Maryland
EMS News

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EMS/DNR Protocols

The following EMS/DNR protocols, which apply to both BLS and ALS providers, are abstracted from the booklet "Maryland Emergency Medical Services Do Not Resuscitate Program." The revised BLS and ALS protocols were necessary to reflect the new DNR initiatives effective July 1, 1998. ***Some section numbers or letters in the protocols below may be missing. This is intentional so that the protocols can be cross-referenced with the EMS DNR Program booklet. Please save this newsletter and place it in your protocol manual.***

Highlights of the protocol changes for EMS/DNR appeared in the May/June 1998 issue of The Maryland EMS News. *The three main areas of change include:*

- *Patients who are completing the DNR Order form are now presented with two options, from which they select one. "Option A—Maximal (Restorative) Care Before Arrest, Then DNR" was added as another choice to the existing "Option B—Limited (Palliative) Care Before Arrest, Then DNR." Thus, a patient choosing Option "A" would receive before arrest the full scope of restorative interventions permissible under the Maryland EMS BLS and ALS protocols.*
- *On the DNR authorization form, the patient may now choose a Medic Alert® DNR bracelet or necklace that indicates the patient's selection of either maximal or limited care. Alternatively, the patient may still choose to receive the free vinyl bracelet indicating his/her choice. Both are considered valid Maryland EMS/DNR orders.*
- *Upon request of the patient, family, or caregivers, some Option "B" DNR patients may now be transported directly to one of four approved inpatient hospice facilities for pain control or symptom management. Such transport would be in place of transport to a hospital-based emergency department.*

Copies of the "Maryland Emergency Medical Services Do Not Resuscitate Program," a 112-page booklet, may be obtained by calling 410-706-4367. This booklet contains not only the complete EMS/DNR protocol but also updated general information about DNR forms, guidelines for physicians regarding medical conditions and DNR options, a reprint of the Health Care Decisions Act incorporating changes through the end of the 1998 General Assembly session, and guidelines for attorneys, federal facilities, and out-of-state facilities requesting Maryland EMS/DNR forms.

B. EMS/DNR (Effective July 1, 1998)

A. PREFACE
- As of 7/1/98, EMS/DNR Order forms, bracelets, and necklaces will recognize two patient options for care prior to arrest:
  Option A (ALS)–Maximal (Restorative) Care Before Arrest, Then DNR, **or**
  Option B (BLS)–Limited (Palliative) Care Only Before Arrest, Then DNR

D. VALID EMS/DNR BRACELET WITH INSERT or AUTHORIZED METAL EMBLEM HAS SAME EFFECT AS FORM.
- Typically only one EMS/DNR device is needed to initiate the EMS/DNR protocol.
- EMS providers should only request a second instrument (i.e. a bracelet when a form has already been presented) if there is reason to question the validity of the first produced notification device.

E. RECIPROCITY
- A standardized EMS/DNR Order from another State may be honored.
- Treat out-of-state EMS/DNR Orders as Option "B" EMS/DNR patients.
- See chart in EMS/DNR program booklet for how other states will treat Maryland devices.

G. ORAL EMS/DNR ORDERS
- EMS providers may follow an oral EMS/DNR Order directly from a Maryland- licensed physician (MD or DO) that is physically present "on-site". EMS shall not accept orders from attendings by telephone.
- EMS providers may follow an oral EMS/DNR Order from a Maryland-licensed physician "on-line" via the EMS Communications System (i.e. radio or telephone consult that is routed through a public service access point [PSAP] for audio recording).

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H. ACCEPTABLE & UNACCEPTABLE EMS/DNR ORDERS

- The following **are** acceptable for implementing the EMS/DNR protocol:
  1. MD EMS/DNR Order Form
  2. Other State EMS/DNR Order Form
  3. MD EMS/DNR Bracelet Insert
  4. Medic Alert DNR® Bracelet or Necklace
  5. Oral DNR Order from EMS System Medical Consultation
  6. Oral DNR Order from other on-site physician
- The following **are not** acceptable for implementing the EMS/DNR protocol:
  1. Advance directives without an EMS/DNR Order
  2. Facility specific DNR orders
  3. Notes in medical records
  4. Prescription pad orders
  5. DNR stickers
  6. An oral request from someone other than a physician
  7. An oral order from an attending who is not on site
  8. Any other device or instrument not listed above as acceptable.

