

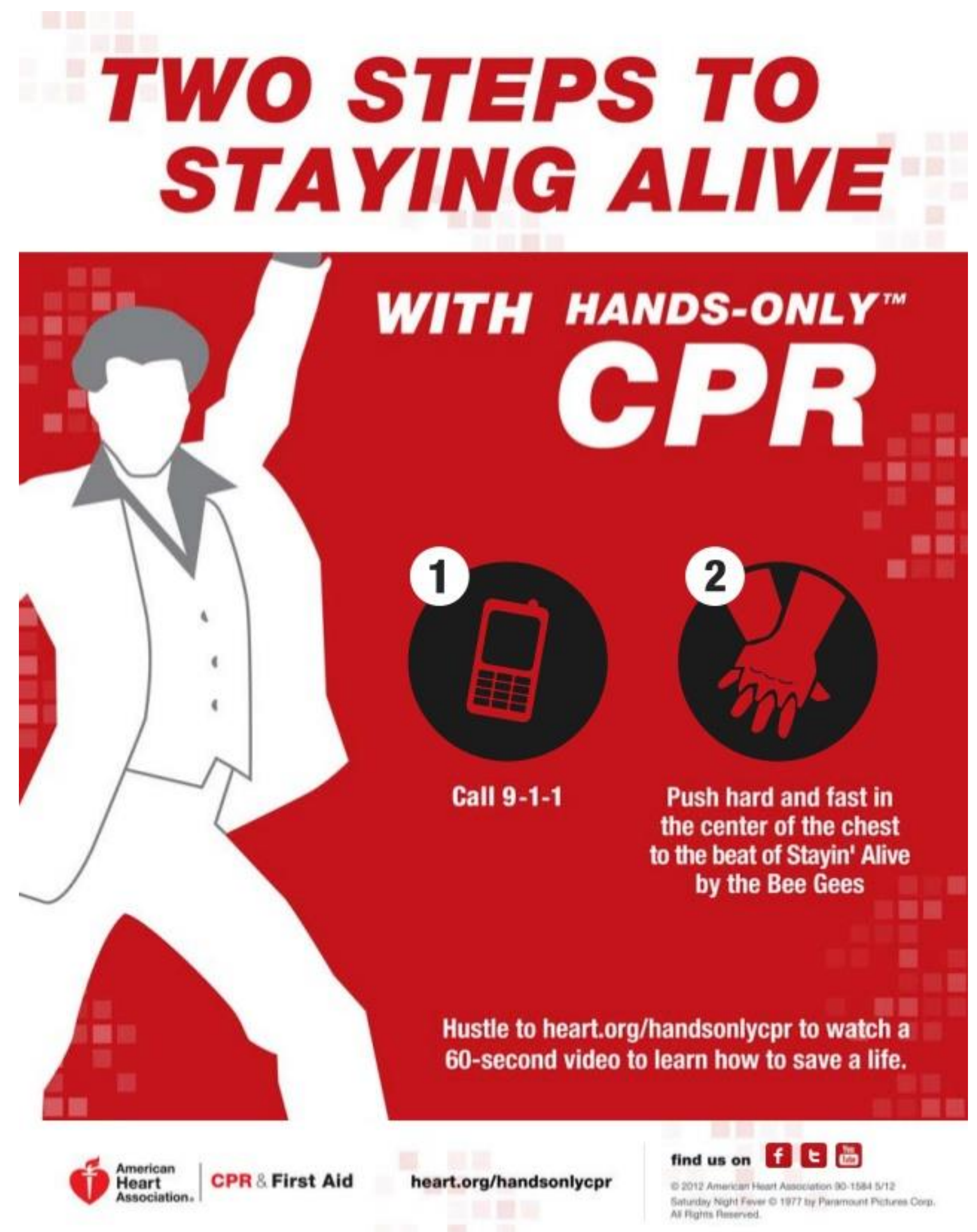
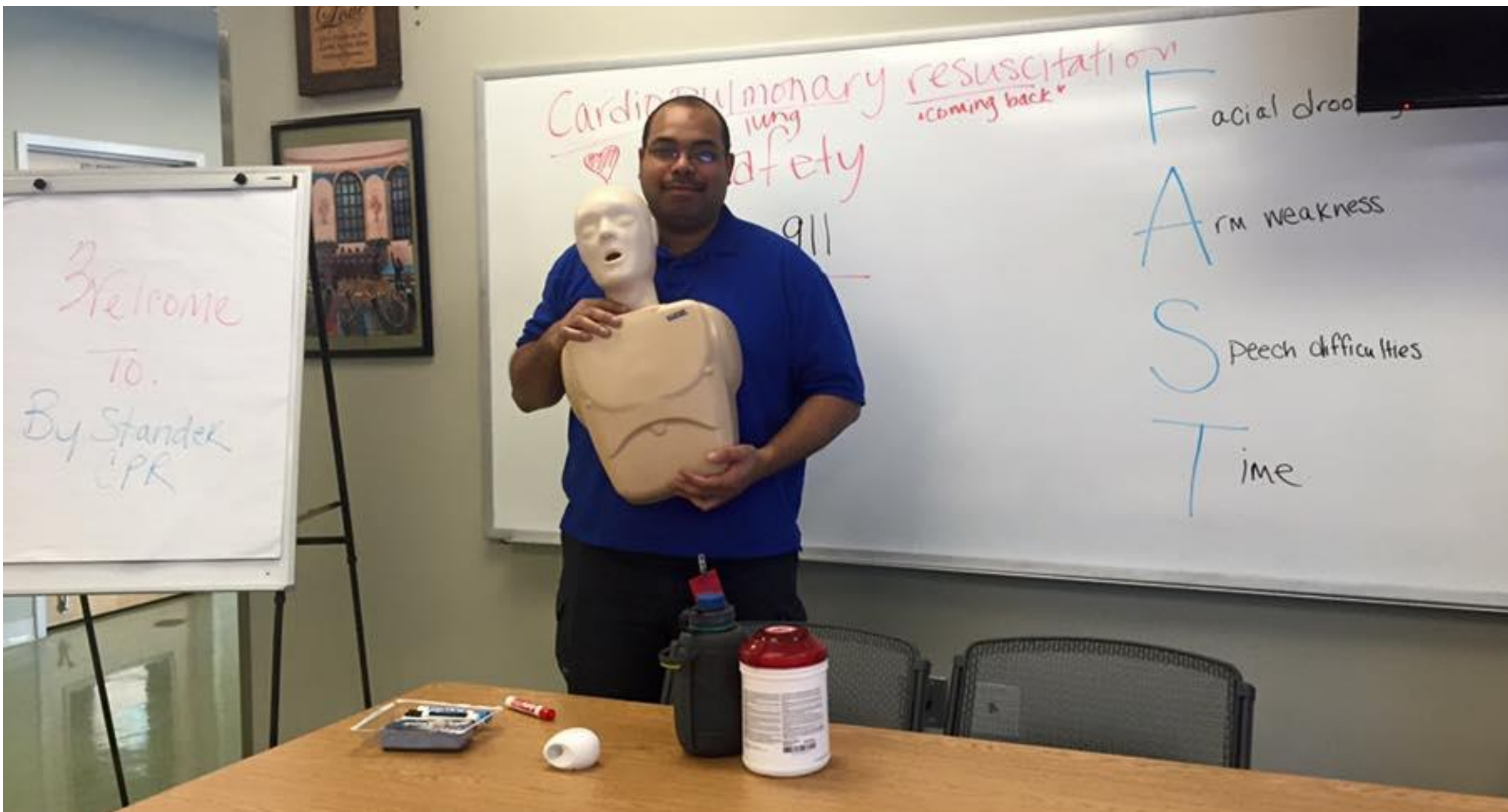
An Emergency Department Nurse-Led Educational Intervention of Bystander Hands-Only Cardiopulmonary Resuscitation in the Homeless Community

