EL DORADO COUNTY EMS AGENCY
FIELD POLICIES

Effective: July 1, 2015 **EMS Agency Medical Director**
Reviewed: July 2021
Revised: October 2022

DO NOT RESUSCITATE (DNR)

PURPOSE:

To establish criteria for Do Not Resuscitate (DNR) orders and to provide guidance for prehospital personnel in situations involving patients in hospice care.

DEFINITIONS:

Aid-in-Dying Drug – A drug (or combination of drugs) prescribed by a physician for a qualified terminally ill individual for the purpose of hastened death. The prescribed drug(s) may take effect within minutes to 1 or 2 days after self-administration.

Advanced Health Care Directive (AHCD) - An official document established in conformance with California statutory law by which an individual may give specific instructions about health care and/or name an agent to make health care decisions in the event the individual becomes unable to make such decisions for them self.

Allow Natural Death Order- A hospice form that is interchangeable with a DNR and is used for terminally ill patients currently under hospice care. This form must be completed and signed to be considered valid. **See Appendix A.**

Do Not Resuscitate (DNR) - No chest compressions, no defibrillation, no assisted ventilation, no endotracheal intubation, and no resuscitative medications. This does not exclude treatment for airway obstruction, pain, dyspnea, or hemorrhage.

DNR Form - Official State document developed by the California EMS Authority and the California Medical Association which allows a patient to forgo resuscitative measures that may keep them alive.

DNR Medallion - Medic Alert medallion (usually necklace or bracelet) which states "Do Not Resuscitate" as approved by the California EMS Authority.

End of Life Option Act – This **law** allows a terminally-ill adult **California** resident to request a drug from his or her physician that will **end** his or her **life**. A person who has obtained an aid-in-dying drug has met extensive stringent California state law requirements. The law offers protections and exemptions for health care providers but is not clear or explicit regarding EMS responses to patients who have initiated the End of Life Option.

Physician Orders for Life-Sustaining Treatment (POLST) - Official document developed by the California State EMS Authority and the California Coalition for Compassionate Care which allows a person to specify preferences for specific resuscitative or life-sustaining measures in the event that the person is unable to otherwise communicate preferences. A copy of the POLST form is also a valid POST form.

Respite Care - is the term used to refer to the act of leaving a loved one with special needs in the temporary care of another party.

PROCEDURE:

I. Resuscitation must be performed when indicated, but may be withheld or discontinued upon receipt of the following documents:

- A completed and signed Prehospital DNR Request Form. See Appendix A
- A completed and signed POLST form. See Appendix B
- The patient is wearing a DNR medallion. See Appendix C
- A written, signed DNR order in the patient's medical record stating "Do Not Resuscitate", "No Code", or "No CPR" signed by a physician, with the patient's name and date
- A paper copy of the electronic medical record (EMR) order for DNR containing the physician name and date. See Appendix D
- An Advanced Health Care Directive (AHCD). See Appendix E
- A verbal order from the patient's physician provided the physician immediately contacts and advises the Base Hospital

II. Contact Base for guidance if:

- The paramedic is presented with any other type of written medical directive or directive not signed by physician indicating patient's DNR request and/or family verbally states patient's DNR request
- A valid DNR order is present and the family requests resuscitation. Begin resuscitation until the situation can be clarified
- For any reason the DNR order does not seem to apply to the situation, resuscitation should be initiated and Base contacted immediately

III. Verification shall be accomplished by:

- The presence of a DNR order, the physician's name signing the order, and the date of the order documented on the Prehospital Care Report (PCR).
- The DNR form (original or copy), DNR medallion, AHCD, POLST form, or a copy of the valid DNR order from the patient's medical record shall be taken with the patient.

