



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Virginia Hastings, Executive Director
Reza Vaezazizi, M.D., Medical Director

DATE: February 5, 2009

TO: EMS Providers – ALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers, PLNs
EMS Training Institutions, EMS CE Providers
Inyo, Mono and San Bernardino County EMCC Members
Other Interested Parties

FROM: Reza Vaezazizi, M.D. *Reza Vaezazizi, MD*
ICEMA Medical Director

Virginia Hastings *Virginia Hastings*
ICEMA Executive Director

SUBJECT: EMERGENCY PROTOCOL IMPLEMENTATION

The following emergency protocol has been revised and approved by ICEMA. **This protocol is effective on February 5, 2009.** A copy is contained with this mailing and also available online at <http://www.sbcounty.gov/icema/> or www.icema.net.

EMERGENCY PROTOCOL EFFECTIVE FEBRUARY 5, 2009

REFERENCE #14008 WITHHOLDING RESUSCITATIVE MEASURES

This protocol establishes the criteria for withholding resuscitative measures for patients not meeting the Determination of Death protocol (Reference #14007) in the prehospital setting. On January 1, 2009, the Emergency Medical Services Authority (EMSA) approved and put into effect the Physician's Order for Life Sustaining Treatment (POLST) form as required by AB 3000. This emergency protocol will provide immediate guidance for this new POLST form, which is already in the EMS system. The EMSA will be amending the DNR guidelines to include POLST and if any other changes occur to the form, ICEMA will update the protocol to match the changes at that time.

In addition to the POLST form, the current EMSA/Prehospital CMA form and the Medic Alert medallion and bracelets are still accepted as valid DNR forms.

This emergency protocol will remain in effect for one hundred and twenty (120) days, following which the protocol will be formally adopted after public comment is reviewed.

If you have questions regarding the implementation of this emergency protocol, please do not hesitate to contact Sherri Shimshy, RN at (909) 388-5816 or SShimshy@cao.sbcounty.gov.

RV:VH:SS:mae

WITHHOLDING RESUSCITATIVE MEASURES EMERGENCY PROTOCOL

PURPOSE

To establish criteria for withholding resuscitative measures from person(s) who do not otherwise meet the "Determination of Death" criteria in the pre-hospital setting and/or during inter-facility transport

AUTHORITY

Division 2.5, Sections 1797.220 and 1798 of the California Health and Safety Code

POLICY

The DNR only applies to cardiopulmonary resuscitative measures. An order not to resuscitate is not an order to withhold other necessary medical treatment or nutrition. The treatment given to a patient with a DNR agreement should in all respects be the same as that provided to a patient without such an agreement.

DEFINITIONS

Do Not Resuscitate (DNR): A written order by a physician or the presence of a DNR medallion/bracelet or necklace indicating that an agreement has been reached between the physician and patient/or surrogate that in the event of cardiac or respiratory arrest the following medical interventions will **NOT** be initiated:

- Chest compressions,
- Defibrillation,
- Endotracheal intubation,
- Assisted ventilation or
- Cardiotonic drugs, e.g., epinephrine, atropine,
- Or other medications intended to treat a non-perfusing rhythm

Absent vital signs: Absence of respiration and absence of carotid pulse

DNR medallion/bracelet/necklace: A medallion/bracelet/necklace worn by a patient, which has been approved for distribution by the California Emergency Medical Services Authority (EMSA).

Pre-hospital DNR form: Form developed by the California Medical Association (CMA) for use statewide for pre-hospital DNR requests. This form has been approved by EMSA, and ICEMA. This form should be available to pre-hospital personnel in the form of the white original DNR form or as a photocopy. The original or copy of the DNR form will be taken with the patient during transport. **The DNR form shall not be accepted if amended or altered in any way.**

Pre-hospital Personnel: Any EMS field responder currently certified and/or accredited in San Bernardino, Inyo or Mono Counties

Physician Orders for Life-Sustaining Treatment (POLST): A physician's order that outlines a plan of care reflecting the patient's wishes concerning care at life's end. The POLST form is voluntary and is intended to assist the patient and their family with planning and developing a plan to reflect the patient's end of life wishes. It is also intended to assist physicians, nurses, health care facilities and emergency personnel in honoring a person's wishes for life-sustaining treatment.

