Determination of Death/Withholding Resuscitative Efforts

Aliases

None noted

Patient Care Goals

All clinically dead patients will receive all available resuscitative efforts including cardiopulmonary resuscitation (CPR) unless contraindicated by one of the exceptions defined below.

Patient Presentation

A clinically dead patient is defined as any unresponsive patient found without respirations and without a palpable carotid pulse.

Inclusion/Exclusion Criteria:

1. Resuscitation should be started on all patients who are found apneic and pulseless unless the following conditions exist
    a. Medical cause or traumatic injury or body condition clearly indicating biological death (irreversible brain death), limited to:
        i. Decapitation: the complete severing of the head from the remainder of the patient's body
        ii. 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.
        iii. Evidence of dependent lividity or rigor mortis in setting of last seen time consistent with such finding and absence of other explainations for such findings
        iv. 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.
        v. Incineration: 90% of body surface area with full thickness burns as exhibited by ash rather than clothing and complete absence of body hair with charred skin.
        vi. Injuries incompatible with life (such as massive crush injury, complete exsanguination, severe displacement of brain matter).
        vii. Futile and inhuman attempts to "compelling reasons" for withholding resuscitation.
        viii. In blunt and penetrating trauma, if the patient is apneic, pulseless, and without other signs of life upon EMS arrival including, but not limited to. spontaneous movement, ECG activity, or pupillary response
        ix. Nontraumatic arrest with obvious signs of death including dependent lividity or rigor mortis.

OR

a. A valid DNR order (form, card, bracelet) present, when it:
    i. Conforms to the state specifications for color and construction.
    ii. Is intact: it has not been cut, broken or shows signs of being repaired.
    iii. Displays the patient's name and the physician's name.

Patient Management

Assessment

Assess for dependent lividity with rigor mortis and/or other inclusion criteria.

Treatment and Interventions

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

    a. If the patient has other actionable medical order (e.g. POLST/MOLST form), CONTACT Medical Control for guidance on resuscitative efforts.
2. If CPR has been initiated but all the components above have been subsequently confirmed, CPR may be discontinued and on-line medical control contacted as needed.
3. If any of the findings are different than those described above, clinical death is not confirmed and resuscitative measures should be immediately initiated or continued. The Termination of Resuscitative Efforts guideline should then be implemented.
4. Do Not Resuscitate order (DNR/MOLST/POLST) with signs of life:
    a. If there is a DNR bracelet or DNR transfer form and there are signs of life (pulse and respirations), provide standard appropriate treatment under existing protocols matching the patient's condition
    b. To request permission to withhold treatment under these conditions for any reason, obtain on-line medical control.
    c. If there is documentation of a Do Not Intubate (DNI/MOLST/POLST) advanced directive, the patient should receive full treatment per protocols with the exception of any intervention specifically prohibited in the patient's advanced directive.
    d. If for any reason an intervention that is prohibited by an advanced directive is being considered, on-line medical control should be obtained.

Patient Safety Considerations

In cases where the patient's status is unclear and the appropriateness of withholding resuscitation efforts is questioned, EMS personnel should initiate CPR immediately and then contact on-line medical control.

Notes and Educational Pearls Key Considerations

- For scene safety and/or family wishes, provider may decide to implement CPR even if all the criteria for death are met.
- At a likely crime scene, disturb as little potential evidence as possible.

Pertinent Assessment Findings

- No recommendations

Quality improvement

Associated NEMSIS Protocol(s) (eProtocol.01)

- 9914201—Cardiac Arrest-Determination of Death/Withholding Resuscitative Efforts
- 9914169—Cardiac Arrest-Do Not Resuscitate

Key Documentation Elements

- Clinical/situational details that may be available from bystanders/caregivers
- Documentation of details surrounding decision to determine death
    - Time of contact with on-line medical control
    - Time of death determination
- Names and contact information for significant bystanders

Performance Measures

None recommended

References

1. *'Do Not Attempt Resuscitation' in the Out-of-Hospital Setting*. American College of Emergency Physicians; October 2003. ACEP Policy Statement.
2. Millin MG, Galvagno SM, Khandker SR, Malki A, Bulger EM. Withholding and termination of resuscitation of adult cardiopulmonary arrest secondary to trauma: resource document to the joint NAEMSP-ACSCOT position statements. *J Trauma Acute Care Surg*. 2013;75(3):459- 67.

3. National Guidelines for Statewide Implementation of EMS "Do Not Resuscitate" (DNR) Programs National Association of Emergency Medical Services Directors and the National Association of Emergency Medical Services Physicians. *Prehosp Disaster Med.* 1994;9(2):197- 9.
4. National Association of EMS Physicians, American College of Surgeons Committee on Trauma. Termination of resuscitation for adult traumatic cardiopulmonary arrest. *Prehosp Emerg Care*. 2012;16(4):571.
5. National Association of EMS Physicians, et al. Withholding of resuscitation for adult traumatic cardiopulmonary arrest. *Prehosp Emerg Care*. 2013;17(2):291.