There is no expiration date for DNR

IV. Hospice

- Patients who are terminally ill and under hospice care, as evidenced by the initiation of call for service by hospice personnel, may be transported for the purpose of respite, necessary care or procedures, or if comfort cannot be maintained /provided in their current location.
- Prehospital personnel will honor request for transport to the nearest emergency department by the patient or patient's legal representative. The Base shall be contacted and will notify initiating hospice provider.
- For questions or clarification, prehospital personnel shall contact
  - Hospice at **530-621-7820** on the West-Slope
  - Base Hospital on the East Slope

V. END OF LIFE OPTION ACT:

- Within 48 hours of self-administrating the aid-in-dying drug, the patient is required to complete a "Final Attestation for an Aid–in-Dying Drug to End My Life in a Humane and Dignified Manner" but is not required to keep the final attestation in close proximity.
    i. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person identified in the final attestation by a form of identification or a person present who can reliably identify the patient.
    ii. There are no standardized "Final Attestation forms", but law states it must include:
        - The document identified as a "Final Attestation For An aid-In-Dying Drug to End My Life in a Humane and Dignified Manner"
        - Patient's name and signature
        - Date
- Provide comfort measures when applicable
- Withhold resuscitative measures
- The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental status. In this instance, EMS personnel shall
    i. Provide medical care as per standard protocols.
    ii. Contact their Base for further direction or concerns.

Appendix A

EMSA/CMA APPROVED PREHOSPITAL DNR FORM

1. Under the EMSA/CMA approved Prehospital DNR Form, do not resuscitate (DNR) means no chest compressions, defibrillation, endotracheal intubation, assisted ventilation, or cardiotonic drugs.
2. The patient should receive all other care not identified above for all other medical conditions according to local protocols.
3. Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped and the patient is unconscious, ventilation should not be assisted.
4. Requests must be signed and dated by a physician. No witness to the patient's or surrogate's signature is necessary. Ensuring appropriate informed consent is the responsibility of the attending physician, not the EMS system or prehospital provider.
5. The DNR Form should be clearly posted or maintained near the patient in the home. A typical location might be in an envelope in a visible location near the patient's bed. Copies of the form are valid and will be honored. The patient or family should be encouraged to keep a copy in case the original is lost. The copy should be taken with the patient during transport.
6. In general, EMS personnel should see the written prehospital DNR Form unless the patient's physician is present and issues a DNR order.
7. Correct identification of the patient is crucial, but after a good faith attempt to identify the patient, the presumption should be that the identity is correct if documentation is present and the circumstances are consistent. There should be a properly completed standard EMSA/CMA DNR Form available with the patient. A witness who can reliably identify the patient is valuable.

CMA PUBLICATIONS 1(800) 882-1262 WWW.CMANET.ORG

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

California Medical Association

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 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/Legally Recognized Health Care Decisionmaker Signature Date

_____
Legally Recognized Health Care Decisionmaker's Relationship to Patient

By signing this form, the legally recognized health care decisionmaker acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

I affirm that this patient/legally recognized health care decisionmaker is making an informed decision and that this directive is the expressed wish of the patient/legally recognized health care decisionmaker. 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 cardiotonic 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

Appendix B

EMSA APPROVED POLST FORM

EMS personnel who encounter the EMSA approved POLST form in the field should be aware of the different levels of care in Sections A and B of the form (Section C does NOT apply to EMS personnel).

Section A
Section A applies only to individuals who do NOT have a pulse and are NOT breathing upon arrival of EMS personnel.

1. If an individual has checked “Attempt Resuscitation/CPR”, then EMS personnel should treat the individual to the fullest extent possible according to local protocols regardless of what may be checked in Section B. For this individual this form as filled out does NOT constitute a DNR.
2. If the individual has checked “Do Not Attempt Resuscitation/DNR”, then no attempts should be made to resuscitate the individual and the EMS personnel should follow their local policies, procedures and protocols for declaration of death.

Section B
Section B applies only to individuals who have checked “Do Not Attempt Resuscitation/DNR” in Section A AND who have a pulse and/or are breathing upon the arrival of EMS personnel.

