the nurse educator for verification of BLS certification.”			

Conceptual Framework

- **Donabedian Model:** Framework for evaluating health services and quality of care provided
 - **Structure:** Resources/environment available to deliver care
 - **Process:** Activities and interactions involved in providing care
 - **Outcome:** Effects of healthcare on patients' health status

Methods: Concept Definitions

- **Structural Categories**
 - **Resident characteristics**
 - COVID
 - Hospice
 - **Staff characteristics**
 - Type of staff
 - CPR certification
 - No RN on duty
 - Documented emotional state of staff
 - Documented report of high staff workload or busyness
 - Staff description of unfamiliarity with operations

Methods: Concept Definitions

- **Process Categories**

- **Early detection**

- Missed assessment

- **Logistics**

- Failures in -

- Starting CPR; communication; coordination; policy & procedure implementation; teamwork

- Equipment

- Documentation

- No advanced directives; no documentation of CPR event; no policy for CPR

- Temporal delays

- Calling EMS; identifying code status; starting CPR

Methods: Concept Definitions

- **Outcome Categories**

- **CPR temporal delays**

- ½ hour or less
 - 1 hour
 - 3 to 4 hours

- **Wrong intervention**

- No CPR administered when resident wanted CPR
 - CPR administered when resident was DNR

SAMPLE HIGHQ QUALITY SOD

Example SOD #1

NORLITE NURSING CENTER 235367 0678 J HVBP11 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake MI 352. Based on interview and record review, the facility failed to ensure a resident's choice for advanced directives of Cardiopulmonary Resuscitation (CPR) was followed. This deficient practice was detected at an Immediate Jeopardy (IJ) level due to staff not providing CPR to a Resident (#1) who had elected to have full code resuscitation status and was found to be unresponsive, without pulse, and not breathing. This deficient practice led to Resident #1 not receiving CPR prior to death and had the potential to affect 19 other residents who continued to reside at the facility, and who had elected to have Full Code resuscitation status. The IJ began on [DATE] at 10:51 PM when Resident #1, who had elected to be Full Code status, was found by Certified Nurse Aide (CNA) A to be unresponsive and CPR was not started. The IJ notification was communicated verbally to the Nursing Home Administrator (NHA) on [DATE] at 2:00 PM and followed with an email copy. The IJ was removed on [DATE] at 4:26 PM when the nursing staff with inadequate CPR training were identified and each shift was covered with appropriately trained personnel. The deficient practice continued at a pattern level of potential for more than minimal harm until onsite review confirmation of the full plan of correction.

Findings include: A review of hospital admission paperwork dated [DATE], revealed Resident #1 earlier today was unloading wood from his truck with his son and stepped on a small piece of wood, lost his balance, and fell backwards off of the truck hitting his left hip area. He was discovered to have a left hip fracture non-displaced. Hospital notes revealed, No other concerns outside of this left hip pain. He was walking without any significant aid. Hospital Summarized Data dated [DATE], revealed a status of Full Code for life saving measures. A review of the facility Electronic Medical Record (EMR) for Resident #1 revealed an admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER], high blood pressure, [CONDITION(S)], and [CONDITION(S)]. Resident #1 was designated as their own responsible party, per the facility EMR Face Sheet dated [DATE]. The facility Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] T. document was signed by Resident #1 on [DATE] and the physician on [DATE].

Methods: Analysis

- **Developed Microsoft Access database**
- **Descriptive statistics**
- **Coding process**
 - Two authors coded independently
 - Came to consensus together (reflexivity)
 - Detailed audit trail

Methods: Sample Demographics

State	Nursing Home (<i>n</i> =92)
Minnesota	43 (46.2%)
Ohio	23 (24.7%)
Michigan	17 (18.3%)
Wisconsin	10 (10.8%)

- **J citations:** 86%
- **For-profit:** 74%
- **Bed size:** 29-212 (mean=92)
- **Star rating:** 1-5 (mean=2.5)

