

Emergency Medical Services Program Policies – Procedures – Protocols

Withholding Resuscitative Measures (1008.00)

I. General Provisions:

- A. To establish criteria that recognizes and accommodates a patient's wish to limit prehospital treatment who do not otherwise meet the "Determination of Death" criteria in the prehospital setting or long-term care facilities, during transport between facilities and/or in patient's homes.
- B. The Do Not Resuscitate (DNR) only applies to cardiopulmonary resuscitative measures. An order not to resuscitate is not an order to withhold other necessary medical treatment or nutrition. The treatment given to a patient with a DNR agreement should in all respects be the same as that provided to a patient without such an agreement. The forms (see Appendix) that may be used are:
 - 1. The statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital Do Not Resuscitate form.
 - 2. The EMSA approved Physician Orders for Life Sustaining Treatment (POLST) form.
 - 3. A standard EMSA/KCEMS approved DNR medallion.
 - 4. A Do Not Resuscitate Order in a patient's chart dated and signed by the physician.

II. Definitions:

- A. Do Not Resuscitate (DNR): A written order by a physician or the presence of a DNR medallion/bracelet or necklace indicating that an agreement has been reached between the physician and patient/or surrogate that in the event of cardiac or respiratory arrest the following medical interventions will NOT be initiated:
 - 1. Chest compressions
 - 2. Defibrillation
 - 3. Endotracheal intubation
 - 4. Assisted ventilation
 - 5. Cardiotonic drugs, e.g., Epinephrine, Atropine or other medications intended to treat a non-perfusing rhythm.

- B. Absent Vital Signs: Absence of respiration and absence of carotid pulse.
- C. DNR Medallion/Bracelet/Necklace: A medallion/bracelet/necklace worn by a patient, which has been approved for distribution by the California Emergency Medical Services Authority (EMSA). There are currently only two (2) approved vendors that produce the DNR medallions and bracelets. They are MedicAlert Foundation and Caring Advocates.
- D. Prehospital DNR Form: Form developed by the California Medical Association (CMA) for use statewide for prehospital DNR requests. This form has been approved by EMSA and ICEMA. This form should be available to EMS field personnel in the form of the white original DNR form or as a photocopy. The original or copy of the DNR form will be taken with the patient during transport. The DNR form shall not be accepted if amended or altered in any way.
- E. EMS Field Personnel: Any EMS field responder currently certified and/or accredited in Kern County.
- F. End of Life Options Act: Commonly referred to as Death with Dignity. The act allows a qualified terminally ill patient to request and obtain medications to hasten their imminent death. Patients may die at a time and place of their choosing. The law provides that:
1. Only adult California residents who are mentally competent, diagnosed with a terminal illness, and whose life expectancy is six months or less are eligible. The patient must be capable of self-administering the medication.
 2. Two physicians are required to verify eligibility as stated above.
 3. The patient must make two (2) oral requests in person, fifteen (15) days or more apart for inclusion. A written request must be witnessed by two (2) people, one cannot be an heir. Within forty-eight (48) hours prior to taking the medications the patient must sign a final attestation form.
 4. All forms are part of the statute.
- G. Physician Orders for Life-Sustaining Treatment (POLST): A physician's order that outlines a plan of care reflecting the patient's wishes concerning care at life's end. The POLST form is voluntary and is intended to assist the patient and their family with planning and developing a plan to reflect the patient's end of life wishes. It is also intended to assist physicians, nurses, health care facilities and EMS field personnel in honoring a person's wishes for life-sustaining treatment. May be signed by a physician, physician assistant, or nurse practitioner. EMS Field Personnel who encounter the EMSA approved POLST form in the field

should be aware of the different levels of care in Sections A and B of the form (Section C does NOT apply to EMS personnel).

III. Validation Criteria:

- A. Statewide Prehospital DNR form should include the following to be considered valid:
 - 1. Patient's name
 - 2. Signature of the patient or a legal representative if the patient is unable to make or communicate informed health care decisions.
 - 3. Signature of patients' physician, affirming that the patient/legal representative has given informed consent to the DNR instruction.
 - 4. All signatures are to be dated.
 - 5. Correct identification of the patient is crucial. If the patient is unable to be identified after a good faith attempt to identify the patient, a reliable witness may be used to identify the patient.

