	Fire Chiefs' Association of Broward County Standard Operating Guidelines		
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Subject: Death in the Field			
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I. Overview:

This procedure is divided into separate sections that cover the different situations involving death in the field that the paramedic will encounter. All patients found in cardiac arrest will receive cardiopulmonary resuscitation unless an exception is met as outlined in the following sections:

A. Advanced Directives/Do Not Resuscitate Orders (DNRO).
B. Determination of Death.
C. Discontinuance of CPR.
D. Documentation

A. **Advanced Directive/Do Not Resuscitate Orders (DNRO)**

1 Legislative authority. Under Florida Administrative Code (FAC) 64J-2.018. Do Not Resuscitate Order (DNRO) Form and Patient Identification Device. The Florida DNRO form is the only form approved in the State of Florida. If there is a DNRO/POLST/MOST/MOLST form from another State presented by the patient or family, contact Medical Control as soon as possible for direction.

2 An EMT or paramedic shall withhold or withdraw cardiopulmonary resuscitation:

3 Upon the presentation of an original or a completed copy of DH Form 1896, Florida Do Not Resuscitate Order Form, December 2004, which is incorporated by reference and available from DOH at no cost, or, any previous edition of DH Form 1896; or 1.IV.2.1.2 Upon the presentation or observation, on the patient, of a Do Not Resuscitate Order patient identification device.

B. The Do Not Resuscitate Order:

1 Form shall be printed on yellow paper and have the words "DO NOT RESUSCITATE ORDER" printed in black and displayed across the top of the form. DH Form 1896 may be duplicated, provided that the content of the form is unaltered, the reproduction is of good quality, and it is duplicated on yellow paper. The shade of yellow does not have to be an exact duplicate;

2 Patient identification device is a miniature version of DH Form 1896 and is incorporated by reference as part of the DNRO form. Use of the patient identification device is voluntary and is intended to provide a convenient and portable DNRO which travels with the patient.

3 The device is perforated so that it can be separated from the DNRO form. It can also be hole punched, attached to a chain in some fashion and visibly displayed on the patient. In order to protect this device from hazardous conditions, it shall be laminated after completing it. Failure to laminate the device shall not be grounds for not honoring a patient's DNRO order, if the device is otherwise properly completed.

4 The DNRO form and patient identification device must be signed by the patient's physician. In addition, the patient, or, if the patient is incapable of providing informed consent, the patient's health care surrogate or proxy as defined in Section 765.101, F.S., or court

appointed guardian or person acting pursuant to a durable power of attorney established pursuant to Section 709.08, F.S., must sign the form and the patient identification device in order for them to be valid. The form does not need to be notarized, once signed the form does not expire.

5. An EMT or paramedic shall verify the identity of the patient who is the subject of the DNRO form or patient identification device. Verification shall be obtained from the patient's driver license, other photo identification, or from a witness in the presence of the patient. If a witness is used to identify the patient, this fact shall be documented in the EMS Run Report, which must include the following information:
   a. The full name of the witness.
   b. The address and telephone number of the witness.
   c. The relationship of the witness to the patient
6. During each transport, the EMS provider shall ensure that a copy of the DNRO form or the patient identification device accompanies the live patient. The EMS provider shall provide comforting, pain-relieving and any other medically indicated care, short of respiratory or cardiac resuscitation.
7. A DNRO may be revoked at any time by the patient, if signed by the patient, or the patient's health care surrogate, or proxy or court appointed guardian or person acting pursuant to a durable power of attorney established pursuant to Section 709.08, F.S. Pursuant to Section 765.104, F.S., the revocation may be in writing, by physical destruction, by failure to present it, or by orally expressing a contrary intent.
8. Oral orders from nonphysician staff members or telephoned requests from an absent physician do not adequately assure EMT/paramedics that the proper decision-making process has been followed and are NOT acceptable.
9. In the near future Florida will be adopting POLST (Physician Orders for Life Sustaining Treatment Paradigm) The National POLST Paradigm is an approach to end-of-life planning that emphasizes patients' wishes about the care they receive. The POLST Paradigm is an approach to end-of-life planning emphasizing: (i) advance care planning conversations between patients, health care professionals and loved ones; (ii) shared decision-making between a patient and his/her health care professional about the care the patient would like to receive at the end of his/her life; and (iii) ensuring patient wishes are honored. As a result of these conversations, patient wishes may be documented in a POLST form, which translates the shared decisions into actionable medical orders.

The POLST form assures patients that health care professionals will provide only the care that patients themselves wish to receive, and decreases the frequency of medical errors. POLST is not for everyone. Only patients with serious illness or frailty should have a POLST form. For these patients, their current health status indicates the need for standing medical orders. For healthy patients, an Advance Directive is an appropriate tool for making future end-of-life care wishes known to loved ones.

Several States use the POLST program and there several other forms used by these States, Medical Orders for Life Sustaining Treatment (MOLST), Medical Orders for Scope of Treatment (MOST) and the Physician Orders for Scope of Treatment (POST) form.