Findings: Structure

Staffing	# (%)
LPN	64 (76%)
CNA	63 (75%)
RN	60 (71%)
DON	22 (26%)
Physician	15 (18%)
Nurse Practitioner	14 (17%)
Nurse Manager	12 (14%)
Agency	9 (11%)
ADON	8 (10%)
Charge RN	6 (7%)
Social worker	3 (4%)
Medication aide	2 (2%)
Nurse consultant	1 (1%)

Shift	# (%)
Night	34 (40%)
Day	32 (37%)
Evening	19 (23%)

Findings: Structure Failures

Staffing Characteristics	# (%)
Nursing staff unfamiliar with facility operations	33 (39%)
No RN on duty	21 (25%)
Documentation of staff emotional state	18 (21%)
Incomplete CPR certification	12 (14%)
Report of high workload or busyness	5 (6%)
Misc. staff-related problems	3 (4%)

Nursing staff unfamiliar with facility operations: “RN-A acknowledged she that did not assess or chart any interaction with R1 until approximately 4:45 am on (date), when R1 was found deceased. RN-A stated R1 was cold, and his hands and arms were getting stiff. ***RN-A stated she knew R1 was a full code and should have started CPR but has not experienced a death of a resident and was not sure of what she should do. RN-A stated she is not familiar if the facility has a code blue policy.*** RN-A stated she thought the overnight nursing supervisor would tell her what to do but she did not inform RN-A that R1 was a full code.”

Findings: Process Failures

Early Detection	# (%)
Missed assessment	16 (16%)

“At 4 am RN stated that resident A had heavy breathing and shortness of breath and there were no vital signs or oxygen saturation levels noted. Per facility statement, RN revealed that Resident A was breathing hard, nostrils were flaring, had intercostal contractions. Around 4:30 am it was noted that RN went back to the room and found the resident was not breathing.”

Findings: Process Failures

Logistics	# (%)
Delay in calling EMS	28 (29%)
Delay in identifying code status	33 (34%)
Delay in starting CPR	24 (25%)
Failure to start CPR	44 (45%)

Delay in identifying code status/starting CPR: “At some point during the next hour, they discovered the resident was a full code, contacted their supervisor, and were told to contact EMS. **During the time between resident discovery at 0345 am and EMS contact at 0445 AM, no interventions were done.**”

Findings: Process Failures

Logistics	# (%)
Following CPR policy	75 (89%)
Staff communication	59 (70%)
Staff coordination	59 (70%)
Following code preference	46 (55%)
Communication with family	10 (12%)
No existing CPR policy	5 (6%)
Inadequate CPR policy	1 (1%)

Following CPR policy: “Immediate Jeopardy began on [DATE] at approximately 3:54 A.M. when Resident #40 was found unresponsive lying face down on the floor next to his bed by State tested Nursing Assistant (STNA) #51. STNA #51 immediately alerted Licensed Practical Nurse (LPN) #50. ***Upon entering the room LPN #50 took a photo of Resident #40, sent the photo to the Assistant Director of Nursing (ADON) and called for further instruction, incontinence care was provided, and then Resident #40 was lifted back into his bed, all prior to initiating CPR or calling EMS.*** When EMS arrived, CPR was discontinued, and pronouncement of death was made at 4:23 A.M.”

Findings: Process Failures

Documentation Failures	# (%)
Lack of clarity about code status	39 (46%)
No documentation of CPR incident	16 (19%)
Inaccurate documentation of CPR incident	13 (15%)
None or incomplete advance directives	13 (15%)
No documentation of CPR preference in care plan	10 (12%)

Lack of clarity about code status: “RN #866 then stated she had been told in the report at 7:00 A.M. that the resident's condition was worsening but had not been told that the resident's code status had changed. RN #866 confirmed ***the CNP did not give her a verbal order to change the resident's code status to DNR at any time.*** RN #866 confirmed that to her knowledge, Resident #110 was a Full Code and she would usually start CPR but had found the resident cold, blue in color, without any respirations or vital signs, and the resident had defecated on himself. ***The physician stated he believed there was a mistake made at the hospital related to the resident's code status.***”

