STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

June 7, 2010

The Following Will Be Policy For Emergency Medical Service Care Providers:

GUIDELINES FOR EMR, EMT, AEMT, and Paramedic

DETERMINATION OF DEATH/DISCONTINUATION OF PRE-HOSPITAL RESUSCITATION FOR ADULTS AGE 18 AND OVER

NON-MASS CASUALTY SITUATIONS

PROCEDURE FOR DETERMINATION OF DEATH

Local emergency responders and EMS personnel in Connecticut who are trained in any of the National Standard curricula are instructed to follow the most recent national guidelines of the American Heart Association.

All clinically dead patients will receive all available resuscitative measures including cardiopulmonary resuscitation (CPR) unless contraindicated by one of the exceptions defined below. A clinically dead patient is defined as any unresponsive patient found without respirations and without a palpable carotid pulse.

The person who has the highest level of currently valid EMS certification (above EMR level), has active medical control, has direct voice communication for medical orders, and who is affiliated with an EMS organization present at the scene will be responsible for, and have the authority to direct, resuscitative activities.

In the event there is a personal physician present at the scene who has an ongoing relationship with the patient, that physician may decide if resuscitation is to be initiated. In the event there is a registered nurse from a home health care or hospice agency present at the scene who has an ongoing relationship with the patient, and who is operating under orders from the patient's private physician, that nurse (authorized nurse) may decide if resuscitation is to be initiated. If the physician or nurse decides resuscitation is to be initiated, usual medical direction procedures will be followed.

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Resuscitation must be started on all patients who are found apneic and pulseless UNLESS the following conditions exist (***SECTION I (a-d) are applicable to an EMR level provider):***

I. **Traumatic injury or body condition** clearly indicating biological death (irreversible brain death), limited to:

a. Decapitation: the complete severing of the head from the remainder of the patient's body.

b. Decomposition or putrefaction: the skin is bloated or ruptured, with or without soft tissue sloughed off. The presence of at least one of these signs indicated death occurred at least 24 hours previously.

c. Transection of the torso: the body is completely cut across below the shoulders and above the hips through all major organs and vessels. The spinal column may or may not be severed.

d. Incineration: 90% of body surface area 3° burn as exhibited by ash rather than clothing and complete absence of body hair with charred skin.

Section (e) and (f) require additional assessment and/or confirmation found under "General Procedures," a-d.

e. Dependent lividity with rigor mortis (when clothing is removed there is a clear demarcation of pooled blood within the body, and the body is generally rigid). **DOES NOT APPLY TO VICTIMS OF LIGHTNING STRIKES, DROWNING OR HYPOTHERMIA in which case follow your specific protocols.**

f. Injuries incompatible with life (such as massive crush injury, complete exsanguination, severe displacement of brain matter)

II. Pronouncement of death at the scene by a licensed Connecticut physician or authorized registered nurse.

III. A valid DNR bracelet is present (per CGS 19a-580d), when it:

a. Conforms to the state specifications for color and construction.
b. Is intact: it has not been cut, broken or shows signs of being repaired.
c. Is on the wrist or ankle
d. Displays the patient's name and the physician's name.

GENERAL PROCEDURES:

In cases of dependent lividity **with** rigor mortis and in cases of injuries incompatible with life, the condition of clinical death must be confirmed by observation of the following:

a. Reposition the airway and look, listen, and feel for at least 30 seconds for spontaneous respirations; respiration is absent.

b. Palpate the carotid pulse for at least 30 seconds; pulse is absent.

c. Examine the pupils of both eyes with a light; both pupils are non-reactive.

d. Absence of a shockable rhythm with an AED for 30 seconds or lack of cardiac activity with a cardiac monitor [paramedic] (in at least 2 leads) for 30 seconds.

If all the components above are confirmed, no CPR is required.

If CPR has been initiated but all the components above have been subsequently confirmed, CPR may be discontinued and medical direction contacted as needed.

Special Consideration: For scene safety and/or family wishes, provider may decide to implement CPR even if all the criteria for death are met.

If any of the findings are different than those described above, clinical death is NOT confirmed and resuscitative measures must be immediately initiated or continued and the patient transported to a receiving hospital unless paramedic intercept is pending. Termination of resuscitative efforts could then be implemented by the paramedic protocol below.

DO NOT RESUSCITATE (DNR) WITH SIGNS OF LIFE

If there is a DNR bracelet or DNR transfer form and there are signs of life (pulse and respiration), EMS providers should provide standard appropriate treatment under existing protocols matching the patient's condition. To request permission to withhold treatment under these conditions for any reason, contact Direct Medical Oversight (DMO).

If there is documentation of a DO NOT INTUBATE (DNI) advanced directive, the patient should receive full treatment per protocols with the exception of intubation. If for any reason intubation is being considered in a patient with a documented DNI directive, DMO must be contacted.

TERMINATION OF RESUSCITATIVE EFFORTS (PARAMEDIC LEVEL ONLY):

NONTRAUMATIC CARDIAC ARREST

Discontinuation of CPR and ALS intervention may be implemented after contact with medical direction if all of the following criteria have been met.

