



Health Systems Quality Assurance
Office of Emergency Medical and Trauma Prevention

EMS - NO CPR



GUIDELINES

for Emergency Medical Services Personnel

Revised September, 1995

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Guidelines for EMS Personnel Regarding the EMS-No CPR Program

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Dear Health Care Provider:

The Washington State Department of Health has adopted standardized EMS-No CPR guidelines for use in the prehospital setting. These Guidelines were developed by the Office of Emergency Medical and Trauma Prevention and the EMS-No CPR Work Group. The *EMS-No CPR Guidelines for Emergency Medical Services Personnel* address the need for a statewide protocol to allow adult patients who suffer a cardiac or respiratory arrest the right to refuse unwanted resuscitation attempts from emergency medical providers.

In 1992, revisions to the Natural Death Act included the prehospital setting and required the Department of Health to establish protocols addressing how EMS personnel should handle Do Not Resuscitate orders when a patient experiences a cardiac arrest. During these situations EMS responders, family members and other caregivers have encountered confusion, frustration and even confrontation in the emotional moments surrounding the end of a loved one's life.

With the presence of either a properly executed EMS-No CPR directive or bracelet, prehospital personnel should not attempt resuscitation.

The benefits of this new program are many. The *EMS-No CPR Guidelines* recognize an individual's legal right to make personal health care decisions. Most importantly, EMS personnel will be more aware of the patient's end-of-life choices and can then provide appropriate comfort care. Furthermore, this program promotes participation by family members and/or legal surrogates in the process of understanding the patient's true wishes and desires.

We believe the *EMS-No CPR* program represents a positive, sensible and realistic approach toward recognizing a person's right to appropriate end-of-life medical care. Your suggestions for any improvements to this program are welcome.

Sincerely,

BRUCE A. MIYAHARA, SECRETARY
Department of Health

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How BEST to Tell the Worst News

I. Overview: Patients' Right to a Natural Death

-----Philosophy-----

Individuals have the right to experience a natural death supported by humane comfort measures. This program has been developed to let more people indicate their choice to die without resuscitation attempts by EMS personnel.

Emergency Medical Services providers are challenged to provide care to the dying and their families, while at the same time honoring the rights of individuals to experience a natural end to their life. Resuscitation attempts must be avoided where the patient has so indicated.

-----Legislation-----

The 1992 amendments to the Washington State Natural Death Act direct the Department of Health to:

"adopt guidelines and protocols for how emergency medical personnel shall respond when summoned to the site of an injury or illness for the treatment of a person who has signed a written directive or durable power of attorney requesting that he or she not receive futile emergency medical treatment." (RCW 43.70.)

This document explains the guidelines and protocols that were developed in response to this legislation, and explains how the protocols should be implemented by Washington State Emergency Medical Services providers.

-----Liability for the EMS Provider-----

The EMS provider protection from liability exists in RCW 18.71.210. This law provides protection for all acts and omissions done in good faith. In honoring the EMS-No CPR directive the EMS provider will be acting in accordance with MPD protocol and the physician's directive, and therefore acting in good faith. The MPD is also protected by this provision. In directing EMS personnel to honor the physician's directive, the MPD is relying on the physician's certification that the patient has given informed consent to the withholding of treatment.

