WHEN NOT TO START

Resuscitation efforts should be withheld under the following circumstances:

- **VALID DO NOT RESUSCITATE ORDER:** Refer to DNR, POLST & Advanced Directives Protocol 8.8.
- **SCENE SAFETY**: The physical environment is not safe for providers.
- **DEAD ON ARRIVAL (DOA)**: A person is presumed dead on arrival when all five "Signs of Death" are present **AND** at least one associated "Factor of Death" is present.

Signs of Death (All five signs of death must be present)

- Unresponsiveness.
- Apnea.
- Absence of palpable pulses at carotid, radial, and femoral sites.
- Unresponsive pupils.
- Absence of heart sounds.

Factors of Death (At least one associated factor of death must be present)

- Damage or destruction of the body incompatible with life, such as:
  - ✓ Decapitation.
  - ✓ Decomposition.
  - ✓ Deforming brain injury.
  - ✓ Incineration or extensive full thickness burns.
- Lividity/Rigor mortis of any degree.
- Major blunt or penetrating trauma.

Patients with ventricular assist devices (VAD) should almost never be pronounced dead at the scene, see LVAD Policy 8.9.

SUDDEN UNEXPLAINED INFANT DEATH SYNDROME (SUIDS).

- An infant <**12** months who is apneic, asystolic (no heartbeat or umbilical cord pulse), and exhibiting lividity and/or rigor mortis should be presumed dead.
- For unexpected, unexplained infant death, record carbon monoxide level in room where infant was found unresponsive, if possible.

NEONATE:

- A neonate who is apneic, asystolic, and exhibits either neonatal **maceration** (softening or degeneration of the tissues after death in utero) or **anencephaly** (absence of a major portion of the brain, skull, and scalp) may be presumed dead.

- Contact **Medical Control** hospital if gestational age is less than 20 weeks and neonate shows signs of obvious **immaturity** (translucent and gelatinous skin, lack of fingernails, fused eyelids).

NOTE: Infant and/or neonatal resuscitation and transport may be initiated in cases where the family does not accept the idea of nonintervention.

Policy Continues

Policy Continued

WHEN TO STOP

Termination of resuscitation **MAY BE** considered if return of spontaneous circulation does not return before transport is initiated.

Resuscitation may be stopped under the following circumstances:

- The physical environment becomes unsafe for providers.
- The exhaustion of EMS providers.
- The automatic external defibrillator has advised "no shock" on 5 sequential analyses and ALS/hospital care is not available within 15 minutes (hypothermia is an exception).
- There is no return of spontaneous circulation after 15 minutes of either BLS alone or combined BLS and ALS in the absence of hypothermia, unless the patient exhibits recurrent ventricular fibrillation or ventricular tachycardia and has quantitative waveform capnography (if available) >20 mmHg.
- Extrication is prolonged (>15 minutes) with no resuscitation possible during extrication (hypothermia is an exception).
- If directed to do so by Medical Control.
- There is no return of spontaneous circulation after 30 minutes of either BLS alone or combined BLS and ALS in the hypothermic patient and extrication is going to be prolonged.
- If resuscitation is terminated during transport, continue to the receiving hospital without lights and sirens and notify receiving facility.

- Prolonging resuscitation efforts, beyond 15 minutes, without a return of spontaneous circulation is usually futile, unless cardiac arrest is compounded by hypothermia or immersion in cold water.
- EMS providers are not required to transport every victim of cardiac arrest to a hospital. Unless special circumstances are present, it is expected that most resuscitations will be performed on-scene until the return of spontaneous circulation or a decision to cease resuscitation efforts is made based on the criteria listed under "when to stop" (above). Transportation with continuing CPR may be justified if hypothermia is present or suspected. Current AHA guidelines state: "cessation of efforts in the out-of-hospital setting…should be standard practice."

Policy Continues

Policy Continued

DETERMINING DEATH IN THE FIELD

When efforts to resuscitate are not initiated or are terminated under the above provisions, EMS providers shall:

- Document time of death.
- Notify law enforcement.
- Consider possibility of a crime scene and restrict access.
- Any decision to move the body must be made in collaboration with law enforcement and the medical examiner.
- Leave any resuscitation adjuncts such as advanced airway devices, IV/IO access devices, electrode pads, etc., in place.
- Inform family on scene of patient's death and offer to contact family, friends, clergy, or other support systems.

The above requirements apply to situations in which law enforcement or the medical examiner may take jurisdiction. Law enforcement and the medical examiner are not required to take jurisdiction of hospice or other patients who are known to have been terminally ill from natural causes or congenital anomaly, and death was imminent and expected. Where law enforcement is not involved, EMS providers may provide appropriate assistance to families or other caregivers.

Mass Casualty Incident (MCI): See MCI Protocol 9.1.

Documentation

- Complete a Patient Care Record (PCR) in all cases. If available, include ECG rhythm strips with the patient care report.
- Document special orders including DNR, on-line Medical Control, etc.
- MCI conditions may require a triage tag in addition to an abbreviated PCR.
- Record any special circumstances or events that might impact patient care or forensic issues.