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Introduction

An estimated 360,000 out-of-hospital cardiac arrests (OCHAs) occur each year in the United States. Individuals living in low socioeconomic neighborhoods and members of the homeless population are at a higher risk for death due to cardiovascular complications. The designed education program addressed individual and community needs by providing instruction of best practice from the American Heart Association (AHA) with hands-only cardiopulmonary resuscitation (CPR) to homeless individuals in a transitional setting. Hands-only CPR is to be used when a teen or adult collapses in an everyday setting and then a trained bystander initiates the two basic steps which includes calling 911 and then starting compression-only CPR in which no mouth-to mouth breaths are administered.



Results

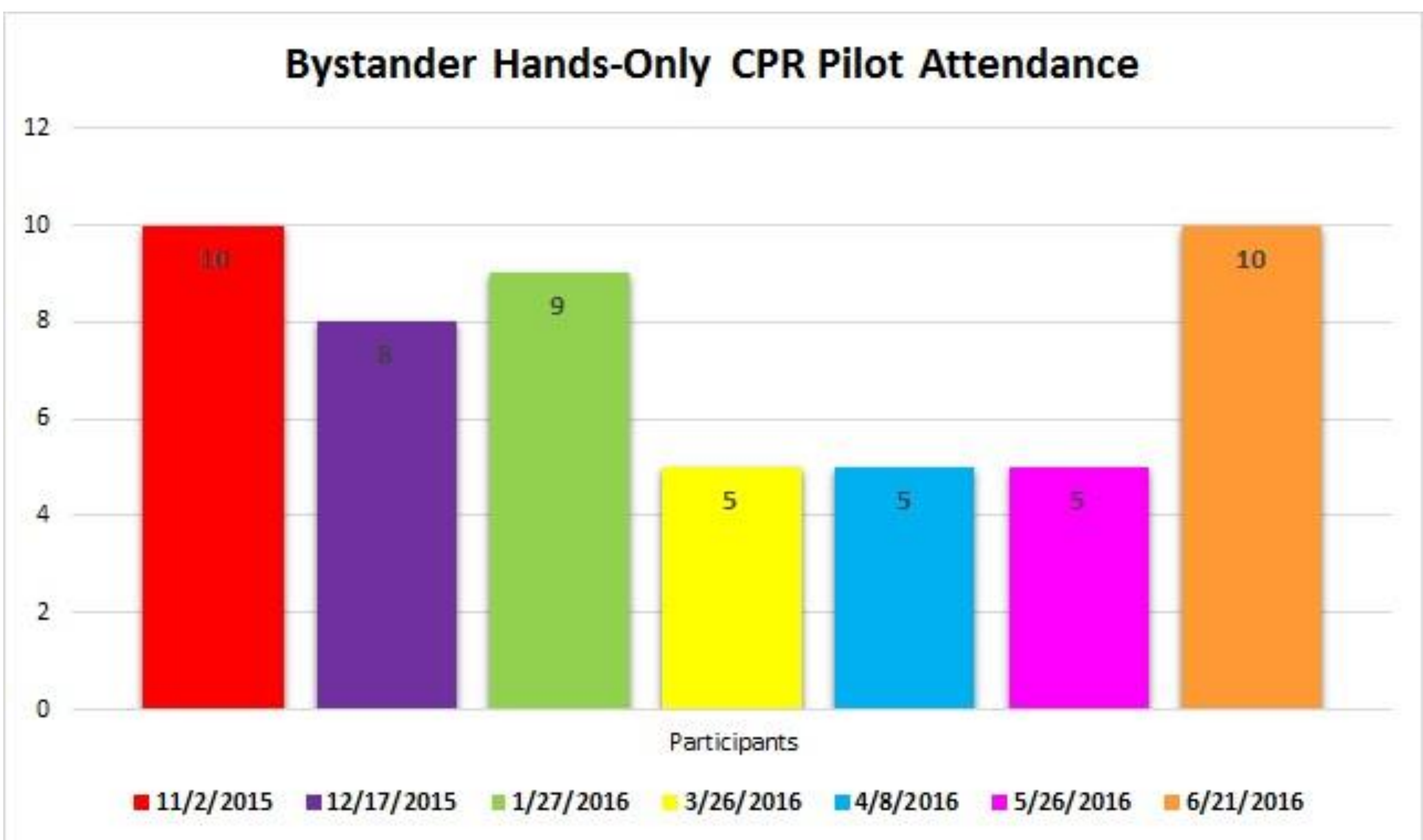
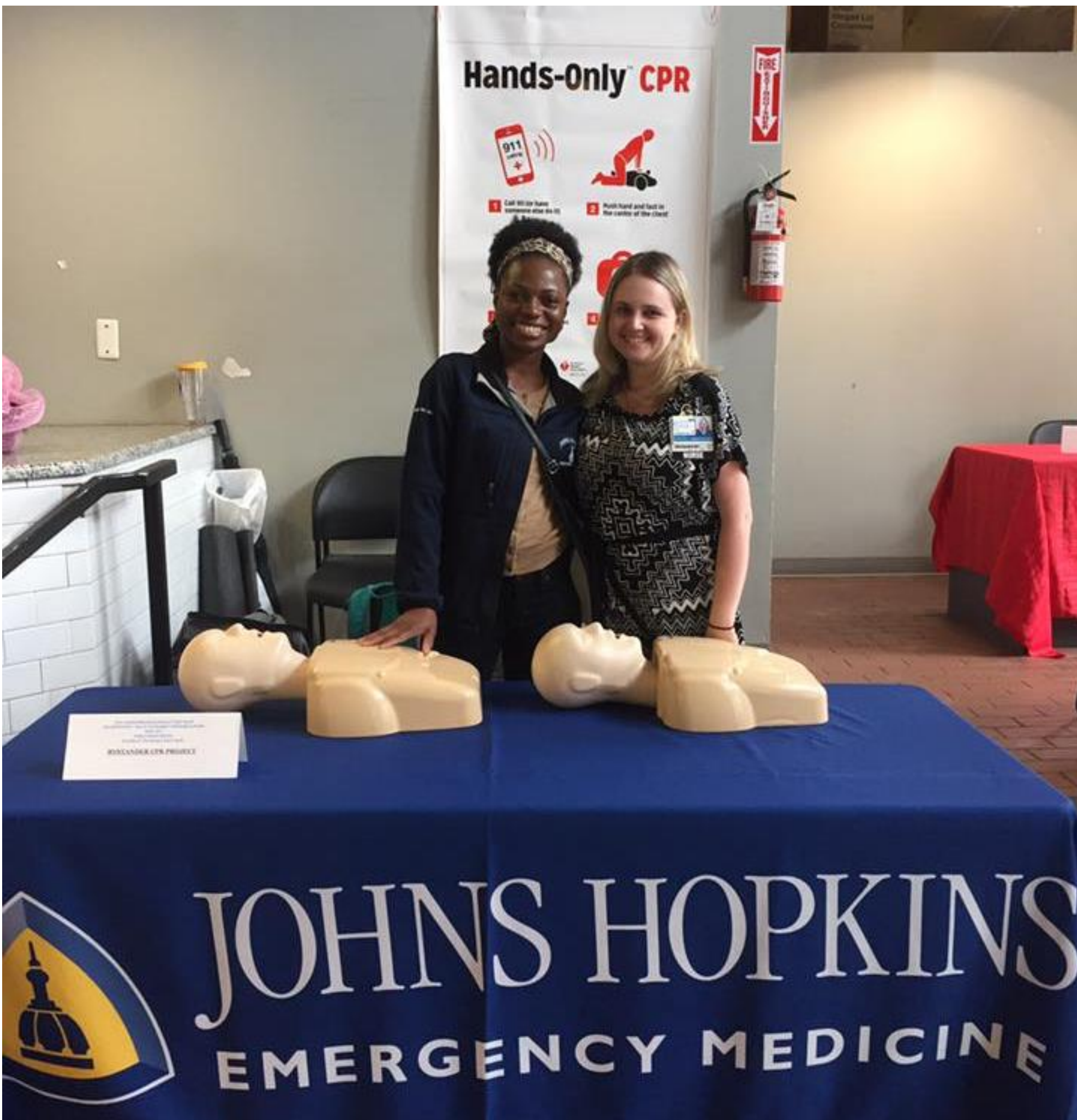
A total of 52 people were trained over seven sessions with emergency RN volunteer instructors. Each session lasted for 30 minutes, with a total of 10 volunteer impact hours.