II. Background: Who is Eligible

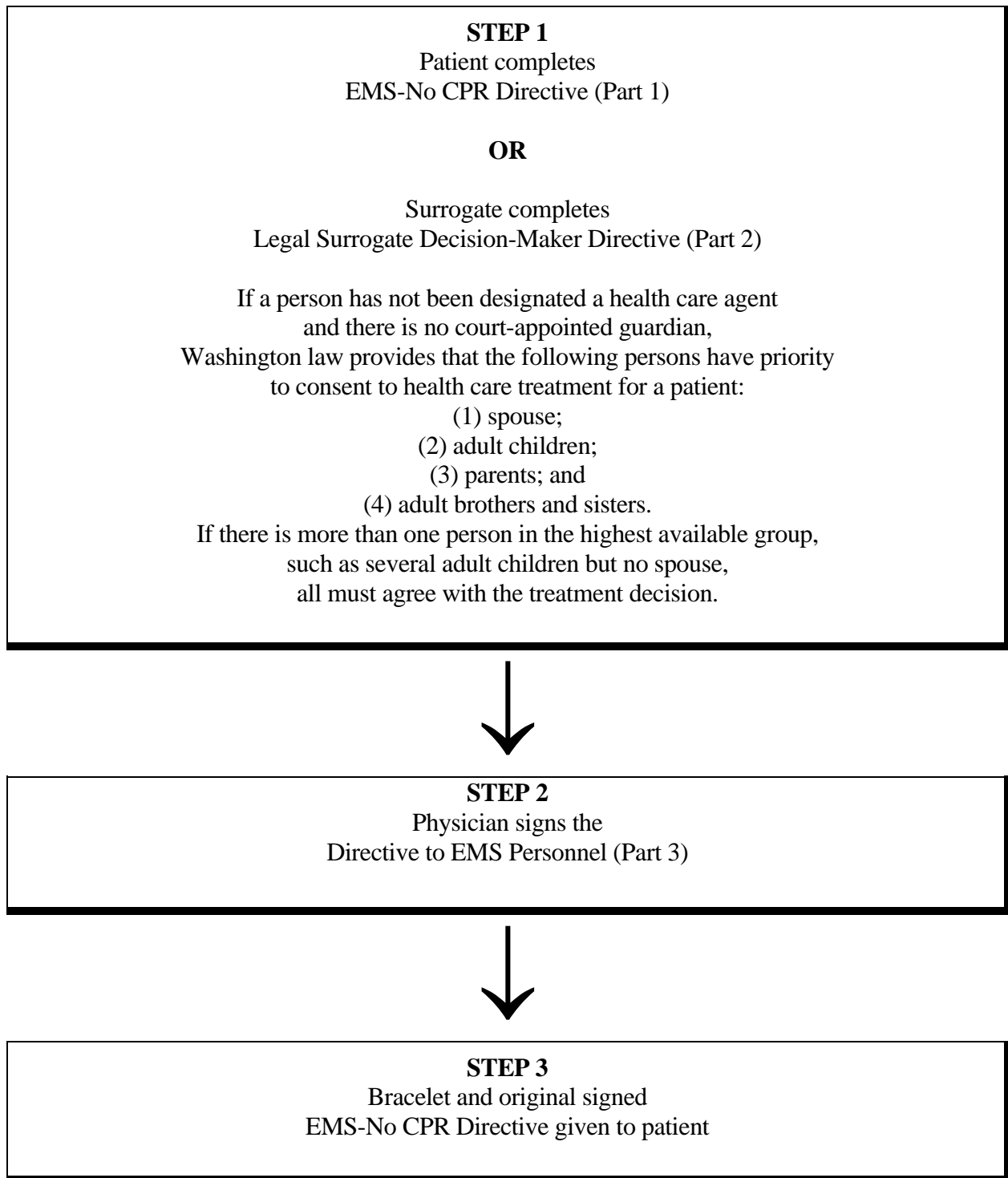
-----Why this Program was Developed-----

Prior to 1992, Washington law did not address specifically how emergency medical personnel should handle No CPR orders when patients experience a cardiac arrest. Emergency personnel, family members and other care givers have encountered confusion, frustration and even confrontation in the emotional moments around the end of a loved one's life. In contrast, in hospitals and nursing homes it is standard practice for health care providers to honor No CPR orders.

-----Who is Eligible-----

In the Washington EMS-No CPR Program, emergency medical personnel honor specially designed and printed "EMS-No CPR" directives and bracelets. This program applies to persons 18 years of age or older who have decided they do not want CPR performed in the event they suffer a cardiac or respiratory arrest. The directive must be signed by the individual's physician.

III. Steps to Using the EMS-No CPR Directive



IV. General Provisions

The Washington EMS-No CPR Program centers around a special EMS-No CPR Directive and bracelet. This approach originally was developed by the EMS Division of the State of Virginia and has had considerable success. The Washington program provides basic orientation for Physicians, EMS Medical Program Directors, EMS personnel, extended care and home care personnel, and patients and family members. The goal of this program is to honor the individual's wishes not to be resuscitated, but to have all appropriate care and support while they die a natural death. Emergency personnel are key individuals in helping to achieve these goals.

CPR includes any ventilation support (other than manually opening the airway), cardiac compressions, endotracheal intubation, advanced airway management, defibrillation, and intravenous resuscitation medications.

EMS personnel are directed to provide comfort care and alleviate pain with other medical interventions such as intravenous fluids, oxygen, or other therapies consistent with their protocols and scope of practice.

The original EMS-No CPR Directive should be maintained and displayed at the patient's home in one of the places specified on the directive, or it should accompany the person if he or she is traveling, especially if the person chooses not to wear the bracelet. Copies of the EMS-NO CPR Directive may be given to other providers for information, but only an original directive is honored by emergency medical personnel. The bracelet should be present on the patient's wrist, ankle, or attached to a necklace.

An EMS-No CPR Directive may be revoked at any time by the patient or by the designated agent or authorized decision maker for the patient, by physical destruction of the directive or by verbal expression of revocation. The EMS-No CPR bracelet should also be destroyed. Additionally, the patient's physician should be informed immediately.