K. VALIDITY OF EARLIER VERSIONS OF EMS/DNR ORDERS

- Older versions of EMS/DNR Orders – i.e. initial version, © 1995 and first revision, 4/1/96 – **continue to be valid and need not be updated** unless the patient or authorized decision maker wishes to take advantage of new features available in the newer forms.
- EMS providers should treat older versions of EMS/DNR order (pre 7/1/98) as "Option B (BLS) - Limited (Palliative) Care Only Before Arrest, Then DNR."

M. REVOCATION OF AN EMS/DNR ORDER

1. An EMS/DNR Order may be revoked at any time by:
   a. Physical cancellation or destruction of all EMS/DNR Order notifications; or
   b. An oral statement by the patient **made directly** to emergency medical services personnel requesting only palliative care or resuscitation. If the patient revokes an EMS/DNR order orally, the EMS/DNR Order notification devices do not need to be destroyed. EMS providers should document thoroughly the circumstances of the revocation. An oral revocation by a patient is only good for the single response or transport for which it was issued.
2. An authorized decision maker, other than the patient, cannot revoke an EMS/DNR Order **orally**. Because of the difficulty in identifying authorized decision makers in emergent situations, it is incumbent upon an authorized decision maker who has authority to revoke an EMS/DNR Order to either destroy or withhold all EMS/DNR Order devices, if they wish resuscitation for the patient.
3. Section 5-610 of the Health Care Decision Act (Health General Article, Annotated Code of Maryland) makes willful concealment, cancellation, defacement, obliteration, or damage of an advance directive (including EMS/DNR Orders), without the patient's or authorized decision maker's consent, a misdemeanor subject to a fine not exceeding $10,000, imprisonment not exceeding one year, or both.

N. ANTICIPATED LOCATIONS FOR EMS/DNR ORDER FORMS

- EMS personnel shall be directed to look for an EMS/DNR Order in the following places:
  1. About a patient's wrist, hung from a necklace or safety-pinned to a patient's clothing.
  2. At medical facilities, in the patient's chart.
  3. In residences and domicile facilities, by the bedside, behind the patient's bedroom door, or on the refrigerator door.
  4. In schools and educational institutions, in the nurse's office, health room, or with the student's attendant caregiver/aide.
  5. Family or caregivers will be expected to retrieve the original EMS/DNR Order prior to the ambulance's arrival.

O. IDENTIFICATION OF PATIENT

1. If the patient is able, the patient can self-identify during the initial assessment.
2. If the patient is unable to communicate, then family, caregivers, or bystanders can identify the patient for EMS providers.
3. If an EMS/DNR vinyl bracelet with insert or metal emblem (bracelet or necklace) is attached to a patient (on wrist, pendant from neck, pinned to clothing, etc.), the patient's identity can be reasonably assumed by EMS providers.

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4. If an EMS/DNR vinyl bracelet insert or metal emblem (bracelet or necklace) is found detached from the patient, EMS personnel must treat it as an EMS/DNR Order form and identify the subject of the EMS/DNR Order as the patient. A valid bracelet insert alone, without the vinyl bracelet, is a valid EMS/DNR Order so long as EMS providers confirm the patient's identity (see Section D and Sections 01-02 of this protocol in the EMS/DNR Program booklet).
5. If EMS personnel are unable to ascertain with reasonable certainty, when required to do so, that the subject of the EMS/DNR Order is the patient, they may resuscitate the patient.

R. HEALTH PROVIDER/EMS PERSONNEL IMMUNITY

1. General immunity provisions, such as Good Samaritan immunity for volunteers and sovereign immunity for government employees, may apply under specific circumstances.
2. In addition to other immunity that may be provided for in law, the Health Care Decisions Act provides the following specific immunity in cases involving the provision, withdrawal, or withholding of care which may be life-sustaining in nature:
   a. EMS providers are not subject to criminal prosecution or civil liability or deemed to have engaged in unprofessional conduct as determined by the appropriate licensing, registering, or certifying authority as a result of **withholding or withdrawing** any health care **under authorization** obtained in accordance with the Health Care Decisions Act. See HG §5-609(a)(1).
   b. EMS providers **providing, withholding, or withdrawing** treatment under authorization obtained under the Health Care Decisions Act do not incur liability arising out of any claim to the extent the claim is based on **lack of consent or authorization** for the action. See HG §5-609(a)(2).
   c. EMS providers **providing** treatment because they reasonably believe that an EMS/DNR order, other than a bracelet, is not valid, do not incur liability arising out of any claim to the extent the claim is based on **lack of consent or authorization** for the action. See HG §5-608(d).