VALIDATION CRITERIA

1. **Statewide Pre-hospital DNR Form** (Appendix A) should include the following to be considered valid.
 - a. Patient's name
 - b. Signature of the patient or a legal representative if the patient is unable to make or communicate informed health care decisions
 - c. Signature of patients' physician, affirming that the patient/legal representative has given informed consent to the DNR instruction
 - d. All signatures are to be dated.
 - e. Correct identification of the patient is crucial. If the patient is unable to be identified after a good faith attempt to identify the patient, a reliable witness may be used to identify the patient.
2. **DNR medallion/bracelet/necklace:** The DNR medallion/bracelet/necklace is made of metal with a permanently imprinted medical insignia. For the medallion or bracelet/necklace to be valid the following applies:
 - a. Patient must be physically wearing the DNR medallion/bracelet/necklace
 - b. Medallion/bracelet/necklace must be engraved with the words "Do Not Resuscitate EMS", along with a toll free emergency information telephone number and a patient identification number
3. **Physician DNR orders:** In licensed health care facilities a DNR order written by a physician shall be honored. The staff must have the patient's chart with the DNR order immediately available for EMS personnel upon their arrival.
4. **POLST:** The POLST form must be signed and dated by a physician. Without this signature, the form is invalid. Verbal or telephone orders are valid if allowed by the institution or facility. There should be a box checked indicating who the physician discussed the POLST orders with. By signing the form, the physician acknowledges that these orders reflect the wishes of the patient or designated decision maker.

PROCEDURE

1. EMS personnel shall validate the DNR request or POLST form.
2. BLS personnel shall continue resuscitative measures if a DNR or POLST cannot be validated.
3. ALS personnel shall contact a Base Hospital for direction if a DNR or POLST cannot be validated. While ALS personnel are contacting the Base Hospital for direction, BLS treatment must be initiated. If contact cannot be made, resuscitative efforts shall continue.
4. If a patient states he/she wishes resuscitative measures, the request shall be honored.
5. If a family member requests resuscitative measures despite a valid DNR or POLST, continue resuscitative measures until Base Hospital contact is made.
6. If patient is not in cardiac arrest and has a valid POLST form, EMS may provide comfort measures as described in section B of the form.
7. The patient shall be transported to the hospital if comfort measures are started by EMS.
8. Any questions about transporting the patient will be directed to the base station.
- ~~6.9.~~ If a patient expires at home law enforcement must be notified.
- ~~7.10.~~ If a patient expires in a licensed health care facility, the facility has the responsibility to make the appropriate notification.
- ~~8.11.~~ All circumstances surrounding the incident shall be documented on the patient care record. If pre-hospital personnel are unable to copy the DNR or POLST form the following shall be documented on the patient care record:
 - a. Presence of DNR or POLST form
 - b. Date of order
 - c. Name of physician who signed form

12. A ~~DNR report form with a~~ copy of the patient care report **and DNR or POLST attached** must be forwarded to ICEMA within one week by either the PLN at the receiving facility if it is a Base Hospital or by the EMT-P's Agency EMS/QI Coordinator.

SUPPORTIVE MEASURES

1. Medical interventions that may provide for the comfort, safety and dignity of the patient should be utilized.
2. The patient should receive palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.
3. Allow any family members/significant others to express their concerns and begin their grieving process.

APPROVED:

February 5, 2009

SIGNATURE ON FILE

ICEMA Medical Director

Date

SIGNATURE ON FILE

ICEMA Executive Director

Date



EMSA #111 B
(Effective 1/1/2009)

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A Check One	CARDIOPULMONARY RESUSCITATION (CPR): <i>Person has no pulse and is not breathing.</i> <input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (<u>A</u> llow <u>N</u> atural <u>D</u> eath) (Section B: Full Treatment required)
	When not in cardiopulmonary arrest, follow orders in B and C .