EMS personnel can think of the bracelet as an extension of the original directive. This bracelet can be honored in lieu of a signed EMS-No CPR Directive. Bracelets may be used as a signal for the emergency medical personnel to look for the original EMS-No CPR Directive in one of the specified places in the patient's home: back of bedroom door, front of refrigerator, or bedside table. In the setting of a cardiac or respiratory arrest, either the bracelet OR the original signed directive is sufficient to permit the emergency personnel to withhold or withdraw cardiopulmonary resuscitation.

V. Definitions for the EMS-No CPR Program

Advance Directives: A communication from a patient to their physician. Advanced directives are instructions to a physician which identify an individual's future medical treatment decisions in the event that he or she is incapable of such decisions.

CPR: For the purposes of these protocols, "CPR" or "Cardiopulmonary Resuscitation" covers the full range of emergency cardiac interventions and is not limited to basic CPR. The "EMS-No CPR" order specifies no ventilation support (other than manually opening the airway), no cardiac compressions, no endotracheal intubation, no advanced airway management, no cardiac monitoring, no defibrillation and no intravenous resuscitation medications.

EMS-No CPR directives do not authorize the withholding of other medical interventions, such as intravenous fluids, oxygen or any therapies necessary to provide comfort or to alleviate pain.

Cardiac Arrest: The heart no longer produces a detectable heartbeat (by manual palpation, blood pressure cuff or Doppler ultrasound). Occasional heartbeats, as measured by a palpable pulse at the carotid artery, are considered part of a cardiac arrest in the terminally ill. These weak "heartbeats" should not be supported with chest compressions, intravenous medications or fluids.

Durable Power of Attorney for Health Care: A document signed by a person which appoints someone else to make health care decisions for the person in the event that the person loses the ability to make their own decisions.

EMS-No CPR Bracelet: A durable identification bracelet with the letters "EMS-No CPR" along the lower window of the bracelet. This bracelet should be honored by EMS personnel. EMS personnel do not need to see the original signed directive. Once applied, the EMS-No CPR bracelet must be cut off to remove it and is not reusable.

EMS-No CPR Directive: A special directive provided by the Department of Health. The directive is specifically designed to help patients, physicians and EMS personnel in No CPR situations. The directive encompasses ALL the documentation needed by the patient, the physician and the EMS personnel. The directive brings together the statement of the patient or surrogate that they want CPR withdrawn or withheld; the physician's directive to EMS personnel not to initiate CPR in the event of a cardiac arrest; and/or the surrogate's directive to EMS personnel to withhold CPR.

Emergency Medical Services (EMS) and Trauma Care System (WAC 246-976-010): An organized approach to providing personnel, facilities, and equipment for effective and coordinated medical treatment of patients with a medical emergency or injury requiring immediate medical or surgical intervention to prevent death or disability.

EMS Personnel, Qualified: Qualified personnel authorized to recognize EMS-No CPR documents are certified by the Washington State Department of Health to provide emergency medical care or treatment. These care givers include First Responders, EMTs, EMT-IV Technicians, EMT-Airway Technicians, EMT-IV/Airway Technicians, and EMT-Paramedics.

Living Will: Common term for a **Health Care Directive**. This is a document that tells your health care provider that if you experience a health condition the document identifies, you want no artificial life support so you can die naturally. EMS providers who see these documents should contact medical control for direction.

Medical Control (WAC 246-976-010): Medical Program Director authority to direct the medical care provided by all certified personnel in patient care in the prehospital EMS system.

Medical Program Director (MPD) [RCW 18.73(4)]: A person who: (a) is licensed to practice medicine and surgery pursuant to Chapter 18.71 RCW or osteopathy and surgery pursuant to Chapter 18.57 RCW; (b) is qualified and knowledgeable in the administration and management of emergency care and services; and (c) is so certified by the Department of Health for a county, group of counties, or cities with populations over four hundred thousand in coordination with the recommendations of the local medical community and local Emergency Medical Services and Trauma Care Council.

Physician: A physician, selected by or assigned to the patient, who has active responsibility for the treatment and care of the patient.

Prehospital (WAC 246-976-010): Emergency medical care or transportation rendered to patients prior to hospital admission or during inter-facility transfer by licensed ambulance or aid service. The EMS-No CPR Directive or bracelet is valid during inter-facility transport of patients, or for patients enroute from hospital to home.

Prehospital Patient Care Protocols (WAC 246-976-010): Written procedures adopted by the Medical Program Director (MPD) which direct the out-of-hospital emergency care of emergency patients, including trauma care patients.

Qualified Patient: Any person 18 years of age or older who informs his/her physician that he/she does not want CPR performed in the event that he/she suffers a cardiac or respiratory arrest and has signed an EMS-No CPR Directive. A legal surrogate may also sign on behalf of a qualified patient. To be valid, the directive must be signed by the person's physician.

Respiratory Arrest: Breathing stops. Agonal respiratory gasps in the terminally ill are considered part of a respiratory arrest and should not be supported with any ventilatory support other than manually opening the airway.