- B. The DNR medallion/bracelet/necklace is made of metal with a permanently imprinted medical insignia. For the medallion or bracelet/necklace to be valid the following applies:
 - 1. Patient must be physically wearing the DNR medallion/ bracelet/necklace.
 - 2. Medallion/bracelet/necklace must be engraved with the words "Do Not Resuscitate EMS", along with a toll free emergency information telephone number and a patient identification number.

- C. In licensed healthcare facilities a DNR order written by a physician shall be honored. The staff must have the patient's chart with the DNR order immediately available for EMS field personnel upon their arrival. The order may contain the words Do Not Resuscitate, No CPR, or No Code and contain the patient's name and the date and signature of the physician.

- D. The POLST form must be signed and dated by a physician, physician assistant, or nurse practitioner. Without this signature, the form is invalid. Verbal or telephone orders are valid if allowed by the institution or facility. There should be a box checked indicating who the physician discussed the POLST orders with. By signing the form, the physician, physician assistant or nurse practitioner acknowledges that these orders reflect the wishes of the patient or designated decision maker.

- E. Advanced Health Care Directives that include a signed DNR or POLST form.

IV. Procedure:

- A. EMS field personnel shall validate the DNR request or POLST form.
- B. BLS field personnel shall continue resuscitative measures if a DNR or POLST cannot be validated.
- C. ALS field personnel shall contact a base hospital for direction if a DNR or POLST cannot be validated or for conflicting requests by family members. While ALS field personnel are contacting the base hospital for direction, BLS treatment must be initiated and continued. If contact cannot be made, resuscitative efforts shall continue.
- D. If a patient states that they wish resuscitative measures, the request shall be honored.
- E. If a family member requests resuscitative measures despite a valid DNR or POLST, BLS or ALS field personnel should not initiate resuscitation. Personnel should contact a base hospital for direction, if needed.
- F. If patient is not in cardiac arrest and has a valid POLST form, EMS field personnel may provide comfort measures as described in Section B of the form.
- G. The patient shall be transported to the hospital if comfort measures are started by EMS field personnel.
- H. Direct any questions about transporting the patient to the base hospital.
- I. EMS field personnel shall attach a copy of the approved DNR form or POLST form to the patient care record, along with any other appropriate written documentation. The DNR form should accompany the patient to the hospital so that it may be incorporated into the medical record at the receiving facility. When DNR orders are noted in medical records in licensed facilities, that fact should be recorded by the EMS provider, along with the date of the order and the physician's name. It should be noted on the patient care record that a written DNR order was present including the name of the physician, date signed and other appropriate information.
- J. All circumstances surrounding the incident must be documented on the EMS

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patient care report. If EMS field personnel are unable to copy the DNR or POLST form, the following shall be documented on the patient care report:

1. Presence of DNR or POLST form.
2. Date of order.
3. Name of physician who signed form.

K. If a patient expires at home, law enforcement must be notified unless patient is under the care of Hospice. In all cases, the coroner must be notified.

L. If a patient expires in a licensed healthcare facility, the facility has the responsibility to make the appropriate notification.

V. Supportive Measures:

A. Medical interventions that may provide for the comfort, safety and dignity of the patient should be utilized.

B. The patient should receive palliative treatment for pain, dyspnea, major hemorrhage or other medical conditions.

C. Allow any family members/significant others to express their concerns and begin their grieving process.

D. Unless a patient is actively dying, medical treatment for other conditions should not be withheld.

VI. End of Life Options

A. If 9-1-1 is requested, providers should contact a base hospital physician for guidance, depending on the situation.

B. If the patient has the whole process approved and implemented, but family is requesting resuscitation, providers should NOT provide resuscitation as long as documentation is available that confirms the patient has been formally approved.

C. If the patient requests treatment during any phase of the End of Life Options process, treatment shall be provided. If the patient has already taken the aid-in-dying drug and the patient requests treatment, the provider shall initiate resuscitation and immediately contact base hospital for direction based upon the medication(s) taken.

