

WEST MICHIGAN REGIONAL PROTOCOL

DO NOT RESUSCITATE POLICY

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Purpose: To provide a mechanism for a patient to provide a do not resuscitate directive consistent with Michigan law.

- I. It is widely recognized that adult competent patients have the right to refuse medical treatment which they deem unduly burdensome and/or of minimal benefit. This is consistent with the Michigan Do Not Resuscitate Procedure Act (PA 192 and PA 193 of 1996).

This policy is to provide EMS providers with guidelines regarding treatment of patients who have made a directive regarding the desire to have no resuscitation initiated. Verbal requests of family members or others at the scene of an emergency cannot be honored. The appropriate "Do Not Resuscitate" (DNR) form (see attachment) and the needs of the patient should be the basis of the decision-making regarding whether to not begin resuscitation (BLS or ALS). Reliance on patient and physician's wishes and the requirements set forth in this policy must be considered.

It should be noted that this order may be rescinded at any time. Also, at the time of the emergency, if the patient or patient advocate revokes the order or indicates that the patient has revoked the order, treatment should be initiated regardless of the existence of this form. Finally, the existence or presentation of this form at the time of an emergency will **NOT** prohibit EMS personnel from providing supportive care or other therapeutic interventions.

Authorized Definitions

DNR - Do Not Resuscitate - in the event of an acute cardiac and pulmonary arrest, no cardiopulmonary resuscitative (CPR or ALS) measures will be initiated.

A. Do Not Resuscitate instructions:

1. Resuscitation will **NOT** be instituted if a valid DNR order a physician signed KCEMS or HOSPICE OF MICHIGAN form* is presented prior to the initiation of resuscitation or if the patient is wearing an approved DNR identification bracelet **. Confirmation of the absence of pulse and respiration by Medical First Responder, EMT-B, EMT-S, Paramedic, nurse, physician or respiratory therapist will be made clinically; ECG criteria must be documented by ALS personnel when available.
2. If a DNR order other than the KCEMS form or the HOSPICE OF MICHIGAN form* or some other type of patient advanced directive form is presented, CPR **ONLY** will be initiated while contact with Medical Direction is established **IMMEDIATELY** to evaluate the form and arrive at a decision regarding the resuscitation.
3. **IF THERE IS ANY QUESTION ABOUT THE AUTHENTICITY OF THE DNR ORDER OR IDENTIFICATION BRACELET OR IF NEITHER IS PRESENTED, CPR WILL BE INITIATED WHILE MEDICAL DIRECTION IS BEING CONTACTED IMMEDIATELY.**
4. If a person, physically present, identifies himself/herself as the patient's personal physician and can produce proper identification, contact the on-line medical direction physician immediately and place him in contact with the personal physician. CPR **ONLY** will be performed until a decision is made **NOT** to initiate further care for the patient.

B. **Medical Direction contact will be made immediately in ALL situations involving DNR orders**

C. DNR orders will NOT be followed:

1. Unless the directive is physically present with the patient
2. When the patient or patient's advocate has revoked the order.
3. When the patient or patient's advocate request resuscitation.
4. When the directive is given verbally.
5. When the directive is given via telephone.
6. When the directive is not legible or not properly signed by all appropriate persons, dated, or witnessed.

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7. When the directive uses alternate wording to limit medical care (e.g. living wills).
 8. When confusion or disagreement occurs over the status of the order.
- D. If a declarant (patient) has one or more vital signs, give supportive care according to the appropriate protocol. The declarant shall not be resuscitated if breathing and heartbeat shall subsequently stop. The supportive care may include ventilations via bag-valve-mask if needed and deemed appropriate in the judgement of EMS personnel, but the patient shall not be intubated by oral or nasal endotracheal tube.
- E. Once care has begun:
1. **In the event care has been initiated on a patient and then a valid DNR order is subsequently identified, immediately discontinue resuscitation.** Documentation shall be made on the run sheet of the events and the order in which they occurred.
 - a. In the event that intubation has been performed on a patient and then a valid DNR order is subsequently identified, immediately discontinue resuscitation. Documentation shall be made on the run sheet of the events and the order in which they occurred. **THE DECISION TO REMOVE THE ENDOTRACHEAL TUBE IN THE PREHOSPITAL SETTING WILL BE MADE BY THE MEDICAL EXAMINER INVOLVED IN THE CASE.**
 2. If care is initiated prior to identifying a DNR directive and a cardiac rhythm has been restored, the patient will be transported to the closest appropriate medical facility. **Contact an on-line medical direction physician immediately.**
- F. Documentation - An EMS form is to be completely filled-out in any case where a DNR form is involved. The patient copy, an EKG rhythm strip and a copy of the DNR form should be maintained in the agency's records.