Specific Authority 381.0011, 401.45(3) FS. Law Implemented 381.0205, 401.45, 765.401 FS. History–New 11-30-93, Amended 3-19-95, 1-26-97, Formerly 10D-66.325, Amended 2-20-00, 11-3-02, 6-9-05, Formerly 64E-2.031.5.

C. **DETERMINATION OF DEATH**

The EMT or paramedic may determine that the patient is dead/non-salvageable and decide not to resuscitate the patient under the following guidelines.

1. The patient may be determined to be dead/non-salvageable and will not be resuscitated or transported if all four (4) presumptive signs of death and at least one (1) conclusive sign of death are identified. The four presumptive signs of death that MUST be present are:
   a. Unresponsiveness.
   b. Apnea.
   c. Pulseless.
   d. Fixed dilated pupils.

2. In addition to the four presumptive signs of deaths, at least one (1) of the following conclusive signs of death MUST be present:
   a. Injuries incompatible with life (e.g., decapitation, massive crush injury, incineration).
   b. Tissue decomposition.
   c. Rigor mortis of any degree with warm air temperature. (Hardening of the muscles of the body, making the joints rigid).
   d. Liver mortis (lividity) of any degree, (venous pooling of blood in dependent body parts causing purple discoloration of the skin, which does blanch with pressure).
3. Patients with suspected hypothermia, barbiturate overdose, or electrocution require full ALS resuscitation unless they have injuries incompatible with life or tissue decomposition.
4. EMS personnel may contact medical direction for a "determination of death" whenever support in the field is desired. Clearly state the purpose for the contact as part of the initial hailing.
5. Children are excluded from this protocol unless EMS personnel make contact with medical direction for consultation. Only in cases of obvious, prolonged death should CPR not be started or discontinued on infants, children, or young adults, or in cases in which an unexpected death has occurred.
6. A trauma victim who does not meet the "Determination of Death" criteria listed above may be determined to be dead/non-salvageable based on the following criteria:
   a. Pulselessness and apnea associated with asystole (confirmed in two leads) and a. Blunt trauma arrest.
   b. Prolonged extrication time (more than 15 minutes) where no resuscitative measures can be initiated prior to extrication.
   c. Arrest from primary brain injury or with no brain stem reflexes; arrest from blunt multiple injuries.
7. If there is any concern regarding leaving the patient at the scene, begin resuscitation and transport.
8. Consideration should be given for the possibility of organ harvest; however, this should not be the sole reason for resuscitation.
9. Absence of pulse or spontaneous respiration in a multiple-casualty situation where EMS resources are required for stabilization of living patients.
10. The local law enforcement agency that has jurisdiction will be responsible for the body once death has been determined. The body is to be left at the scene until a disposition has been made by the Medical Examiner's Office or the local jurisdiction.

D. DISCONTINUANCE OF CPR

1. Resuscitation that is started in the field by EMS personnel cannot be discontinued without an order from online EMS Medical Director or online medical control.
2. EMS personnel are not obligated to continue resuscitation efforts that were started inappropriately by others at the scene.
3. When there is a delay in presenting a DNRO to EMS personnel, resuscitation must be started. However, once the DNRO is presented to EMS personnel, the EMT or paramedic with an order from medical direction may terminate resuscitation.
4. A paramedic with an order from medical direction may terminate resuscitation provided the following criteria are met:
    a. Appropriate BLS and ALS have been attempted without restoration of circulation and breathing.
    b. Advanced airway (supraglottic or ET) has been successfully accomplished.
    c. Intravenous (IV, IO, ETT) medication and countershocks for ventricular fibrillation have been administered according to the appropriate treatment protocol(s) (Adult Protocols or Pediatric Protocols).
    d. Persistent asystole or agonal ECG patterns are present and no reversible causes are identified.
    e. Patients with suspected hypothermia, barbiturate overdose, or electrocution require full ALS resuscitation, unless they have injuries incompatible with life or tissue decomposition.
5. Provide appropriate grief counseling or support to the patient's immediate family, bystanders, or others at the scene.
    a. Provide family members with appropriate referral information, if available.
6. Patient preparation.
    a. Once it has been determined that the patient has died and resuscitation will not continue, cover the body with a sheet or other suitable item. Do not remove any property from the body or the scene for any purpose.
    b. If the death is a suspected homicide (crime scene), do not cover the body (SOG 301).
    c. Immediately notify the appropriate law enforcement agency (if not done already), and remain on scene until their arrival.
    d. Advanced airway placement may be verified by two paramedics for patients who are determined to be dead in the field or for whom resuscitation measures have ceased. Improperly placed advanced airway tubes should be left in place and reported to the appropriate personnel. (Proper advanced airway tube placement must be confirmed prior to terminating resuscitation.).
    e. Consult the patient's family for "organ donor" information, if appropriate.

E. DOCUMENTATION

1. All death in the field patient reports need to have proper documentation on the EMS run report.
2. ECG rhythm documentation must be attached to the EMS Run Report.
3. The advanced airway should be left in place and its confirmation should be recorded on the EMS Run Report.