

February 6, 2008

**CARDIOPULMONARY RESUSCITATION (CPR) AND
ADVANCED CARDIAC LIFE SUPPORT (ACLS) TRAINING FOR STAFF**

1. PURPOSE: This Veterans Health Administration (VHA) Directive issues policy for training appropriate staff to ensure prompt and skilled resuscitations.

2. BACKGROUND

a. Correctly performed Cardiopulmonary Resuscitation (CPR) exerts a significant survival benefit. The 2005 American Heart Association (AHA) guidelines for CPR and Emergency Cardiac Care place increased emphasis on the importance of effective chest compressions in maintaining coronary artery perfusion pressure and enhancing survival rates. For resuscitation to be effective, defibrillation ideally must be applied within three to four minutes of the cessation of normal heartbeats. Every minute that passes between the event and defibrillation, the probability of survival decreases by 7 to 10 percent.

b. Widespread training in CPR and the availability of public access automated external defibrillators (AEDs) has dramatically improved survival from cardiac arrest, even when used by non-medical personnel. However, studies of in-hospital performance of resuscitation practices have demonstrated poor retention of CPR skills. This, along with the need to update providers as new information becomes available, has established the recommendation that all providers undergo training every two years.

3. POLICY: It is VHA policy that each medical facility is required to have local policy governing staff training for CPR and Advanced Cardiac Life Support (ACLS), and should have a mechanism in place to ensure compliance with that policy.

4. ACTION: The Facility Director, or designee, is responsible for:

a. Determining which critical staff is required to maintain current ACLS course completion.
NOTE: Local determinations need to specifically address issues of training for physician, nursing and mid-level provider staff.

b. Ensuring that all clinically active staff have had CPR education, whether through the American Heart Association Basic Cardiac Life Support (BLS) for Healthcare Providers, or through another similar program that includes both CPR and use of public access AED. *NOTE: Clinically active staff nominally includes all physicians, mid-level providers and nurses, but facilities are encouraged to consider more broad training opportunities including non-clinical staff.*

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c. Identifying and also training additional staff who work with higher-risk patients, (for example, physical therapists in a cardiac rehabilitation program), or who work in high-risk areas (intensive care units (ICUs), telemetry, procedure units, Emergency Departments, etc.).

d. Ensuring that local determinations regarding both CPR and ACLS training meet state requirements for provider licensure and are consistent with national VHA policy, including all applicable directives. *NOTE: For instance, current VHA policy dictates that those who use procedural sedation during medical procedures or surgeries out of the operating room need to have current ACLS training; and that VHA police must have CPR and AED training.*

e. Providing broad, facility-wide education to staff, patients, and visitors about how to respond to a possible cardiac arrest occurring anywhere on the campus. This needs to include how and when to activate the internal code alert system, as well as when and where to first activate 911.

f. Providing training, or funds to obtain required training, for full-time VA staff, if such training is required for their work.

(1) Part-time (less than 5/8ths) or contract staff are expected to obtain this training through their primary employer, or at their own expense, before becoming eligible for an assignment with this requirement.

(2) The facility Chief of Staff, at the recommendation of the CPR Committee, may designate certain part-time employees as essential. In this case, training or funds for such training, must be provided by the Department of Veterans Affairs (VA).

g. Implementing a system for monitoring that the maintenance of ACLS and BLS training is in place that includes:

(1) Where this information is to be maintained and how it is to be disseminated to staff who need to know of this qualification,

(2) An action plan to ensure timely renewal of all certifications, and

(3) The consequences, if appropriate training is not maintained.

h. Establishing a facility Committee, (e.g., CPR, Code, Code Blue, etc.) that is appropriately constituted and charged with reviewing local resuscitation policy annually to ensure that it is current and applicable.

5. REFERENCES: M-2, Part IV, Chapter 1, Paragraphs 1.01 and 1.03, which can be found at: http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=831 .

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6. FOLLOW-UP RESPONSIBILITY: Patient Care Services, Medical Surgical Services, (111) is responsible for the contents of this Directive. Questions may be referred to National Program Director for Cardiology at 804-675-5419.

7. RESCISSIONS: VHA Directive 2002-046 is rescinded. This VHA Directive expires February 28, 2013.

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