* A HOSPICE OF MICHIGAN form presented with ONLY a "Verbal order" IS NOT considered valid within the West Michigan Region, a physician's signature MUST be on the form.

**If a DNR Identification bracelet is utilized it must be applied to the patient's wrist and must be imprinted with the words "DO NOT RESUSCITATE ORDER", the name and address of the patient and the name and address of the patient's physician, if any. The words must be printed in a type size that is as easily read as practical.

AMBULANCE TRANSPORTATION GUIDELINES

For Residents with Do Not Resuscitate orders
In Cardiac or Respiratory Arrest

Notify Physician First
Do Not Call EMS

- I. **Call EMS for Emergency Transport for patients with:**
 - A. Cardiac Arrest - Unless patient has "Do Not Resuscitate" order.
 - B. Unconscious, unarousable or decreasing level of consciousness
 - C. Heart Attack Symptoms
 - 1. Chest pain, tightness, pressure
 - 2. Irregular or abnormal pulse
 - 3. Fainting or extreme dizziness
 - 4. Unexplained respiratory distress.
 - D. Difficulty Breathing
 - 1. Choking.
 - 2. Cyanosis
 - E. Shock - Low Blood Pressure
 - 1. Systolic 90 or less, pulse 110 or greater
 - 2. Conditions that may rapidly lead to shock
 - F. Seizure - acute
 - G. Representative is convinced the problem is immediately life threatening.
 - H. A physician in attendance orders EMS response.

- II. **Call for Non-emergency Transport for patients with:**
 - A. Minor injuries without significant pain or discomfort not requiring rapid response
 - B. Chronic conditions with unrelated minor injuries or illnesses.
 - C. A physician in attendance orders that response.
 - D. Transportation for routine medical evaluation when scheduled transportation has not been arranged.

- III. **Emergency Numbers**
 - A. EMS: Ambulance/E-Unit 911
 - B. Ambulance (scheduled transfer)
 - C. Personal Physician
 - D. Next of Kin

**Emergency Medical Services
DO NOT RESUSCITATE ORDER**

I have discussed my health status with my physician, _____. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order is effective until I revoke it. I am aware that I can revoke this order at any time by simply expressing my request verbally or in writing to my caretaking family, physician, or designated patient advocate.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

(Declarant's signature)

(Date)

(Type or print declarant's full name)

(Signature of person who signed for declarant, if applicable)

(Date)

(Type or print full name)

(Physician's signature)

(Date)

(Type or print physician's full name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

(Witness Signature) (Date)

(Witness Signature) (Date)

(Type or print witness's name)

(Type or print witness's name)

**THIS FORM WAS PREPARED PURSUANT TO, AND IS IN COMPLIANCE WITH,
THE MICHIGAN DO-NO-RESUSCITATE PROCEDURE ACT.**

COBRA NOTICE AND WAIVER

Patient's Name: _____

I, the undersigned, intend and desire that the EMERGENCY MEDICAL SERVICES "DO NOT RESUSCITATE ORDER" which I have signed and established shall be honored and adhered to by those individuals providing services within the hospital Emergency Department as well as the pre-hospital emergency medical services personnel who may be transporting me to the hospital Emergency Department. I understand that, pursuant to Federal Law, hospitals that provide such emergency medical services are required to perform a screening examination and provide such emergency medical treatment as necessary to stabilize a patient's emergency medical condition to all persons who present or are presented to the hospital Emergency Department without regard to the person's insurance status or ability to pay for the required examination and treatment.

