Section: Medical Operations General
Subject: END OF LIFE POLICY
Section #: 300.04
Issue Date: March 21, 2011
Revision Date: December 1, 2017
Approved By: Michael Lozano, Jr., M.D., HCFR Medical Director

1. NO CODES – MEDICAL:
    a. The American Heart Association recognizes several situations in which it is permissible to withhold (i.e. not initiate) CPR. These conditions are termed "evidence of irreversible death" and are as follows:
        i. Decapitation
        ii. Rigor mortis
        iii. Dependent lividity
        iv. Tissue decomposition
    b. HCFR Paramedics, EMTs, and First Responders may upon the identification of "evidence of irreversible death", withhold resuscitative efforts (CPR).
        i. In all cases where CPR is withheld, an HCFR Paramedic will continue to the scene to complete documentation, which will address the following areas:
            1. Absence of pulse
            2. Apnea
            3. No heart sounds or electrical activity on monitor (asystole) or wide complex tachycardia with a rate less than 20 beats per minute
                a. Rhythm strip must be included in documentation.
            4. Any and all conditions listed in section (1)(b) of this policy that are applicable
    c. It is understood that sometimes first responders, acting under their own agency's guidelines and without the benefit of an EKG monitor, may have started CPR on a person who fits the criteria in section (1)(a) of this policy.
        i. Paramedics, EMTs, and First Responders may recognize death, but do not legally pronounce death, and have a responsibility to continue CPR already in progress.
        ii. If, in the opinion of the Charge Medic (Paramedics ONLY), the patient exhibits any of the signs listed in section (1)(a) of this policy and CPR has been initiated, CPR may be discontinued without contacting Medic-1.
            1. The Charge Medic must document thoroughly the signs exhibited at the time of CPR termination.
        iii. All other persons upon whom CPR has been initiated will continue to have resuscitative efforts maintained until such time as HCFR Paramedics arrive on scene and care is provided to a receiving facility or until all the requirements described in section (3) of this policy, "Discontinuing Resuscitation Efforts", are fulfilled.
    d. "*Do not resuscitate orders*" (DNRO's):
        i. HCFR personnel will honor properly completed DNRO's in accordance with F.S. 401.45 and Chapter 64E F.A.C.
        ii. The DNRO may be presented as the long form or the DNRO device (wallet card) but must be signed by the patient, the physician, and properly witnessed/notarized.
            1. A copy of a properly completed original is acceptable provided it is legible and printed on yellow paper.
            2. A copy of the DNRO should be scanned into the ePCR whenever possible.
        iii. In the absence of a DNRO, resuscitation efforts may be withheld if a properly identified physician states to you, in person, that no resuscitative measures are to be initiated.
            1. Request that the physician stay on scene until law enforcement arrives.
            2. Document physician's name and license number in patient care report.
            3. If any unusual circumstances arise, contact Medic-1.
        iv. A Living Will or other legal document which clearly identifies the patient's desire to withhold CPR may be honored with the approval of Medic-1 in conjunction with the patient's family and/or physician agreement.

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1. A copy of the living will/other legal document should be scanned into the ePCR.

v. It is otherwise your responsibility to provide treatment and/or resuscitative measures as indicated by State law and HCFR policy.

2. NO CODES – TRAUMA:
   a. Extensive research supports the fact that the outcome of patients who suffer cardio-respiratory arrest from *BLUNT trauma* is uniformly poor.
      i. These patients do not benefit from further intervention.
   b. Any victim of *BLUNT trauma* who meets ALL of the following criteria can be assumed to have sustained a terminal injury, no further resuscitative measures are necessary, and BLS interventions in progress may be stopped:
      i. Present history of *SEVERE BLUNT trauma*
      ii. Pulseless
      iii. Apnea
      iv. No heart sounds or no electrical activity on monitor (asystole) or wide complex ventricular rhythm with a rate less than 20 beats per minute.
   c. Again, as in section (1)(b) of this policy, an HCFR Paramedic will continue to the scene to complete documentation.
      i. Documentation must address each of the areas in section (2)(b) of this policy.
         1. Documentation shall also include a rhythm strip unless obtaining the strip is waived in preference of delivering care at the same scene to other victims.
            a. In the instance of one (1) victim only, a rhythm strip shall be used as part of the criteria for BLUNT trauma code and included with the ePCR.
   d. A copy of the complete medical record (ePCR, EKG, etc.) shall be faxed to the Medical Examiner's Office.
   e. The Charge Medic may decide to continue resuscitative efforts for any reason, including scene safety, and will transport expediently to the nearest appropriate facility.
   f. The handling of patient remains requires a high degree of sensitivity to public perception, human dignity, and scene decorum.
      i. Transfer of the patient remains should take place in a protected location in order to avoid the negative perception of any onlookers.
   g. Contact should be made with a Battalion Chief if any difficulties are encountered.

3. DISCONTINUING RESUSCITATION EFFORTS: *(Paramedics ONLY)*
   a. Resuscitation may be discontinued in the pre-hospital setting when the patient appears clinically dead after an adequate trial of ACLS and with an order from Medic-1.
      i. Because the HCFR Medical Director remains ultimately responsible for determination of death, this decision must be made in conjunction with the Medic-1.
   b. Before contacting Medic-1 for approval to discontinue resuscitation efforts, the following criteria MUST be met:
      i. An airway has been achieved by intubation or other approved rescue airway.
      ii. Vascular access has been achieved by either intravenous or intraosseous line.
      iii. Rhythm appropriate medications and countershocks for ventricular fibrillation have been administered according to ACLS guidelines for at least 20 minutes.
      iv. Asystole or slow electrocardiographic patterns are present and no reversible causes are present.
      v. The patient IS NOT hypothermic.
      vi. Appropriate treatment for drug overdose has been administered, if indicated.

vii. Family members have been consulted prior to termination of resuscitation, if possible.
1. Based on discussion of the patient's pertinent medical history and the situation encountered on the call, transport may be warranted in certain circumstances, despite the extremely small likelihood of benefit to the patient.
2. The Charge Medic of the resuscitation effort can always elect to continue resuscitation and transport.
3. When Medic-1 authorizes the cessation of resuscitative efforts, the body is to be covered with a clean sheet.
a. IV/IO lines and advanced airway adjuncts shall be left in place and the local law enforcement agency notified immediately.

4. Unless the patient meets the ***BLUNT trauma*** criteria, once the patient has been loaded into the ambulance, resuscitation should continue until arrival at the receiving facility.
a. Stopping resuscitation with the patient in the ambulance creates a complex legal situation that would involve the local law enforcement agency, the medical examiner, and any potential receiving facility.
b. Once resuscitation begins in an HCFR vehicle, it SHALL continue until the patient is delivered to an appropriate hospital.

5. When there is ANY doubt as to whether or not resuscitation should be initiated, START RESUCITATION.

6. PALLIATIVE CARE:
a. Defined as supportive care for a patient with a valid DNRO
i. A copy of the DNRO should be scanned into the ePCR
ii. Respiratory Distress
1. Supplemental O2
2. Suction as needed
3. Position of comfort
4. No Ventilation
iii. External bleeding
1. Standard hemorrhage control measures.
iv. Fractures
1. Standard treatment to include pain management.
v. Pain
1. See HCFR PAIN MANAGEMENT protocol
2. IM/IN route is preferred for medication administration.
3. If patient is refusing transport, contact Medic 1 for authorization prior to the administration of a controlled substance.
vi. Reversible conditions (i.e. hypoglycemia, dehydration, pain control etc.)
1. Establish an IV line for supportive care.