T. EMS/DNR MEDICAL PROTOCOLS (See EMS/DNR Protocol Flow Chart in the EMS/DNR Program booklet.)

1. DISPATCH

1.3 Option B EMS/DNR patients (7/98 version) or patients with older version EMS/DNR orders (see Section K) only require a BLS response. Medevac requests are not appropriate for these patients.

1.4 Option A EMS/DNR patients (7/98 version) who are not in arrest may require a range of responses from BLS through the highest echelon of response available. This will depend on the information available to dispatch and the service requested. The response complement in these cases will be dictated by local standard operating procedures (SOP).

1.5 If a dispatch center is unclear whether the DNR order is an EMS/DNR order or is unclear about the pre-arrest patient care option selected (A or B), the dispatch center shall dispatch the appropriate resources based on the information available.

1.6 In the absence of knowledge to the contrary, information from medical professionals at a health care facility about the EMS/DNR status of a patient may be presumed to be reliable.

2. PERFORM LIMITED PATIENT ASSESSMENT

2.1 Vital signs.

2.1.1 Check for absence of a palpable pulse.

2.1.2 Check for absence of spontaneous respirations in an unresponsive patient.

2.1.3 Check for a valid EMS/DNR Order form, vinyl bracelet insert worn either on the wrist, as a necklace, or pinned to clothing, or for a metal emblem (bracelet or necklace).

4. MAXIMAL (RESTORATIVE) CARE PROTOCOL

4.1 When Option A - "Maximal (Restorative) Care Before Arrest, Then DNR" is selected on an EMS/DNR Order, the patient shall receive the full scope of restorative interventions permissible under the Maryland EMS Medical Protocols (including intubation for respiratory distress, cardiac monitoring, synchronized cardioversion for pulse-present ventricular or superventricular tachycardia, cardiac pacing for pulse-present symptomatic bradycardia, insertion of IV's, and drug therapy), in an attempt to forestall cardiac or respiratory arrest (see Maryland EMS Medical Protocols for full description of permissible interventions).

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4.2 This option was requested primarily by long-term care facilities for their patients who are on DNR orders for potentially prolonged periods of time. Many of these patients are less concerned about palliation of pain and more concerned about the quality of life after a stroke or heart attack. The primary medical conditions seen in the field necessitating this option have been the desire to administer Lasix for pulmonary edema, dextrose for diabetic emergencies, and epinephrine for anaphylactic reactions in patients who, upon arrest, are not to be resuscitated.

4.3 If, despite these efforts, the patient becomes pulseless or stops breathing spontaneously, EMS providers shall then withhold or withdraw cardiopulmonary resuscitation including, but not limited to, no CPR, no cardiac pacing, no defibrillation, withdrawal of active ventilatory assistance upon cardiac arrest, and withholding or withdrawal of drug therapy (i.e. chemical resuscitation).

IF MAXIMAL CARE IS SELECTED AND THE PATIENT'S CONDITION REQUIRES ALS, AN ALS UNIT SHOULD BE REQUESTED IF FEASIBLE GIVEN THE LOCATION OF THE INCIDENT RELATIVE TO THE NEAREST APPROPRIATE FACILITY AND THE AVAILABILITY OF AN ALS UNIT, AND ITS ABILITY TO ARRIVE OR RENDEZVOUS IN A MEDICALLY APPROPRIATE PERIOD OF TIME.

5. PALLIATIVE CARE PROTOCOL

5.1 Supportive Care for Control of Signs and Symptoms

5.1.1 Respiratory distress

5.1.1.1 Open the airway using non-invasive means (e.g. chin lift, jaw thrust, finger sweep, nasopharyngeal airway, oropharyngeal airway, and Heimlich maneuver, **but** no laryngoscopy, no Magill forceps, no cricothyroidotomy, and no tracheostomy).