1. Patient must be least 18 years of age.
2. Patient is in cardiac arrest at the time of arrival of advanced life support, no pulse, no respirations, and no heart sounds.
3. ACLS is administered for at least twenty (20) minutes, according to AHA/ACLS Guidelines
4. There is no return of spontaneous pulse and no evidence of neurological function (non-reactive pupils, no response to pain, no spontaneous movement).
5. Patient is asystolic in two (2) leads
6. No evidence or suspicion of any of the following: drug/toxin overdose, hypothermia, active internal bleeding, preceding trauma.
7. All Paramedic personnel involved in the patient's care agree that discontinuation of the resuscitation is appropriate.

All seven items must be clearly documented in the EMS patient care report (PCR).

DMO should be established prior to termination of resuscitation in the field. The final decision to terminate resuscitative efforts should be a consensus between the on-scene paramedic and the DMO physician. **CONTACT DMO** for confirmation of terminating resuscitation efforts.

If any of the above criteria are not met and there are special circumstances whereby discontinuation of pre-hospital resuscitation is desired, contact DMO.

Logistical factors should be considered, such as collapse in a public place, family wishes, and safety of the crew and public.

Examples: Inability to extricate the patient, significant physical environmental barriers, unified family wishes with presence of a living will.

All patients who are found in ventricular fibrillation or whose rhythm changes to ventricular fibrillation should in general have full resuscitation continued and transported.

Patients who arrest after arrival of EMS should be transported.

TRAUMATIC CARDIAC ARREST:

1. Patients must be at least 18 years of age.

2. Resuscitation efforts may be terminated with approval of DMO in any blunt trauma patient who, based on thorough primary assessment, is found apneic, pulseless, and asystolic on ECG upon arrival of emergency medical services at the scene.

3. Victims of penetrating trauma found apneic and pulseless by EMS, should be rapidly assessed for the presence of other signs of life, such as pupillary reflexes, spontaneous movement, response to pain and electrical activity on ECG. Resuscitation may be terminated with permission of DMO if these signs of life are absent. If resuscitation is not terminated, transport per protocol.

4. Do not delay initiating proper BLS resuscitation in order to contact DMO.

5. Cardiopulmonary arrest patients in whom mechanism of injury does not correlate with clinical condition, suggesting a non-traumatic cause of arrest, should have standard ALS resuscitation initiated.

DISPOSITION OF REMAINS:

I. Disposition of dead bodies is not the responsibility of EMS personnel but efforts must be taken to insure that there is a proper transfer of the responsibility for scene security. However, to be helpful to family, police, and others, EMS personnel may assist those who are responsible.

II. When a decision has been made to withhold or withdraw resuscitation, the body may be removed in one of the following ways:

   a. The Office of the Chief Medical Examiner (860-679-3980 or 1-800-842-8820) must be notified of any death, which may be subject to investigation, by the Chief Medical Examiner (CGS19a-407), which includes all deaths that occur outside a health care institution. Normally the police make this notification otherwise EMS personnel should make the notification and document on the patient care record.

   b. If the body is in a secure environment (protected from view by the public or from being disturbed or moved by unauthorized people), the police should be contacted if not present already. The personal physician or coverage must be notified if at all possible and EMS personnel may leave when the patient has been turned over to the police. Example: a death at home

c. If the body is not in a secure environment notify the police. The police may contact the Office of the Chief Medical Examiner for authorization to move the body by hearse, or the medical Examiner may elect to send a vehicle for the body. EMS personnel may leave after turning the scene over to other appropriate authority. Example: death occurring on the street.

d. If the body is not in a secure environment and police have not yet arrived, transport the body to the hospital if scene safety is a concern. Example: death in the street with an unruly crowd of people.

DETERMINATION OF DEATH/DISCONTINUATION OF RESUSCITATION NOTES:

Consider the needs of survivors when considering the discontinuation of resuscitation, especially if crisis management services may be needed. Transport from the scene may be the better option.

Scene management and safety of the crew and public may prevent withholding/discontinuation of resuscitation. In general, do not cease resuscitation in public places/establishments.

Tubes and IV lines may be removed if patient is being picked up by a funeral home. If the patient is deemed a medical examiner's case, leave tubes and lines in place. In all cases of trauma, tubes and IV lines must be left in place.

Documentation of all encounters with the patient's family, personal physician, scene physician or nurse, medical examiner, law enforcement, and DMO should be on the PCR.

DNR TRANSFER FORM

a. To transmit a DNR order during transport by an EMS provider between healthcare institutions, the DNR order shall be documented on the DNR transfer form.

b. The DNR transfer form shall be signed by a licensed physician or a registered nurse and shall be recognized as such and followed by EMS providers.

c. The DNR remains in place during transport as well as to the point of admission to the receiving facility.

REVOCATION OF THE DNR

When EMS providers are providing care *in pre-hospital emergency settings*, a patient or authorized representative may revoke a DNR order by removing a DNR bracelet from a patient's extremity or by telling the EMS provider. If the EMS provider is told to revoke the DNR, the provider documents the request or causes the request to be documented in the patient's permanent medical record and notifies the attending physician and the physician who issued the DNR order. CGS 19a-580d-7.

In the event that EMS providers cannot verify the DNR status, the patient should be transported with normal care protocols followed.

A copy of all PCRs documenting pre-hospital deaths must be provided to medical direction within 24 hours of the event.

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