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The Importance of Being Prepared in the Event of a Code

By Sing Palat, MD, FPALTC

When was the last time you initiated cardiopulmonary resuscitation (CPR) in the skilled nursing facility setting? How did you react? My Long-Term Care & Rehab Consultants colleague Jayne Ciarlanti, FNP-BC, of Littleton, CO, found herself initiating codes in the skilled rehab setting not once but twice in the past year. While unexpected and traumatic, her training as a family nurse practitioner meant that the patients under her care received prompt, effective CPR.

After the last code, she sent a quick note to others in our practice who may not have been in a similar situation recently, with practical tips and a reminder to seek support for the emotional toll a code can have.

Ms. Ciarlanti hoped that her letter would prompt the others in her practice to take a moment to remember the steps needed for CPR and visualize what it would look like in their setting if it was needed.

Hello!

I wanted to review what to do if a patient codes in the facility. Although these cases are few and far between, it is always helpful to review the process.

If you are in the facility when a code occurs, it is most likely that you as the advanced practice provider (APP) are the more experienced person in the room. I have not personally had an experience where the nurses did not look to me for guidance when a patient is found without a pulse.

First and foremost, always confirm the code status. If the orders or Medical Orders for Life-Sustaining Treatment (MOLST) form are not readily available, then ideally you should be preparing for the worst while

waiting for updated information. Flatten the bed. Deflate an air mattress. Get the code cart. Place a board under the patient's back.

If the patient status is Do Not Resuscitate (DNR) then you should not initiate resuscitation. Have nursing clean up your patient to look presentable while phone calls and arrangements are made.

If the patient status is FULL Code, the work has just begun. Make sure 911 is called. As in our Basic Life Support (BLS) training, point to the person you want to call emergency services. I have pulled out my phone and called 911 myself when the nursing staff was unable. We want Emergency Medical Services (EMS) on the way ASAP as they are the experts in these situations, and time is tissue!

Ideally, the patient should be brought to the floor as this will improve the effectiveness of CPR. If you are unable to do this due to patient size or lack of assistance, you can continue to use the backboard and initiate chest compressions ASAP. If a bag-valve-mask (Ambu bag) is available and you have multiple people to assist you, begin 30:2 chest compressions per breath per BLS guidelines. If not, continue chest compressions. Don't forget to rotate positions between personnel performing chest compressions and those providing breaths, every 1-2 minutes if possible.

As if this is not enough happening at once, don't forget the automated external defibrillator (AED)! Ensure the machine is turned on and the pads are placed appropriately. Listen to the machine when it talks to you: "Deeper compressions." "Rotate."

EMS tends to show up quickly when they know a patient is without a pulse. Once they have arrived, let them take over. Most of our emergency services have a machine (the Lucas Chest Compression System or similar) to perform chest compressions. While mechanical chest compression devices are not associated with superior outcomes compared to manual CPR, they could benefit in situations where high-quality manual chest compressions are not possible.[1]

Another consideration is intravenous (IV) access. I have never prioritized IV access in a patient who is not breathing. When EMS arrives, they will insert an intraosseous line which is a much quicker form of access. If IV access is already in place, EMS will be pleasantly surprised.

These situations are never easy and often come when you least expect it. If you ever feel overwhelmed in the moment and cannot remember what to do, the 911 dispatcher on the phone will literally walk you through each step: Is the patient breathing? Do they have a pulse? Lay them flat. Can you bring them to the floor? And they will stay on the phone with you until EMS is on scene.

Encourage the leadership at your facility to perform mock codes if possible. Ensure that all staff are certified in BLS. Some homes require licensed practitioners to be trained in Advanced Care Life Support (ACLS). The more qualified and rehearsed everyone is in the facility, the smoother these events will go. Participate in the codes if you are able (especially if you don't know it's a mock!). Staff should all know where life support equipment is stored and how to use it.

Unfortunately, survival rates are less than 11% after out-of-hospital cardiac arrests.[2] *Survival rates among older patients in nursing home settings may be less than 3%. In each scenario, chances of survival are improved in cases of witnessed cardiac arrest and when bystander CPR is provided.*[3]

Review your patients' MOLST forms regularly throughout their short-term and long-term stays, especially if they indicate full code.

If you do have a code situation, do not hesitate to reach out for emotional support and guidance. These situations are challenging, whether it is your first or 10th experience. We know these patients and come to care for them, their families and the staff.

Ms. Ciarlanti's reminder to reach out for support is crucial. More than a reminder of what steps are needed for CPR in a care facility, sharing this letter with other practitioners in response to acute events underscores the need for ongoing education among us as well as connection with those who can relate.

References

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Sing Palat is a market medical director for Optum Home & Community Care Delivery in Englewood, CO.

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