5.1.1.2 Administer oxygen as follows.

5.1.1.2.1 If the patient is not on a ventilator and would benefit from oxygen therapy, provide passive oxygen via nasal cannula or non-rebreather mask (but no positive pressure oxygen via ambu bag, demand valve, or ventilator).

5.1.1.2.2 If the patient is found on an outpatient ventilator and is not in cardiac arrest, maintain ventilatory support during transport to the hospital.

5.1.1.2.3 If the patient is found on an outpatient ventilator and is in cardiac arrest, contact on-line medical direction to consult about disconnecting the ventilator.

5.1.1.3 Maintain an open airway by non-invasive means (e.g. chin lift, jaw thrust, finger sweep, nasopharyngeal airway, oropharyngeal airway, and Heimlich maneuver, **but** no laryngoscope, no Magill forceps, no cricothyroidotomy, and no tracheostomy).

5.1.1.4 Suction as necessary.

5.1.1.5 Position for comfort.

5.1.2 External bleeding

5.1.2.1 Standard treatment (dressing, elevation, direct pressure, pressure points, cold packs, tourniquets, etc.).

5.1.2.2 No MAST/PASG trousers or IV's.

5.1.3 Immobilize fractures using skills and devices that minimize pain.

5.1.4 Uncontrolled pain or other symptoms (e.g. severe nausea)

5.1.4.1 Allow patient, family, or health care providers (other than the prehospital provider) to administer patient's prescribed medications. Such health care providers administering medication will not have to accompany the patient to the hospital.

5.1.4.2 Patient controlled analgesia (PCA) systems for pain medication delivery and other patient controlled medication (PCM) systems shall be left in place in DNR patients and monitored to the extent possible according to the provider's level of certification or licensure.

5.1.5 Existing IV lines may be in place and, if so, shall be monitored to the extent possible according to the provider's level of certification and licensure.

5.2 Inappropriate Care for a Palliative Care Patient

5.2.1 Cardiac monitoring, including 12-lead EKG, pacing, cardioversion and defibrillation

5.2.2 Initiation of IV therapy

5.2.3 EMS Initiated Medications - Except passive oxygen

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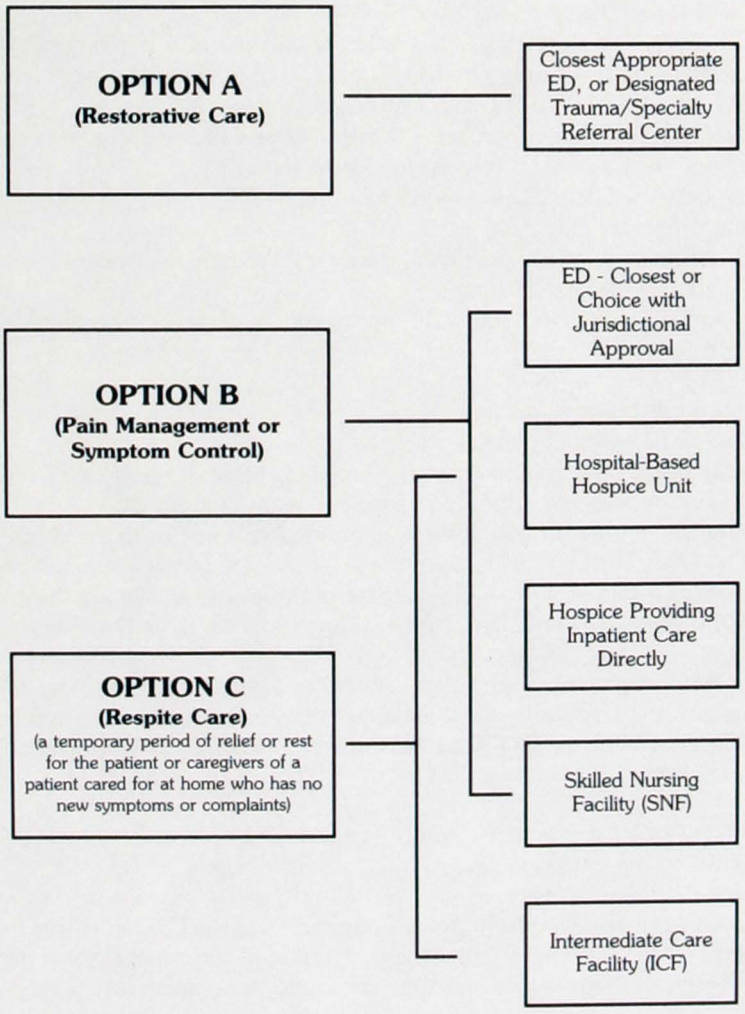
5.2.4 CPR
5.2.5 Intubation (EOA, endotracheal, nasotracheal, or gastric tube)
5.2.6 Pneumatic anti-shock garment (PASG)
5.2.7 Active ventilatory assistance, unless on an outpatient ventilator (see 5.1.1.2)

