Criteria

Florida Resuscitation Center Committee

Regional Resuscitation Center

Revision 3

PURPOSE

Establish a Resuscitation System of Care with performance improvement and data analysis, identify evidence-based interventions, designate hospitals as Resuscitation Centers, develop care guidelines, and create support networks for survivors and families.

Resuscitation System of Care

- Create a facilitated Resuscitation System of Care similar to the current trauma system with performance improvement, data collection/analysis, and enhanced stakeholder engagement.
- Identify evidence-based educational interventions, treatments and protocols to improve the level of care offered to patients needing active resuscitation either in the prehospital, hospital, rehabilitation and post discharge care areas.
- Designate eligible hospitals as Resuscitation Centers and develop EMS transportation guidelines directing patients to these centers of excellence.
- Develop by consensus, a "bundle of care" for cardiac arrest and cardiogenic shock patients that can be used to develop EMS, Hospital and rehabilitation treatment guidelines.
- Create a network of support systems for survivors of cardiac arrest and their families to enhance their rehabilitation and promote post event wellness.

Healthcare facilities agree to achieve the following criteria in treating resuscitation patients to be recognized as "Primary Resuscitation Centers."

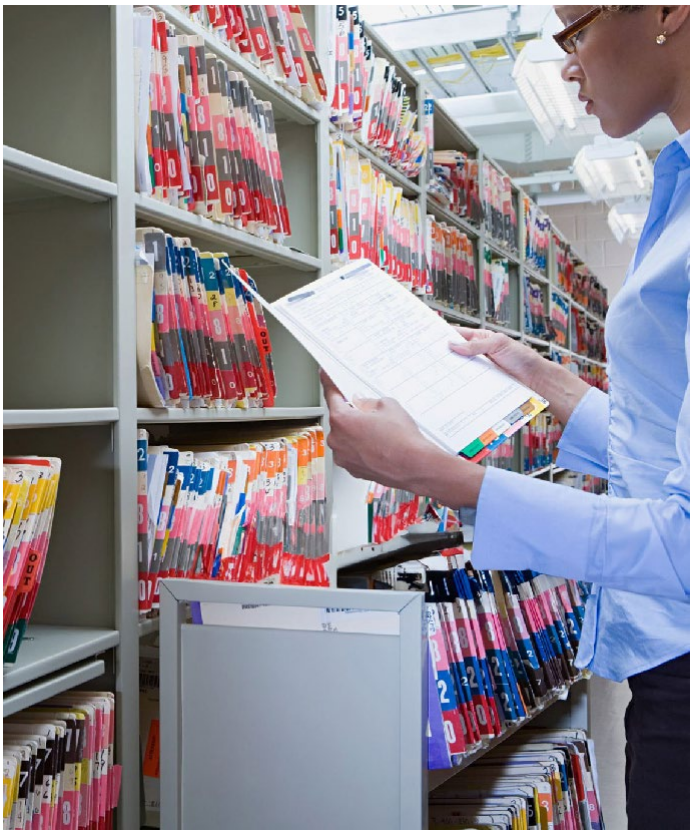
Primary Resuscitation Centers shall have commitment from their senior administration as well as their medical staff, will submit data, participate in benchmarking, and participate in performance improvement (PI) review. This shall be signified by signatures on this Letter of Attestation (LOA) that each facility will complete prior to receiving OHCA patients as a **Primary Resuscitation Center**. The following tenets represent the core of this LOA for **Primary Resuscitation Centers**.

> Primary Resuscitation Center Criteria:

- ☐ EMS collaboration to develop an aggressive system of care.
- ☐ Resuscitation Centers will use a Bundle of Care approach, with defined order sets, standing nursing orders, structured documentation, and structured documentation.
- ☐ Objective criteria for termination of emergency department resuscitation efforts that includes (in addition to length of time of resuscitative efforts) at least some consideration of physiological parameters (such as waveform end tidal CO2 monitoring, point of care ultrasound, lactic acid level etc.).
- ☐ In- house 24/7 PCI capability. Mandatory interventional cardiology emergency department consultation for all sustained ROSC patients.
- ☐ Activation of cardiac cath lab with rapid response (within 60-90 minutes) for patients with cardiac arrest who have achieved ROSC with evidence of STEMI and/or probable cardiac cause of cardiac arrest with initial shockable rhythm. Unless patient has demonstrable and documented clinical features suggesting very high risk and/or futility.
- ☐ Start evidence based targeted temperature management (TTM) within 2 hours of arrival on patients who do not have purposeful response regardless of presenting rhythm post ROSC utilizing comprehensive patient care guidelines, procedures, and equipment.
- ☐ Care plans and order sets with aggressive avoidance of post ROSC hypotension.
- ☐ Interfacility transfer guidelines to transfer appropriate resuscitation patients to a higher level of care.
- ☐ Resuscitation Center patients should have at least daily, or as appropriate for patient condition, multidisciplinary rounds with appropriate team members for confirmation that Bundle of Care elements have been appropriately implemented and that an aggressive plan of care is in place.
- ☐ Nutrition, PT/OT, Rehab and Spiritual Care aspects of care shall be addressed/implemented on admission.
- ☐ Neurologic prognostication: Prognostication of survival should not be implemented for 72 hours post recovery from TTM unless overwhelming structural evidence of brain death is evident.
    - Daily EEG monitoring (continuous if available) of post cardiac arrest patients who undergo TTM is encouraged to monitor neurological status.
- ☐ An evidence-based ICU termination of resuscitation protocol (including a 72-hour moratorium on termination of care for patients receiving hypothermia as part of their TTM).
- ☐ Palliative care guidelines and resources available for patients and families.
- ☐ Protocol for organ donation with evidence of active participation with an organ procurement organization and tissue bank.

> Primary Resuscitation Center Criteria (Continued):

- ☐ Mandatory CARES participation and data entry with timely completion for every OHCA patient
- ☐ Provide all Resuscitation Center patients and families cardiac risk reduction, smoking cessation, nutrition/diabetic diet, and behavior modification education before discharge.
- ☐ Provide all appropriate patients and their families with hands only CPR and choking education before discharge from the hospital.
- ☐ Provide all patients and their families with Survivor Support Education and referral to resources in the community to mitigate the psycho-social impacts of sudden cardiac arrest. Ensure screening for depression, anxiety and PTSI with referral to appropriate clinicians.
- ☐ Have a multi-disciplinary team that will manage patients who are post arrest and/or in cardiogenic shock. The following roles should be recognized:
  - ☐ Resuscitation Center (RC) Medical Director
  - ☐ Emergency department medical director
  - ☐ Intensive Care Unit Medical Director and/or Cardiac Care Unit Medical Director.
  - ☐ RC Program Nursing Director
  - ☐ RC Nurse Specialist/Educator
  - ☐ RC Program Registrar
  - ☐ RC Rehab Team Leader (PT/OT/Speech)
  - ☐ RC Spiritual Care/Ethics Champion
  - ☐ RC Cardiac Rehab/Home care/Clinic Nurse Case Manager
  - ☐ RC Pharmacy Liaison
  - ☐ RC Nutrition/Dietary Services Liaison
- ☐ Shall have on-call medical specialty support in the following disciplines:
  - Interventional Cardiology
  - Pulmonary-Critical care
  - Neurology
  - Infectious Disease
  - Palliative Care/Hospice
- ☐ It is recommended to have specialist support in the following disciplines:
  - ☐ Cardiac Electrophysiology
  - ☐ Vascular Surgery
  - ☐ Cardio-Thoracic Surgery
  - ☐ Gastroenterology
  - ☐ Nephrology
  - ☐ Otolaryngology
  - ☐ Physical Medicine and Rehabilitation
  - ☐ Neuro Radiology
  - ☐ Geriatrics
  - ☐ Behavioral Health



Healthcare facilities agree to achieve the following criteria in treating resuscitation patients to be recognized as a "Comprehensive Resuscitation Center."

Comprehensive Resuscitation Centers shall have commitment from their senior administration as well as their medical staff, will submit data, participate in benchmarking, and participate in Performance Improvement (PI) review. This shall be signified by signatures on this Letter of Attestation (LOA) that each facility will be completed prior to being identified as a **Comprehensive Resuscitation Center**. The following tenets represent the core of this LOA for **Comprehensive Resuscitation Centers.**

> Comprehensive Resuscitation Center Criteria:

- ☐ Must meet all primary resuscitation center criteria (including all recommended specialties).
- ☐ Have in-house 24/7 Pulmonary/Critical Care or CCU care.
- ☐ In-house Mechanical Circulatory Support (MCS) capabilities (i.e. ECMO etc.).
- ☐ Neurological critical care monitoring with neuro-intensivist consultation services.
- ☐ Involvement in research and advancement of the science of cardiac arrest care.
- ☐ Outreach program to community organizations to promote health and lifestyle modifications to decrease the prevalence of cardiac disease.
- ☐ EMS collaboration to develop an aggressive system of care.
- ☐ Promote and teach community efforts to increase bystander CPR and recognition of sudden cardiac arrest.

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