Objectives

The aim of this community-based health education project was to evaluate the feasibility of an emergency registered nurse (RN) led bystander CPR education program for homeless adults in Baltimore, MD.

Methods

Instruction was provided in-house at a low barrier emergency shelter for individuals experiencing homelessness. Attendance was voluntary, but the shelter incentivized participation with their self-sufficiency development program. The class size was limited to 10 participants and was taught by volunteer RNs. Instructional methods followed the AHA hands-only curriculum. RNs demonstrated high-quality hands-only CPR on manikins and provided real-life scenarios in which OCHAs can occur.



The highest attendance was during the code blue alert months (defined by Baltimore City as October to March). A total of 32 participants attended during code blue months, while 20 attended during non-code blue months. A 63% difference in attendance was apparent. Attendance was lower during the warmer months, when residents were typically less likely to participate in community-based education programs at the shelter.

Conclusion

The AHA hands-Only CPR curriculum is simple to teach and designed for populations with varying levels of health literacy. The straightforwardness of the hands-only course allows for the educators to specifically target people who live in low-income neighborhoods and communities with an increased risk to die from cardiac arrest. Attendance to this in-house program was voluntary, but there was some internal motivation through the shelter's self-sufficiency development program. A focus that was met for this program was to gain the participant's trust of emergency services with the instruction given by emergency nurses who could advocate to create a culture of health and promote a change to increase community safety.