6. TRANSPORT
See DNR transportation algorithm below.

6.2.1 Upon request of the patient, family, or caregivers and in lieu of transport to a hospital-based emergency department, EMS providers may transport Option B EMS/DNR patients who require transportation for **pain control or symptom management** or respite care to a specified inpatient hospice facility.
6.2.2 A current list of those facilities is available from the MIEMSS Program Development Office (410) 706-4367 (4DNR). The receiving status of a particular facility can be ascertained from EMRC (24 hours a day) by EMS radio, EMSTEL, or red phone, or by calling 1 (800) 492-3805.
6.2.5 Additional facilities under 6.2.2 or 6.2.4 may be authorized by the State EMS Board, if recognized in the future by DHMH in accordance with 42 CFR 418.98 and 42 CFR 418.100. EMS jurisdictions and commercial ambulance services will be notified by MIEMSS of any facilities that become eligible and elect to receive patients by ambulance, become ineligible, or elect to discontinue their participation.

6.3 Take original copy of EMS/DNR Order, vinyl bracelet with insert, or metal emblem (bracelet or necklace) to the hospital with the patient. If returning the patient from a previous transport, be sure to request the original EMS/DNR

DNR Transportation Algorithm



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Order form, vinyl bracelet with insert, or metal emblem (bracelet or necklace) from the staff (see section H2 on page 20 of the EMS/DNR Program booklet and the "EMS/DNR Order Retrieval Strategies" on page 58 of the EMS/DNR program booklet).

7. COMMUNICATIONS
   - 7.1 Consultation requirements for Option A EMS/DNR patients shall be dictated by the Maryland EMS Medical Protocols in accordance with the patient's medical needs. EMS providers shall notify the hospital of the patient's EMS/DNR status (i.e. Option A) and the identity of patient's physician.
   - 7.2 No consultation is required for the Option B EMS/DNR patients, but the receiving hospital or inpatient hospice facility should be notified to expect the patient and prepare accordingly. Also make the hospital or inpatient facility aware of the patient's EMS/DNR status (i.e. Option B) and the identity of the patient's physician.
   - 7.3 If there is misunderstanding with family members or others present at the scene or if there are other concerns about following the EMS/DNR Order and the patient's condition permits, contact the physician signing the order, or the patient's hospice program, or on-line medical direction for assistance.

8. DOCUMENTATION
   - 8.1 If possible, make or retain a copy of the EMS/DNR Order and attach it to the official copy of the call runsheet that is kept by the EMS service. **Having a copy of the EMS/DNR Order can significantly reduce documentation requirements.** Encourage sending facilities to provide you with a copy of the EMS/DNR order, in addition to an original of the order, with the patient's transfer documents.
   - 8.2 If the EMS/DNR protocol is initiated:
     - 8.2.1 On the 7/94 MAIS runsheet, until the supply of those runsheets is exhausted, complete the "Hospice" dot in the "Conditions" section under "Assessment." On the 7/95 and subsequent MAIS runsheets, complete the DNR dot. On runsheets shipping 7/1/98 you will be able to select DNR-A or DNR-B to match the patient care options on the 7/1/98 revision of the EMS/DNR Orders;
     - 8.2.2 Document, in the narrative section:
       - 8.2.2.1 Who gave you the EMS/DNR Order (as an applicable person physically providing the written order, name of on- site physician, or name of on-line medical direction physician) or
       - 8.2.2.2 Where the EMS/DNR Order was found;
     - 8.2.3 Document the EMS/DNR order number, the effective date of the order, the name of the patient, the patient's date of birth, and the name of the physician signing the order;
     - 8.2.4 Document the time the EMS/DNR protocol was initiated;
     - 8.2.5 Document any care rendered;
     - 8.2.6 If the patient arrests while under your care, document the time the patient lost spontaneous respirations or palpable pulse, if able to determine; and
     - 8.2.7 If the patient arrests while under your care, document the chain of custody of body until the body is out of custody of EMS.