1. If an individual has checked “Full Treatment” then they should be treated to the fullest extent possible. This includes, but is not limited to, intubation and other advanced airway interventions, mechanical ventilation and defibrillation/cardioversion.

   Should the individual’s condition deteriorate after EMS personnel have arrived and they have indicated “DNR” in Section A, then resuscitation efforts should be attempted up to, but NOT including, chest compressions. Then EMS personnel should follow local protocols regarding declaration of death.

   EMS personnel shall ignore the check box marked “Trial Period of Full Treatment” as it is not applicable to pre-hospital care.

2. If an individual has checked “Selective Treatment” the following care may be provided (in addition to the care outlined below):

   VI. Administration of IV fluids

   - May use non-invasive positive airway pressure to include: continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations according to local protocols. This does NOT include intubation

   VII. EMS personnel shall ignore the subjective phrase “avoid burdensome measures” when considering treatment options for the patient. EMS personnel shall follow

their local protocols, policies and procedures regarding patient treatments and if necessary contact medical control for further guidance

VIII. EMS personnel shall ignore the check box marked “Request transfer to hospital only if comfort needs cannot be met in current location”. EMS personnel shall follow their local protocols, policies and procedures regarding patient transport

3. If an individual has checked “Comfort-Focused Treatment” the following care may be provided:
    - The patient should receive full palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions (includes medication by any route) according to local protocols
    - Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped and the patient is unconscious, ventilation should not be assisted
    - EMS personnel shall ignore the statement “Request transfer to hospital only if comfort needs cannot be met in current location”. EMS personnel shall follow their local protocols, policies and procedures regarding patient transport
4. EMS personnel shall obtain online medical control prior to following any orders listed under “Additional Orders”.

EMSA approved POLST forms must be signed and dated by a physician and the patient or legally recognized decision-maker. No witness to the patient's or legally recognized decision-maker's signature is necessary. Ensuring appropriate informed consent is the responsibility of the attending physician, not the EMS system or prehospital provider.

The EMSA approved POLST form should be clearly posted or maintained near the patient. A typical location might be in an envelope in a visible location near the patient's bed. Copies of the form are valid and will be honored. The patient or family should be encouraged to keep a copy in case the original is lost. The copy should be taken with the patient during transports.

In general, EMS personnel should see the written EMSA approved POLST form unless the patient's physician is present and issues a DNR order.

Correct identification of the patient is crucial, but after a good faith attempt to identify the patient, the presumption should be that the identity is correct if documentation is present and the circumstances are consistent. There should be a properly completed EMSA approved POLST form available with the patient. A witness who can reliably identify the patient is valuable.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 10/1/2014)*

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

_____

C ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Healthcare Agent if named in Advance Directive:

☐ Advance Directive not available Name: _____

☐ No Advance Directive Phone: _____

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary. 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 patient who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Mailing Address (street/city/state/zip):	Phone Number:	Office Use Only:

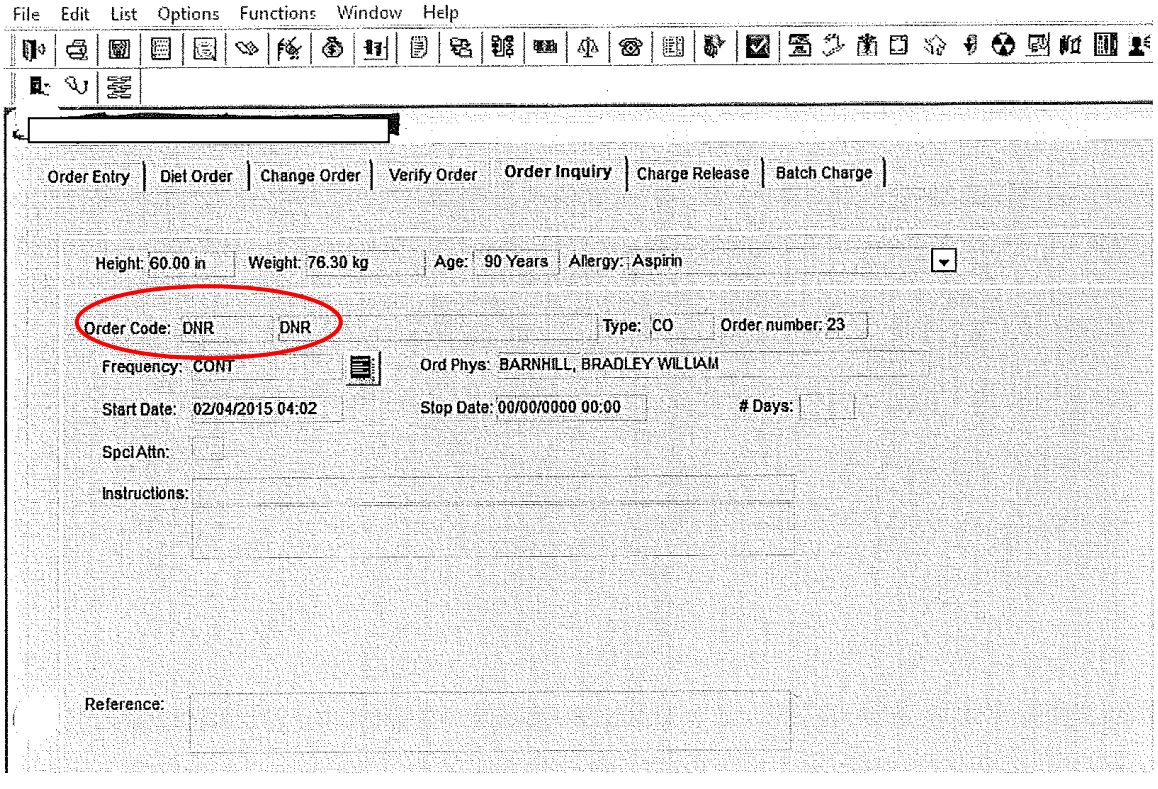
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Appendix C

DNR MEDALLION

Appendix D

EXAMPLES OF APPROVED ELECTRONIC DNR ORDERS



Paragon WebStation for Physicians Page 1 of 1

PARAGON 3.0 ENTERPRISE 1045 MARSHALL WAY PLACERVILLE, CA 95667 (530)622-1441
Printed By: DIRICKX, AMY F. at 09:01 AM on 2015 Feb 05

Non Pharmacy Orders

Visit ID
Med Rec #
Admitted: 02/04/2015 01:50
Location: INTENSIVE CARE UNIT - 0400-08

Name:
Sex:
Birth Date:

Visit ID: 2129696
Description: DNR
Alt Description:
Order # 23
Priority:
Order Status: Active
Days:

Code: DNR
Frequency: CONT
Order Start Date: 02/04/2015 04:02

Type: CODE STATUS
Ordered By: BARNHILL, BRADLEY W.
Order Stop Date: 00/00/0000 00:00

Special Attn:
Reference Data:
Instructions:
Prep Detail:

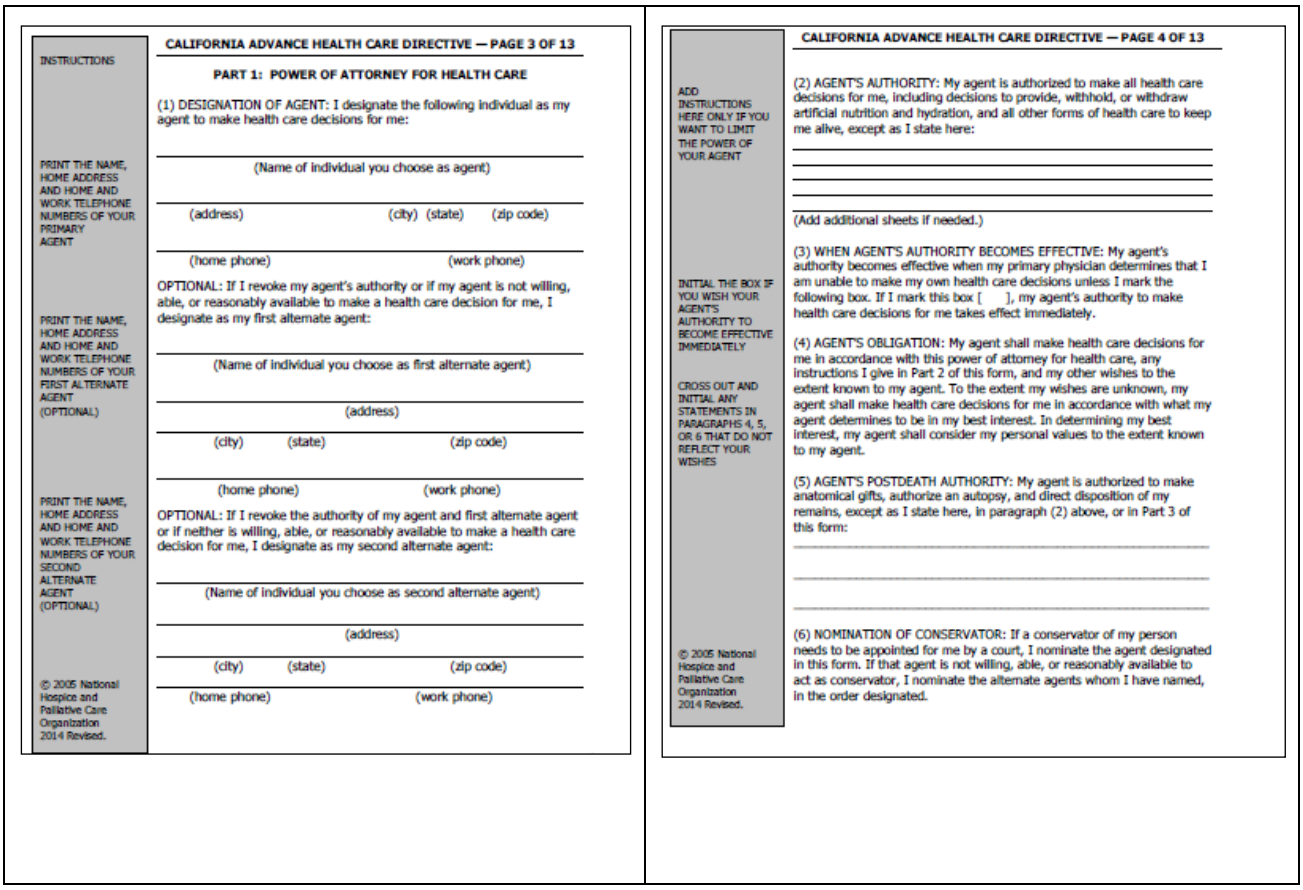
EL DORADO COUNTY EMS AGENCY
FIELD POLICIES

Effective: July 1, 2015
Reviewed: July 2017, **2019**
Revised: July 2021
Scope: BLS, ALS

EMS Agency Medical Director

Appendix E

EXAMPLES OF ADVANCED HEALTH CARE DIRECTIVE



INSTRUCTIONS

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT (OPTIONAL)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT (OPTIONAL)

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CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE — PAGE 3 OF 13

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(Name of individual you choose as agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(Name of individual you choose as first alternate agent)

(address)

(city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(Name of individual you choose as second alternate agent)

(address)

(city) (state) (zip code)

(home phone) (work phone)

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4, 5, OR 6 THAT DO NOT REFLECT YOUR WISHES

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CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE — PAGE 4 OF 13