In making my application for pre-hospital limited treatment, I hereby acknowledge my intent to withhold my consent or refuse to consent to the performance by hospital emergency department personnel, of any such screening examination or provision of appropriate medical treatment necessary to stabilize my emergency medical condition as may otherwise be required under Federal Law. I intend that this withholding/refusal of consent to such examination and treatment be applicable to and equally binding upon those pre-hospital emergency medical service personnel who are responding to my request for limitation of patient care services while transporting me to the hospital as well as those hospital emergency department physicians and other medical personnel that respond to my request when or if I am ultimately presented to the hospital Emergency Department.

I understand that my expression of intent to forego such a screening examination and provision of stabilizing treatment is subject to being changed/reversed if I so desire and that, therefore, if I, or a legally responsible person on my behalf, request performance of a screening examination and provision of necessary stabilizing treatment upon my presentment to the hospital Emergency Department, such examination and treatment will be provided to me, subject to the clinical judgement of the Emergency Department personnel responding to my presentment.

Date

Patient's signature or signature of Medical
Durable Power of Attorney or Legal Guardian

Date

Witness

TAKE THIS FORM WITH YOU TO THE EMERGENCY DEPARTMENT IF YOU HAVE TO GO.

3/25/98

Instructions for Do Not Resuscitate Order Form

This Do Not Resuscitate order is applicable in a setting outside of a hospital, including a nursing home, or a mental health facility owned or operated by the department of community health. It is applicable when a patient's breathing and heart stop.

For this form to be valid:

1. The declarant (patient) must be over 18 years of age and of sound mind;
2. The order MUST be dated and signed by each of the following:
 - a. The declarant (patient) or another person who, at the time of the signing, is in the presence of the declarant and acting pursuant to the direction of the declarant.
 - b. The declarant's attending physician.
 - c. Two witnesses 18 year of age or older, at least one of which is not the declarant's spouse, parent, child, grandchild, sibling or presumptive heir.

The names of those signing the form must be printed or typed below the corresponding signature.

At any time after the form is completed and witnessed, the declarant or an individual designated by the declarant may apply an identification bracelet to the declarant's wrist. The bracelet must be imprinted with the words "DO NOT RESUSCITATE ORDER", the name and address of the patient and the name and address of the patient's physician, if any. The words must be printed in a type size that is as easily read as practical.

A declarant who executes this do not resuscitate order shall maintain possession of the order and must have the order accessible within his or her place of residence.

An attending physician who signs a declarant's do not resuscitate order shall immediately make a copy or obtain from the declarant a duplicate of the executed order and make that copy or duplicate part of the declarant's permanent medical record.

Revocation

The declarant or a patient advocate who executes a Do Not Resuscitate order on behalf of a declarant may revoke an order at any time verbally, in writing or by any means by which he or she is able to communicate. If the revocation is not in writing, the person who observes the revocation shall describe the circumstances of the revocation in writing and sign the writing. Upon revocation, the declarant, patient advocate or attending physician or someone delegated by the attending physician who has actual notice of the revocation shall destroy the order and remove the declarant's do no resuscitate identification bracelet, if the declarant is wearing one. The attending physician or someone delegated by the attending physician who received actual notice of a revocation of a do not resuscitate order shall immediately make the revocation including, if available the written description of the circumstances of the revocation as mentioned above, part of the declarant's permanent medical record.

3/25/98

**Emergency Medical Services
DO NOT RESUSCITATE ORDER**

I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order is effective until it is revoked by me. I am aware that I can revoke this order at any time by simply expressing my request verbally or in writing to my caretaking family, or designated patient advocate.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

(Declarant's signature) (Date)

(Type or print declarant's full name)

(Signature of person who signed for declarant, if applicable) (Date)

(Type or print full name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

(Witness Signature) (Date) (Witness Signature) (Date)

(Type or print witness's name) (Type or print witness's name)

**THIS FORM WAS PREPARED PURSUANT TO, AND IS IN COMPLIANCE WITH,
THE MICHIGAN DO-NO-RESUSCITATE PROCEDURE ACT.**