Revocation: A procedure by which the EMS-No CPR Directive may be made ineffective. The EMS-No CPR Directive may be revoked at any time by any of the following methods:

- 1) **Being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by a qualified patient, or his/her surrogate decision maker if directive was executed by the surrogate; or**
- 2) Verbal communication by a qualified patient or his/her surrogate decision maker expressing the patient's revocation of the EMS-No CPR Directive. The surrogate decision maker cannot verbally revoke a patient executed directive. Such verbal revocation becomes effective upon its actual communication to the physician or EMS personnel.

Surrogate Decision Maker: A person authorized to provide informed consent with respect to an EMS-No CPR Directive on behalf of a patient who is not capable of making his/her own health care decisions. A surrogate decision maker must be one of the persons below, in the following order of priority:

- 1) Appointed guardian of the patient, if any;
- 2) Individual, if any, to whom the patient has given a durable power of attorney that encompasses authority to make health care decisions;
- 3) Patient's spouse;
- 4) Children of the patient who are at least eighteen years of age;
- 5) Parents of the patient; and
- 6) Adult brothers and sisters of the patient.

VI. The EMS-No CPR Directive and Bracelet

-----Original Directives vs. Copies-----

Only the original EMS-No CPR Directive or bracelet will be honored. The original EMS-No CPR Directive should be kept at the patient's home or with the patient if traveling. The Physician should retain the yellow copy for the medical records. EMS providers must see the original directive or the unaltered bracelet on the individual.

-----Location of EMS-No CPR Directive in Residences, Extended or Intermediate Care Facilities-----

The original EMS-No CPR Directive should be located at the patient's bedside (bedside table) or on the back of the door to the patient's room or on the refrigerator. Patients should carry the original directive with them if traveling. If the patient is being transported by ambulance, the original directive should accompany the patient. However, the bracelet alone will be sufficient authorization to withhold CPR during ambulance transport if a cardiac or respiratory arrest should occur.

For patients in extended or intermediate care facilities, the EMS-No CPR Directive should be kept with the patient's chart.

-----The EMS-No CPR Bracelet-----

The EMS-No CPR bracelet is a white water-resistant ID bracelet uniquely designed with the Department of Health logo imprinted on the band portion. This bracelet is considered an extension of the original signed EMS-No CPR Directive. As such, it can be honored by EMS personnel in the absence of the original signed directive.

The letters "EMS-No CPR" appear along the lower portion of the bracelet. The bracelet is made of strong but easily cut plastic (similar to hospital ID bands).

-----Bracelet Location-----

The bracelet should be worn on the wrist or ankle. If extremities are not suitable then a sealed and closed bracelet should be placed on a necklace or neck chain, and worn by the patient.

-----Revoking the EMS-No CPR Directive or Bracelet-----

The EMS-No CPR Directive or bracelet may be revoked at any time by any of the following methods:

1. By being **intentionally** canceled, defaced, obliterated, burned, torn or otherwise destroyed by a qualified patient or his/her surrogate decision maker if the directive was executed by the surrogate; or
2. By verbal communication from a qualified patient.

Note: Either an intact EMS-No CPR bracelet or the original EMS-No CPR directive must be present for the EMS-No CPR directive to be honored.

-----Distribution of the EMS-No CPR Directives and Bracelets-----

These directives and bracelets are no longer being distributed

VII. EMS Provider's Protocols for EMS-No CPR Directive

1. **The responding EMS provider should perform routine patient assessment and resuscitation or interventions until they confirm the EMS-No CPR status in one of the following ways:**
 - a) Determine that the EMS-No CPR bracelet is intact and not defaced. The bracelet can be located on either wrist, either ankle, or on a necklace or neck chain, and worn by the patient. OR
 - b) If no bracelet is located, look for the **original** EMS-No CPR Directive at the bedside, on the back of the bedroom door, or on the refrigerator. In extended or intermediate care facilities, look for the directive with the patient's chart.
 - c) Begin resuscitation if bracelet is not attached, or if it has been defaced and no valid EMS-No CPR Directive is located.
 - d) Begin resuscitation if, in your medical judgement, your patient has attempted suicide or is a victim of a homicide.
2. **When the patient is determined to be "obviously dead," resuscitation measures shall not be initiated.**
 - a) The "obviously dead" are victims who, in addition to absence of respiration and cardiac activity, have suffered one or more of the following:
 - b) Decapitation
 - c) Evisceration of heart or brain
 - d) Incineration
 - e) Rigor Mortis
 - f) Decomposition
3. **After confirming that the patient has a valid EMS-No CPR Directive, the EMS provider should carry out these standard EMS-No CPR orders when indicated:**
 - a) Open the airway using AHA/ARC manual methods (do not provide positive pressure ventilation with a bag valve mask, pocket mask or endotracheal tube).
 - b) Clear the airway (including stoma) of secretions with appropriate suction device.
 - c) Provide oxygen per nasal cannula at 2-4 l/min.
 - d) Make the patient comfortable and provide emotional support.
 - e) Control any bleeding.
 - f) Provide pain medications as per local protocols.
 - g) Provide emotional support to the family.
 - h) Contact patient's physician or on-line medical control if directed by local protocols or if questions or problems arise.