   - 8.3 If resuscitation protocols are initiated, document:
     - 8.3.1 Care rendered as per normal practice;
     - 8.3.2 The reason the EMS/DNR protocol was not initiated, if relevant (e.g. unable to find EMS/DNR Order, EMS/DNR is not or does not appear to be valid, patient request, etc.);
     - 8.3.3 If resuscitation was started because there was reasonable doubt as to the validity of an EMS/DNR Order;
       - 8.3.3.1 The EMS/DNR Order number, the effective date of the order, the name of the patient, the patient's date of birth, and the name of the physician signing the order; and
       - 8.3.3.2 Who gave you the EMS/DNR or where the EMS/DNR Order was found.

   - 8.4 Transfer any EMS/DNR Order to the appropriate authorities (if transported, to hospital or in-patient hospice personnel or if deceased, to the physician/police/medical examiner). If possible at the receiving facility, and if not already done, make a copy of the EMS/DNR Order. **DO NOT RETAIN** an original EMS/DNR Order (see Section H2 of the EMS/DNR Program booklet).

   - 8.5 If a copy of the EMS/DNR Order is available to EMS providers, it shall be attached to the official copy of the call runsheet that is retained by the EMS service.

   - 8.6 A vinyl bracelet with insert or metal emblem (bracelet or necklace) shall be left where found on the patient. Bracelets or metal emblems shall not be removed without the permission of the patient or the patient's authorized decision maker and when possible, shall be returned with the patient to the sending facility (see Section C of the EMS/DNR program booklet).

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9. PATIENT DISPOSITION IF NOT TRANSPORTED
   - 9.1 If the EMS/DNR Protocol is implemented and the patient is not transported because the patient arrested at the response site, EMS personnel shall:
     - 9.1.1 Follow local operational procedures for handling deceased patients **(see "How to Best Tell the Worst News" below);**
     - 9.1.2 Do NOT remove an EMS/DNR vinyl bracelet or metal emblem (bracelet or necklace) from the deceased patient;
     - 9.1.3 Law enforcement personnel or a representative of the medical examiner's office needs to be notified only in the case of sudden or unanticipated death which occurs:
       a. By violence
       b. By suicide
       c. As a result of an accident
       d. Suddenly, if the deceased was in apparent good health, or
       e. In any suspicious or unusual manner.

How Best to Tell the Worst News

Reprinted from "Maryland Emergency Medical Services Do Not Resuscitate Program Booklet"

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

It's not a pleasant job to tell someone 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 18, 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 16 tips:

1. **One EMS provider on a team takes the lead.** Decide quickly who might be most effective for these particular circumstances.

2. **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.
   - medical history
   - the event itself
   - relationship between patient and survivor
   - plans for disposition of the body

3. **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.

4. **Get physically lower.** If possible, sit down or have the family sit down and kneel next to them.

5. **Make eye contact** with the person closest to you, and 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.

6. **When to touch:** If someone reaches out to you first.

7. **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."

8. **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."

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Governor Parris N. Glendening

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DATED MATERIAL

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9. **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.

10. **Convey sympathy for a grieving family,** yet don't let this sound like an apology. Family members can resent too many comments about a very intimate experience 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 you feelings with a phrase such as "You have my (our) sincere sympathy" rather than "I am (we are) sorry."

11. **Find someone to be with them** during this time. Do they want you to call a neighbor, family member, or clergyman?

12. **Would you like to say good-bye 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.

13. **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.

14. **Ask if they have any questions.** Answer these directly. Use simple sentences. People in crisis have trouble understanding complex messages.

15. **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 the 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.)

16. **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.