

CONNECTICUT STATE BLS GUIDELINES
GUIDELINES FOR WITHHOLDING RESUCITATION
ADULT - AGE 18 AND OVER

Purpose:

To provide specific instruction regarding the protocols used to withhold or withdraw resuscitation in the field.

Introduction:

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 for initiating CPR.

All clinically dead patients will receive all available resuscitative measure 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, and who 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 Control procedures will be followed.

Procedure:

The following conditions are the ONLY exceptions to initiating and maintaining resuscitative measures in the field on a clinically dead patient:

- 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, or there is the odor of decaying flesh. 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: ninety percent of body surface area 3° burn as exhibited by ash rather than clothing and complete absence of body hair with charred skin.
 - e. Dependent lividity with rigor: when clothing is removed, there is a clear demarcation of pooled blood within the body, and major joints are immovable. * **NOTE: SECTION (e) DOES NOT APPLY TO VICTIMS OF LIGHTNING STRIKES, DROWNING OR HYPOTHERMIA.**

*Requires additional confirmation as found under **“General Procedures,” II, a-c**
- II. Pronouncement of death at the scene by a licensed Connecticut physician or authorized registered nurse by:

Physician or authorized registered nurse **at the scene in person.**

- III. A valid DNR bracelet is present, when it:
 - a. Conforms to the state specifications for color and construction.
 - b. Is intact: it has not been cut or broken.
 - c. Is on the wrist OR ANKLE
 - d. Displays the patient's name and their physician's name.

- IV. At a mass casualty incident, if clinical death is determined prior to patient's arrival in the treatment area.

General Procedures:

- I. In cases of decapitation, decomposition, transection of the torso, or incineration, the condition of clinical death must be determined by noting the nature and extent of the condition of the body as defined above. No CPR need be performed and Medical Control need not be notified.

- II. In cases of dependent lividity **with** rigor mortis, 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 if AED is available.

If all the components of Section II are confirmed, no CPR is required.

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

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

- III. When a valid DNR bracelet is present, the Connecticut College of Emergency Physicians (CCEP) guidelines will be followed. Once a patient has been found not be breathing, examination for a valid DNR bracelet will take place. If there is a valid bracelet, no mouth-to-mouth or other means of artificial respiration will be administered, and no external cardiac compressions will be initiated. If previously initiated, resuscitative measure will be DISCONTINUED.
- IV. A complete documentation of the initial examination, findings and resulting procedures (if any) will be entered on the EMS patient care record.
- V. If EMS personnel are delayed or precluded from making an appropriate physical examination by law or fire officials protecting the integrity of the scene, they shall so note on their patient care form. If subsequent access to the patient is allowed, then EMS personnel shall proceed according to this protocol. EMS personnel are required to provide documentation of the patient's physical condition only to the extent of the physical examination they performed.
- VI. **Special Consideration:** For scene safety and/or family wishes, provider may decide to implement CPR even if all the criteria for death are met.

Special Procedures:

- I. A private physician at the scene who has an on-going relationship with the patient must produce identification showing the physician's name and the Connecticut license number (MD or DO). That physician may pronounce death on a clinically dead patient even if EMS personnel are present. The physician's pronouncement relieves the emergency personnel of the responsibility to begin or continue resuscitative measures. If the patient is not pronounced and the physician wishes to assume care of the patient, the physician must agree to assume responsibility for the patient's care and accompany the patient to the hospital in the ambulance if the patient is to be transferred to the hospital. The Medical Control hospital will be notified and the information will be documented on the EMS patient care form.

- II. A registered nurse from a home health care or hospice agency at the scene, who has an ongoing relationship with the patient, and who is operating under orders from the patient's private physician and is authorized by law to pronounce death, may pronounce a clinically dead patient dead even if EMS personnel are present. The nurse's pronouncement relieves the emergency personnel of the responsibility to begin or continue resuscitative measures. The Medical Control hospital will be notified and the information will be documented on the EMS patient care form.

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. If the body is in a secure environment (where it is 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 attending physician or coverage should 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. **In all such cases, the police must be notified.**
 - b. 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.
 - c. If the body is not in a secure environment notify the police. The police may contact the Office of the Chief Medical Examiner (860-679-3980 or 1-800-842-8820 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.

- III. 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 (CG19a-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.

Documentation:

- I. A patient care record will be completed for each clinically dead patient who has resuscitation performed and for whom resuscitation was discontinued or was withheld. All Medical Control orders will be noted on the patient care record.
- II. In cases of decapitation, decomposition, transection of the torso, or incineration, when resuscitation was discontinued or not initiated, detailed findings consistent with these conditions will be entered on the patient care record.
- III. In cases of dependent lividity with rigor, when resuscitation was discontinued or not initiated, the following detail will be documented on the patient care record:
 - a. Breathing absent when airway was repositioned and assessed for at least 30 seconds.
 - b. Carotid pulse was absent upon palpation for at least 30 seconds.
 - c. The pupils of both eyes are non-reactive.
 - d. The time an AED, if available, indicated the absence of a shockable rhythm. Attach a copy of the print out if available.
 - e. A description of the dependent lividity and rigor mortis.
 - f. The name and telephone number of the private MD contacted.

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DO NOT RESUSCITATE (DNR)

If there is a DNR bracelet or DNR transfer Form and there are signs of life:

Contact Medical Direction before introducing any invasive procedures or therapies.

If there are no signs of life: DO NOT start CPR

DNR Bracelet

A DNR bracelet shall be the only valid indication recognized by EMS providers that a DNR order exists for patients outside a healthcare institution, other than those patients received by EMS provider directly from a healthcare institution.

A valid DNR bracelet shall:

- a. Conforms to the state specifications for color and construction.
- b. Is intact: it has not been cut or broken.
- c. Is on the wrist OR ANKLE
- d. Displays the patient's name and their physician's name.

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

- a. The patient or “authorized representative” may verbally tell a certified EMT they wish to alter their DNR status.
- b. This statement must be entered on the pre-hospital care report.
- c. Any witnesses present should support this statement (if at all possible, document the names of these witnesses).