4. **If resuscitative efforts have been started before learning of a valid EMS-No CPR order, then the EMS provider should STOP these treatment measures:**
 - a) Basic CPR.
 - b) Intubation (leave the endotracheal tube in place, but stop any positive pressure ventilations).
 - c) Cardiac monitoring and defibrillation.
 - d) Administration of resuscitation medications.
 - e) Any positive pressure ventilation (through bag valve masks, pocket face masks, endotracheal tubes).
5. **Other DNR Orders: We continue to encourage medical facilities to use the Department of Health EMS-No CPR Directive.**
 - a) Sometimes health care facilities prefer to use their own health care DNR orders. When EMS providers see other DNR orders, they should do the following:
 - b) Verify that the order has a physician signature requesting "Do Not Resuscitate."
 - c) Verify the presence of the patient's name on the order.
 - d) Contact on-line medical control for further consultation. In most cases, on-line medical control will advise to withhold CPR following verification of a valid physician-signed DNR order.
6. **Revoking the EMS-No CPR Directive. The following people can inform the EMS system that the EMS-No CPR Directive has been revoked:**
 - a) The patient (by destroying the directive and bracelet, or by verbally revoking the directive).
 - b) The physician expressing the patient's revocation of the directive.
 - c) The legal surrogate for the patient expressing the patient's revocation of the directive. (The surrogate cannot verbally revoke a patient executed directive).
7. **Documentation**
 - a) Complete the Medical Incident Report (MIR) directive approved by your Medical Program Director.
 - b) State in writing in the upper left hand corner of the narrative summary:

"Patient identified as EMS-No CPR by directive, bracelet, or both."
 - c) Record the name of the patient's physician, and state whether you contacted the physician.
 - d) Record the reason why the EMS system was activated.
 - e) Comfort the family and bystanders when patients have expired (see Appendix).
 - f) Follow your local Medical Program Director's protocols for patients who have expired. Actions may include contact of the local coroner's office, the local law enforcement agency, the local chaplain service, or funeral home. The MIR form must still be completed.

8. Comfort Care Measures

- a) No CPR does not mean No Treatment or No Caring. Providing comfort care measures is an important responsibility and service you provide to patients and their families at a crucial moment in their lives.
- b) Comfort care measures for the dying patient may include:
- c) Suctioning the airway;
- d) Administering oxygen;
- e) Positioning for comfort;
- f) Splinting;
- g) Controlling bleeding;
- h) Providing pain medications;
- i) Providing emotional support;
- j) Contacting patient's physician or on-line medical control if directed by local protocols or if questions or problems arise.

Special situation:

The patient's wishes in regard to resuscitation should always be respected. Sometimes, however, the family may vigorously and persistently insist on CPR even if a valid EMS-No CPR Directive or bracelet is located. These verbal requests are not consistent with the patient's directive. However, in such circumstances:

- a) *Attempt to convince family to honor the patient's decision to withhold CPR. If family persists, then*
- b) *Initiate resuscitation efforts until relieved by paramedics (for First Responders and EMTs).*

Advanced life support personnel should continue treatment and consult medical control.

Remember:

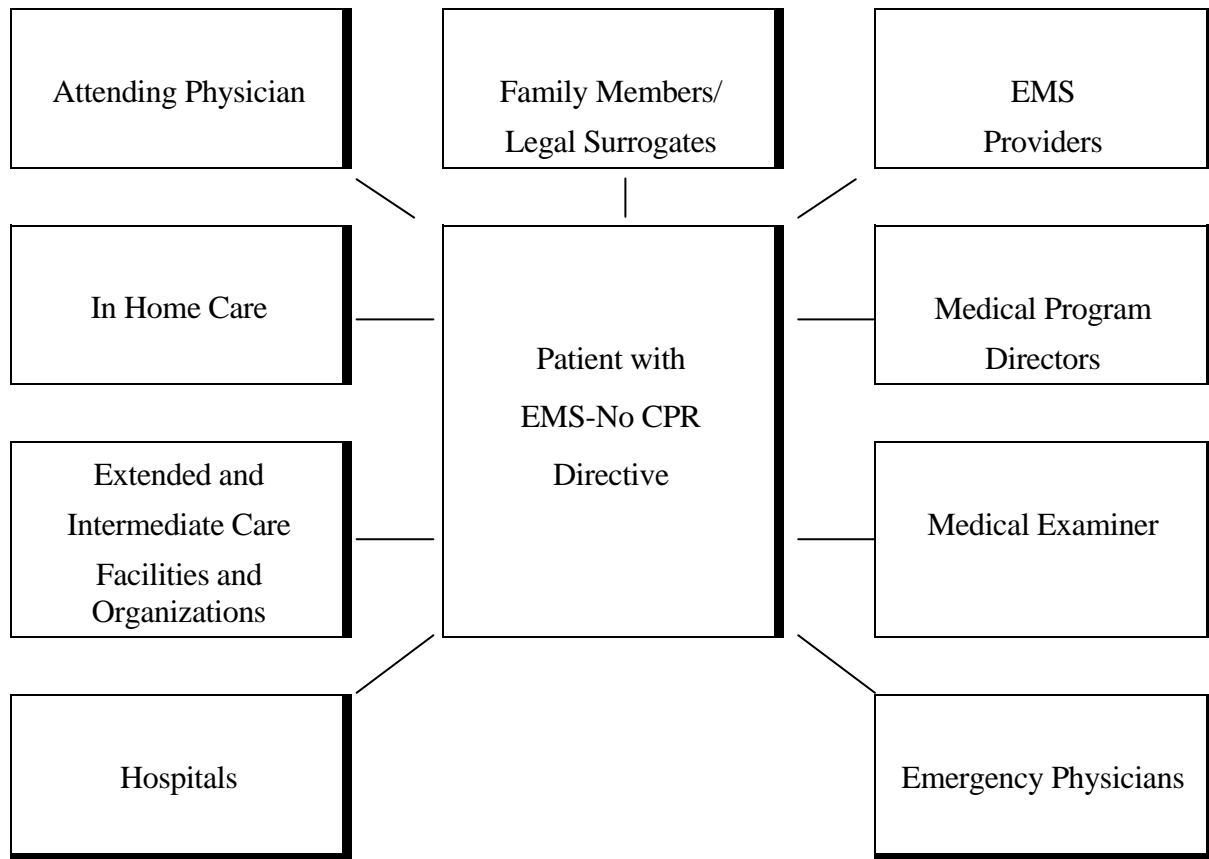
Once a death has occurred, the family and relatives become your patients.

VIII. The EMS-No CPR Decision and Associated Responsibilities

The EMS-No CPR Decision involves many groups of people:

1. Physician
2. Person Choosing EMS-No CPR
3. Family Members
4. EMS Providers
5. Medical Program Directors
6. Emergency Department Physicians
7. Hospitals and Medical Centers
8. Extended and Intermediate Care Providers (Nursing and Boarding Homes)
9. Hospice Units and Home Health Care Providers
10. Medical Examiner

Each of these groups has specific responsibilities in regard to the EMS-No CPR decision, as displayed in the following figure:



1. Physician Responsibility

The physician has the following responsibilities toward patients and the EMS-No CPR decision:

- a) Explain to the patient (or durable power of attorney) and/or family the alternatives, including the EMS-No CPR decision.
- b) Explain to the patient (or durable power of attorney) and/or family the proper response to end-of-life events, such as when to call 911, what to do upon an expected death and when to call the funeral home.
- c) Check to see that the patient has signed **Part 1 of the EMS-No CPR Directive** or that the patient's legal surrogate decision maker has signed **Part 2**.
- d) **If Part 1 of the EMS-No CPR Directive** is signed by the patient, **sign Part 3, Physician's Directive to EMS Personnel** on the EMS-No CPR Directive.
- e) Explain how the EMS-No CPR decision is revoked: verbally by the patient [regardless of their mental capacity (RCW 70.122.040)] or by the legal surrogate decision maker; or the directive or bracelet can be removed and destroyed by the patient or legal surrogate decision maker.
- f) Issue the bracelet and directive, and keep a copy of the directive in the patient's medical record.

2. Patient (or Legal Surrogate Decision Maker) Responsibility

The patient (or legal responsible decision maker) should:

- a) Make an informed decision concerning resuscitation from cardiac or respiratory arrest.
- b) Make sure that family members, or the staff of a care giving facility, are aware of this decision and that they know the location of the original EMS-No CPR Directive.
- c) Understand that he/she can revoke the EMS-No CPR Directive at any time by destroying the directive and removing the bracelet. Patients may simply state (or otherwise indicate) that they wish to be resuscitated, regardless of their mental capacity. A surrogate may not revoke the patient's choice unless he/she believes the patient would want to do so under the circumstances.

3. Family Responsibility

The family, and/or the staff of a care giving facility, should:

- a) Be aware of the No CPR decision and where the original EMS-No CPR Directive is located.
- b) Have instructions on when to call 911. 911 calls should be placed to obtain **emergency medical help** either for the patient or the family members.

911 should not be called simply to report a death.