B Check One	MEDICAL INTERVENTIONS: <i>Person has pulse and/or is breathing.</i> <input type="checkbox"/> Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. Transfer if comfort needs cannot be met in current location. <input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> Do Not Transfer to hospital for medical interventions. Transfer if comfort needs cannot be met in current location. <input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care. Additional Orders: _____ _____
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C Check One	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible and desired.</i> <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. <input type="checkbox"/> Long-term artificial nutrition by tube. Additional Orders: _____
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D	SIGNATURES AND SUMMARY OF MEDICAL CONDITION: Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Health Care Decisionmaker <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Court Appointed Conservator <input type="checkbox"/> Other:	
	Signature of Physician My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.	
	Print Physician Name	Physician Phone Number Date
	Physician Signature (required)	Physician License #
	Signature of Patient, Decisionmaker, Parent of Minor or Conservator By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.	
	Signature (required)	Name (print) Relationship (write self if patient)
	Summary of Medical Condition	Office Use Only

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle)		Date of Birth	Gender: M F
Patient Address			
Contact Information			
Health Care Decisionmaker	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional**Completing POLST**

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen “Do Not Attempt Resuscitation.”

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with “Comfort Measures Only,” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only.”
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment.”

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void POLST, draw a line through Sections A through D and write “VOID” in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests.

California Coalition for Compassionate Care

The Coalition is the lead agency for implementation of POLST in California. This form is approved by the Emergency Medical Services Authority in cooperation with the California Coalition for Compassionate Care and the statewide POLST Task Force.

For more information or a copy of the form, visit www.finalchoices.org.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED



EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



Purpose

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel to forgo resuscitation attempts in the event of a patient's cardiopulmonary arrest. Resuscitative measures to be withheld include chest compression, assisted ventilation, endotracheal intubation, defibrillation, and cardiotoxic drugs. The form does **not** affect the provision of other emergency medical care, including palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

Applicability

This form was designed for use in **prehospital settings** – i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion) from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

Instructions

The Prehospital Do Not Resuscitate (DNR) Form must be signed by the patient or by an appropriate surrogate decisionmaker if the patient is unable to make or communicate informed health care decisions. The surrogate should be the patient's legal representative (e.g., a health care agent, a court-appointed conservator, a spouse or other family member) if one exists. The patient's physician must also sign the form, affirming that the patient/surrogate has given informed consent to the DNR instruction.

The **first copy** of the form should be retained by the patient. *The completed form (or the approved wrist or neck medallion – see below) must be readily available to EMS personnel in order for the DNR instruction to be honored.* Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The **second copy** of the form should be retained by the physician and made part of the patient's permanent medical record.

The third copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (1-888-755-1448, 2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of a patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

Revocation

If a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) form should be directed to the local EMS agency.



EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



An Advance Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand that I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate Signature

Date

Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotoxic medications are to be initiated.

Physician Signature

Date

Print Name

Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 1 – To be kept by patient



EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



An Advance Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand that I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate Signature

Date

Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotoxic medications are to be initiated.

Physician Signature

Date

Print Name

Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 2 – To be kept in patient's permanent medical record



EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



An Advance Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand that I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate Signature

Date

Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotoxic medications are to be initiated.

Physician Signature

Date

Print Name

Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 3 – If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock CA 95381



INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo, and Mono Counties
 515 N ARROWHEAD AVENUE
 SAN BERNARDINO, CA 92415-0060
 909-388-5823 FAX: 909-388-5825

DO NOT RESUSCITATE REPORT FORM

TODAY'S DATE: _____ DATE OF INCIDENT _____
 EMT-P NAME _____ LOCAL ACCRED #: _____
 EMPLOYER: _____ CONTACT TIME W/PATIENT: _____
 PATIENT NAME: _____ PATIENT AGE: _____
 ADDRESS: _____
 LOCATION AT TIME OF ARREST: _____

TYPE OF DNR REQUEST

_____ DNR MEDALLION/BRACELET/NECKLACE ID#: _____
 _____ PREHOSPITAL DNR FORM
 _____ WRITTEN DNR ORDER or ADVANCED DIRECTIVE ON THE PATIENT'S CHART
 (For Licensed Healthcare Facilities ONLY)

PATIENTS CONDITION UPON ARRIVAL: _____
 WITNESSES PRESENT: _____
 DISPOSITION OF PATIENT: _____

This DNR report form must be filed with the Base Hospital within 24 hours of the incident. The Base Hospital PLN shall review this report and forward a copy to the ICEMA QI Coordinator within 72 hours of the incident with any irregularities in policy noted, pursuant to Standard Practice Protocol, Reference #14008.

A COPY OF THE PATIENT CARE RECORD MUST BE ATTACHED

BASE HOSPITAL PLN COMMENTS: _____