(2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

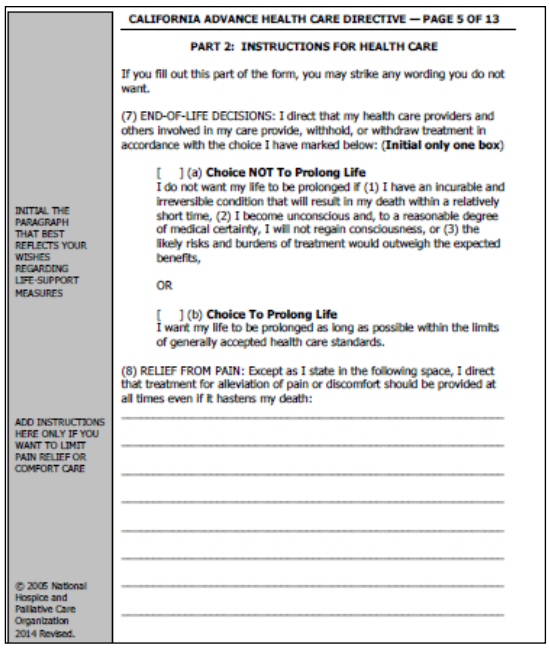
(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here, in paragraph (2) above, or in Part 3 of this form:

(6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.



CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE — PAGE 5 OF 13

PART 2: INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(7) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (**Initial only one box**)

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

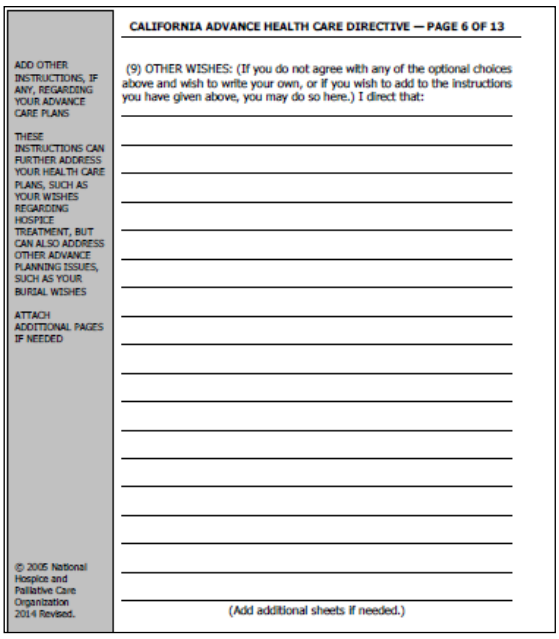
[ ] (a) **Choice NOT To Prolong Life**
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

[ ] (b) **Choice To Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT PAIN RELIEF OR COMFORT CARE



CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE — PAGE 6 OF 13

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

Appendix F

Snowline Hospice
Care Beyond the Cure

Patient Name: _____ **DOB:** _____

Allow Natural Death (DNR)

Request to Limit the Scope of Emergency Medical Care
Do Not Resuscitate

- I understand Allow Natural Death (DNR) means that if I stop breathing or my heart stops beating, no medical procedure to restart breathing or heart functioning will be initiated.
- I understand this decision will not prevent me from receiving other emergency medical care prior to my death.
- I understand I may change my decision at any time.
- I give permission for this information to be given to care providers, doctors, nurses or other personnel as necessary to carry out my wishes.

I hereby agree to the ALLOW NATURAL DEATH (DNR) order.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Witness Date

_____ _____
Attending Physician Signature Date

_____ _____
Medical Director Signature - *Jeanine Ellinwood, MD* Date

****

Revocation Provision - I hereby revoke the Allow Natural Death (DNR) order.

_____ _____
Patient/Legal Representative Signature **Date**

G:\Admin\FORMS\AND-DNR\AND\DNR Request..doc (8-10-12) Distribution: WHITE - Office YELLOW - Patient