- c) Know under what circumstances to call the physician or the funeral home. For example, the patient has a terminal illness and expresses a desire to die at home.

4. EMS Provider's Responsibility

When called, EMS providers should:

- a) Remember that the EMS-No CPR Directive applies only to persons who have suffered a cardiac or respiratory arrest and who have a signed EMS-No CPR Directive or other valid physician-signed DNR order. Other written DNR orders can be honored providing you:
 - 1) contact on-line medical control for further consultation;
 - 2) verify the order has a physician signature requesting "Do Not Resuscitate";
 - 3) verify the presence of the patient's name on the order.
- b) Assess the patient's status and needs through an initial assessment and focused history and exam of the patient.
- c) Look for the original EMS-No CPR Directive or bracelet (or both).
- d) Honor the original EMS-No CPR Directive once located, if and when the patient stops breathing or loses their pulse.
- e) Begin usual treatment of the patient, including resuscitation efforts, if the EMS-No CPR Directive or bracelet is not present.
- f) Continue supportive care of patients who have not yet had a cardiac arrest.

Note: The patient's wishes in regard to resuscitation should always be respected. Sometimes, however, the family may vigorously and persistently insist on CPR even if a valid EMS-No CPR Directive or bracelet is located. In such circumstances, initiate resuscitation efforts until relieved by paramedics (for First Responders and EMTs). Advanced life support personnel should continue treatment and consult medical control.

- g) EMS dispatchers, when called, should follow routine protocols for identification of cardiac arrest and offering CPR instructions. This is because the only personnel who can honor the EMS-No CPR Directives are those who see the original directive. Though dispatchers cannot see the directive or bracelet, they should remind family members to have the original directive available for EMS personnel when they arrive.

5. EMS Medical Program Director Responsibility

The Medical Program Director should be the resource concerning EMS-No CPR Directives and procedures. They should:

- a) Make available the educational material about implementing these procedures.
- b) Assure local and regional EMS policies are consistent with these guidelines.
- c) Support EMS personnel whenever questions or issues arise about implementation of the EMS-No CPR program.
- d) Advise and promote the EMS-No CPR program to other physicians and health facilities.
- e) Revise EMS medical protocols to permit other physician-signed "DNR" orders to be recognized by EMS personnel.

6. Emergency Department Physician Responsibility

The Emergency Department physicians, particularly those responsible for medical control, should:

- a) Understand the EMS-No CPR Directive and guidelines.
- b) Intervene in prehospital management of patients when necessary.
- c) Be a resource for First Responders, EMTs, paramedics and extended care facility personnel when problems develop during a call.
- d) Interact with the Physician when necessary.
- e) Advise and promote the EMS-No CPR program to other physicians and facilities.

7. Hospital Responsibility

Hospitals should:

- a) Provide EMS-No CPR Program information, bracelets and directives for appropriate patients.
- b) Hospitals should consider the presence of a patient's EMS-No CPR Directive or bracelet as valid and legally recognized within a hospital setting. Hospitals are encouraged to write policies and procedures to address the matter of appropriate care responses by hospital personnel to the EMS-No CPR Directive or bracelet.
- c) Provide assistance to physicians, patients and families when they engage in planning for patients who choose EMS-No CPR.
- d) Encourage in-hospital physicians to discuss the EMS-No CPR Directive and bracelet with patients, family members or legal surrogates before discharging patients from the hospital.

8. Extended and Intermediate Care Facility Responsibility

These facilities should:

- a) Make available the EMS-No CPR Directives and bracelets.
- b) Assure that signed original EMS-No CPR Directives are available if EMS personnel are called to provide comfort care for patients who have chosen EMS-No CPR.
- c) Provide EMS-No CPR information, bracelets and directives for physicians to use with appropriate patients.
- d) Educate their employees about the EMS-No CPR Directive.
- e) Pre-plan with the physicians and local EMS agencies about the appropriate actions to take when EMS-No CPR patients experience a cardiac or respiratory arrest.

9. Hospice Units and Home Health Care Providers Responsibility

These organizations should:

- a) Provide EMS-No CPR information, bracelets and directives for physicians to use with appropriate patients.
- b) Educate their employees about the EMS-No CPR Directive.
- c) Pre-plan with physicians and local EMS agencies about the appropriate actions to take when patients with EMS-No CPR Directives experience a cardiac or respiratory arrest.

10. Medical Examiner Responsibility

The Medical Examiner should:

- a) Interact with the physician when necessary.
- b) Interact with EMS providers when necessary.
- c) Advise and promote the EMS-No CPR program to other physicians.

For further information on or clarification of the EMS-No CPR program
contact the
Washington State Department of Health
Office of Emergency Medical and Trauma Prevention
Education, Training and Regional Support Section
(360) 236-2840

EMS-NO CPR APPENDIX

How BEST to Tell the Worst News

"When you end a resuscitation, you gain a new set of patients: the grieving family."