Findings: Process Failures

Equipment not used	# (%)
AED	6 (7%)
Code cart	5 (6%)
Backboard	4 (5%)
Ambu bag	1 (1%)

Equipment problems	# (%)
Code cart	6 (7%)
Backboard	3 (4%)
Ambu bag	2 (2%)
AED	1 (1%)

Findings: Outcome Failures

Wrong Intervention	# (%)
No CPR when full code	41 (49%)
CPR provided when DNR	4 (5%)

Temporal Delays	# (%)
½ hour or less	13 (15%)
1 hour	4 (5%)
3-4 hours	1 (1%)

No CPR when full code: “Review of LPN #20’s written statement, dated (date) at 12.42 pm, revealed STNA #56 called out to LPN #20 to come assess Resident #11 as she did not think Resident #11 was breathing. LPN #20 handed her blood pressure cuff and pulse oximeter to STNA #56 while LPN #20 was donning PPE. ***LPN #20 entered the room, placed her hand on Resident 11’s chest and noted no respirations. LPN #20 felt his feet and they were cold to touch. LPN #20 was aware of Resident 11’s full code resuscitation status; however, LPN #20 did not initiate CPR.*** LPN #20 left the room and called MD #77 at 9:13 PM. MD #77 verbally called Resident #11’s time of death at 9:02 pm and verbally gave the order to release the body. LPN #20 notified hospice and ADON #232.”

Discussion

- CPR not provided when indicated in nearly half of cases
- Patterns of practice failures
 - **Staff communication/coordination of CPR** (or lack thereof)
 - Due to lack of familiarity with facility procedures/policies; lack of CPR certification/training; emotions/workload
 - **Lack of understanding** of patient preferences
 - Due to unclear or no documentation; poor systems in place
 - **Equipment** sometimes not used/not available
 - **Poor documentation** of CPR-related events
 - **Lack of national requirement for AEDs**

Discussion/ My 2 cents!

CPR practice is understood as component of advance care planning. The expectation is that staff should do what a CPR certified stranger should do in an out-of-hospital CPR event.

There may be a need to explore advance care planning processes that change from the hospital to the nursing home, creating unhelpful confusion for nursing staff.

Nursing staff need to know the signs of rigor mortis that affect their obligation to perform CPR.

Nursing staff need to be clear about hospice specific practices at time of death, and state specific regulations about who has authority to determine death & when CPR may be discontinued.

Limitations

- **Sample** limited – CMS Region V
- SODs did not include **L citation**
- Limited **access** – resident, facility, staff characteristics
- No **comparative** analysis – F-678 non-IJ citations

Opportunities for QI/Research

- Consider **inherent tension** (emergent vs chronic care) accompanying CPR situations (i.e., emotion, confusion, etc.)
- Nursing staff need to be **consistently trained/certified** to deliver high quality CPR in compliance with AHA (including knowing when NOT to perform CPR)
- Facilities need to have **standards** (policy, CPR ID) in place to support timely CPR aligned with patient preferences
- Consider use of **advance directive champions** to explore patient choice and take responsibility for documenting it

Opportunities for QI/Research

- Standardize **CPR-preference ID** to be kept on their person
- **AHA CPR guideline in every room**
- Ensure **equipment** use and stock aligns with regulation standards (i.e., AED)
- Routinely **audit accuracy** including CPR documentation, care plan & preference documents/ID
- Use high quality **SODs/content analysis** as a QAPI data source

Opportunities for Ombudsman Advocacy

- Does nursing home **have an AED?**
- Does the nursing home have readily accessible **ambu-bags?**
- Are all nursing staff **CPR-certified?**
- Is there an ongoing **audit of POLST/MOLST** documentation?
- Are nursing assistants allowed to **initiate CPR?**
- Does the nursing home have routine **CPR drills?**
- Do nursing staff know what their **CPR policy** is?
- Is **paperwork readily available** to show EMS staff that a resident is a DNR?

Other opportunities?



Questions?

Related Work



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