D. This does not affect the resuscitation of suicide attempts outside of this process.

Revision Log:

01/01/2017: Creation. EMCAB approval.

Do Not Resuscitate (DNR) Form

CMA PUBLICATIONS 1(800) 882-1262 WWW.CMANET.ORG



EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



PURPOSE

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel regarding a patient's decision to forego resuscitative measures in the event of cardiopulmonary arrest. Resuscitative measures to be withheld include chest compressions, assisted ventilation, endotracheal intubation, defibrillation, and cardiotoxic drugs. This form does not affect the provision of life sustaining measures such as artificial nutrition or hydration or the provision of other emergency medical care, such as palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

APPLICABILITY

This form was designed for use in prehospital settings –i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed request regarding resuscitative measures, including a Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion), from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

INSTRUCTIONS

The Prehospital Do Not Resuscitate (DNR) Form must be signed by the patient or by the patient's legally recognized health care decisionmaker if the patient is unable to make or communicate informed health care decisions. The legally recognized health care decisionmaker should be the patient's legal representative, such as a health care agent as designated in a power of attorney for health care, a court-appointed conservator, or a spouse or other family member if one exists. The patient's physician must also sign the form, affirming that the patient/legally recognized health care decisionmaker has given informed consent to the DNR instruction.

The white copy of the form should be retained by the patient. The completed form (or the approved wrist or neck medallion—see below) must be readily available to EMS personnel in order for the DNR instruction to be honored. Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The goldenrod copy of the form should be retained by the physician and made part of the patient's permanent medical record.

The pink copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (1(888)755-1448, 2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of the medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of the patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

REVOCATION

In the absence of knowledge to the contrary, a health care provider may presume that a request regarding resuscitative measures is valid and unrevoked. Thus, if a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) Form should be directed to the local EMS agency.

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**EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM**



An Advance Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand that I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate Signature

Date

Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotoxic medications are to be initiated.

Physician Signature

Date


Print Name

Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Physician Orders for Life-Sustaining Treatment (POST) Form

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
 <p>EMSA #111 B (Effective 1/1/2016)*</p>	<h2>Physician Orders for Life-Sustaining Treatment (POLST)</h2>	
	<p><u>First follow these orders, then contact Physician/NP/PA.</u> A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.</p>	
	Patient Last Name:	Date Form Prepared:
	Patient First Name:	Patient Date of Birth:
	Patient Middle Name:	Medical Record #: (optional)
A Check One	CARDIOPULMONARY RESUSCITATION (CPR): <i>If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i>	
	<input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B) <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (<u>Allow Natural Death</u>)	
B Check One	MEDICAL INTERVENTIONS: <i>If patient is found with a pulse and/or is breathing.</i>	
	<input type="checkbox"/> Full Treatment – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <input type="checkbox"/> Trial Period of Full Treatment. <input type="checkbox"/> Selective Treatment – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> Request transfer to hospital <u>only</u> if comfort needs cannot be met in current location. <input type="checkbox"/> Comfort-Focused Treatment – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital <u>only</u> if comfort needs cannot be met in current location. Additional Orders: _____	
C Check One	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible and desired.</i>	
	<input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. Additional Orders: _____ <input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____ <input type="checkbox"/> No artificial means of nutrition, including feeding tubes. _____	
D	INFORMATION AND SIGNATURES:	
	Discussed with: <input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker	
	<input type="checkbox"/> Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive: <input type="checkbox"/> Advance Directive not available Name: _____ <input type="checkbox"/> No Advance Directive Phone: _____	
	Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA) My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.	
	Print Physician/NP/PA Name:	Physician/NP/PA Phone #: Physician/PA License #, NP Cert. #:
	Physician/NP/PA Signature: (required)	
	Date:	
	Signature of Patient or Legally Recognized Decisionmaker I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.	
	Print Name:	Relationship: (write self if patient)
	Signature: (required)	Date:
Mailing Address (street/city/state/zip):	Phone Number:	
FOR REGISTRY USE ONLY		
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED		

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

EMSA/EMS Division Approved Medallion