It's not a pleasant job to tell someone that their relative has died due to cardiac arrest. Although telling relatives about a death is an important issue in emergency care, it has not received much practical attention. Initial contact with the family has a strong effect on how they respond to grief. Bad news conveyed in an inappropriate, incomplete or uncaring manner may have long-lasting psychological effects on a family. Here are some recommendations about how to convey bad news. These ideas were accepted by the 1992 National American Heart Association Conference and portions of this document are directly from the October 28, 1992 JAMA publication of the Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care.

As a rescuer, one of the hardest switches in Emergency Medicine is to turn from a failed resuscitation to a family in shock from sudden grief. Rescuers go from technical aspects of directing a resuscitation (a "no time for feelings" situation), to the post resuscitation situation where feelings, thoughts and empathy for loss begin a grief reaction. Feelings of failure, sadness and inadequacy make it difficult to initially support and counsel the patient's family.

Here are 18 tips:

- 1. One EMS provider on a team takes the lead.** Decide quickly who might be most effective for these particular circumstances.
- 2. Get yourself ready.** Recognize that you may be discouraged or overwhelmed. Take a deep breath and do what has to be done.
- 3. Gather information about the death.** Obtain as much information as possible about the patient and the circumstances surrounding the death. Carefully go over the events as they happened:
 - a) Medical history;
 - b) The event itself;
 - c) Relationship between patient and survivor.
- 4. Find a quiet location.** When not in an enclosed building, be sure the location is a safe distance from hazards. Normal reactions to extreme grief can include involuntary physical responses such as walking or running about.
- 5. Get physically lower.** If possible, sit down or have the family sit down and kneel next to them.
- 6. Nonverbal actions speak louder than words.** Make eye contact with the person closest to you. If there are several people, be sure to make eye contact with each of them during this conversation. Make eye contact, touch when appropriate and share.

7. **Listen, and be still.** Silent reactions are fine. Don't endlessly chatter. Answer questions.
8. **When to touch:** If someone reaches out to you first.
9. **Briefly review the history and circumstances.** Allow as much time as necessary for questions and discussion. Go over the events several times to make sure everything is understood and to facilitate further questions.

Example A: "You have known that George had a long history of heart trouble and has had pain for several days."
Example B: "You know your baby-sitter found your son, John, not breathing in his crib."
10. **Use the word "death" or "dead."** Such simple terms are clear. Euphemisms are easily misunderstood. Avoid euphemisms such as "he's passed on", "she is no longer with us" or "he's left us". Instead use the words "death", "dying" or "dead".
11. **Expect any reaction** and allow time to express anguish. Normal reactions to a loved one's death range through a variety of physical, mental and behavioral responses. Silent reactions are fine. Allow time for the shock to be absorbed.
12. **Convey sympathy for a grieving family**, yet don't let it sound like an apology. Family members can resent too many comments about a very intimate experience that you cannot share. Saying words like "I'm sorry" can be mistaken for guilt at not having been able to recall a patient to life. Convey your feelings with a phrase such as "You have my (our) sincere sympathy" rather than "I am (we are) sorry".
13. **Find someone to be with them** during this time. Do they want you to call a neighbor, family member or clergyman?
14. **Would you like to say goodbye to -----** (use the patient's first name) and see him/her now? (For many, this establishes death). If equipment is still connected, let the family know.
15. **Tell them the plan for disposition of the body.** What is going to happen next? Know in advance what happens next and who will sign the death certificate. Physicians may impose burdens on staff and family if they fail to understand policies about death certification and disposition of the body. Know the answers to these questions before meeting the family.
16. **Ask if they have any questions.** Answer them directly. Use simple sentences. People in crisis have trouble understanding complex messages.
17. **Don't lie to them.** This is especially important when a crime scene is involved or an autopsy will be performed. (Example: We have to take your baby to the hospital for an autopsy to find out why he died. Perhaps we can learn something so this kind of thing won't happen again).
18. **Leave clear information about follow-up contacts** for the family for when you have gone (social worker, counselor, chaplain). Enlist the aid of a social worker or the clergy if not already present. If time allows, offer to contact the patient's physician and remain available if there are further questions.

Summary

The community thinks of EMS personnel as superhuman rescuers who can work miracles in brief periods of time. Expectations about what EMTs and Paramedics can do for the surviving relatives are frequently unrealistic. In the short period of time after resuscitation, rescuers can do little more than set into motion a normal grief reaction. EMS providers must prepare for the next emergency. The most important task is to mobilize personal and community resources for those plunged into sorrow by the unexpected loss of a loved one.

References

Excerpts in this portion are from: Emergency Cardiac Care Committee and Subcommittees, American Heart Association, *Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care*, I: Introduction. JAMA. 1992, 268:2172-2183.

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