Death in the Field – 00.030

PURPOSE:
The purpose of the Death in the Field Protocol is to define under what conditions medical care can be withheld or stopped once it has been started.

PROCEDURE:

Resuscitation efforts may be withheld if:

A. The patient has a valid, signed "DNR" order. POLST registry # 877-367-7657
B. The patient is pulseless and apneic in a mass casualty incident or multiple patient scene where the resources of the system are required for the stabilization of living patients.
C. The patient is decapitated.
D. The patient has rigor mortis in a warm environment.
E. The patient is in the stages of decomposition.
F. The patient has skin discoloration in dependent body parts (dependent lividity).

TRAUMATIC ARREST:

1. A victim of trauma (blunt or penetrating) who has no vital signs in the field may be declared dead on scene. If opening the airway does nor restore vital signs/signs of life, the patient should NOT be transported unless there are extenuating circumstances.
2. A cardiac monitor may be beneficial in determining death in the field when you suspect a medical cause or hypovolemia: A narrow complex rhythm (QRS < .12) may suggest profound hypovolemia, and may respond to fluid resuscitation.
3. At a trauma scene, the paramedic should consider the circumstances surrounding the incident, including the possibility that a medical event (cardiac arrhythmia, seizure, and hypoglycemia) preceded the accident. When a medical event is suspected, treat as a medical cardiac event. VF should raise your index of suspicion for a medical event.
4. In instances prior to transport where the patient deteriorates to the point that no vital signs (i.e. pulse/respiration) are present, a cardiac monitor should be applied to determine if the patient has a viable cardiac rhythm. A viable rhythm especially in patients with penetrating trauma may reflect hypovolemia or obstructive shock (tamponade, tension pneumothorax) and aggressive care should be continued.

MEDICAL CARDIAC ARREST:

In addition to the conditions listed above under Death in the Field, a medical patient should generally be declared dead if:

I. ECG shows asystole or agonal rhythm upon initial monitoring, and after at least two lead changes, the patient, in the paramedic's best judgment, would not benefit from resuscitation:
   a. The PIC should determine DIF and notify Law Enforcement;

   - OR -

   b. Begin BLS procedures, and contact OLMC with available patient history, current condition, and with a request to discontinue resuscitation.

2. If after the airway is established and the asystole protocol has been exhausted the patient persists in asystole, (confirm in 3 leads) consider termination of efforts. The PIC may declare the patient to be dead in the field.
3. The patient who has PEA/Asystole and has not responded to the initial cycle of ACLS may be determined to be dead at the scene after appropriate consultation with OLMC.
4. All patients in VF/VT should be treated and transported unless a valid, signed DNR is present.

NOTES & PRECAUTIONS:

1. ORS allows a layperson, EMT or Paramedic to determine “Death in the Field”
2. The EMT is encouraged to consult OLMC if any doubt exists about the resuscitation potential of the patient.
3. A person who was pulseless or apneic and has received CPR and has been resuscitated, is not precluded from later being a candidate for solid organ donation.
4. $ETCO_2$ may be a useful adjunct in the decision to terminate resuscitation with PEA. An $ETCO_2$ of 10 or less in patients in PEA after 20 minutes of ACLS resuscitation does not correlate with survival.
5. Survival from trauma arrest is low, but not completely zero.
6. If person has been identified as an organ donor, contact OLMC as soon as possible.