



Medical Directive

Directive Number	<u>16-10</u>
Publish Date	<u>07 September 2016</u>
Effective Date	<u>21 September 2016</u>
Subject	<u>Termination of Resuscitation Criterion and Baylor Scott & White Medical Center Lakeway</u>
Update to Clinical Operating Guidelines v 02.17.16	

Credentialed System Responder	Action
Credentialed EMT	Action
Credentialed EMT-Intermediate	Action
Credentialed EMT-Paramedic	Action
Credentialed EMD	Action

This Medical Directive represents necessary COG changes to bring the System into alignment with the Texas Health and Safety Code Sec.773.016 which requires online Physician involvement in making decisions to terminate resuscitation efforts in the prehospital environment.

Additional changes with this Medical Directive reflects a hospital ownership and name change FROM: Lakeway Regional Medical Center, TO: Baylor Scott & White Medical Center-Lakeway.

We also wanted to move away from using the term protocol (s), to using the more accurate nomenclature of guideline (s) or clinical guideline (s). We feel this more clearly describes how we apply the algorithms and other clinical documents used to care for system patients.

The enclosed table of changes identifies the specific documents where changes were made. Please review this information in preparation for the implementation of these changes on September 21, 2016 at 0700 hours.

Thanks for all you do. Questions relating specifically to the COGs can be sent to cogs@austintexas.gov

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COG Change	Effected Documents
Revised criteria to contact System MD for Termination Of Resuscitation (TOR)	Clinical Reference CR-17, Clinical Standards CS-05, CS-06, CS-08, CS-14, Universal Guideline U-04 and Trauma Arrest, Adult and Pedi T-01
Nomenclature change: FROM: Protocol (s) TO: Guideline (s) or Clinical Guideline (s)	All COG documents where the term "protocol (s)" were found.
Hospital Name Change: FROM: Lakeway Regional Medical Center TO: Baylor Scott & White Medical Center-Lakeway	Clinical Reference CR-13 and Appendix A-02



Discontinuation of Prehospital Resuscitation

Standard:

Unsuccessful cardiopulmonary resuscitation (CPR) and other advanced life support (ALS) interventions may be discontinued prior to transport when this standard is followed.

Purpose:

The purpose of this standard is to allow for discontinuation of prehospital resuscitation after the delivery of adequate and appropriate ALS therapy.

Application:

1. For cardiac arrest with ongoing resuscitation efforts > 30 minutes:
 - Inclusion Criteria
 1. Adequate CPR has been administered
 2. Airway has been successfully managed with verification of device placement. Acceptable management techniques include endotracheal intubation, blind insertion airway device (BIAD) or cricothyrotomy
 3. IV/IO access has been achieved
 4. Rhythm-appropriate medications and defibrillations have been administered according to clinical guideline
 5. All Paramedic Credentialed providers on scene agree with decision to cease efforts
 6. If all of the above are met contact an on call System Medical Director

The lead Paramedic Provider based upon patient presentation, clinical circumstances and their clinical judgement may contact System Medical Director for Termination of Resuscitation (TOR) with < 30 minutes of resuscitation.

- Exclusion Criteria:
 1. Cause of arrest is due to suspected hypothermia;
 2. Sustained ROSC at any time during the resuscitation
 3. Persistently recurring or refractory ventricular fibrillation/tachycardia or any continued neurological activity (eye opening, or motor response).
2. When an on call System Medical Director is involved in the decision to terminate; resuscitative efforts must be continued while:
 - the family is counseled on the patients unchanging condition and impending discontinuation of efforts; (if termination of efforts is anticipated Victim Services, should be requested as early as possible)
 - someone is requesting a TOR from an on call System Medical Director
 3. Should the on call System Medical Director decline the TOR request, the patient must be immediately transported to the closest appropriate hospital
 4. Document all patient care and any interactions with the patient's family, personal physician, medical examiner, law enforcement, and medical control in the EMS patient care report (PCR)

Reference: Texas Health and Safety Code Sec.773.016.



Criteria for Death or Withholding Resuscitation

Standard:

Define the parameters in which providers in the ATCEMS System may withhold resuscitative efforts.

Purpose:

CPR and ALS treatment are to be withheld only if the patient is obviously dead per criteria below or has a valid OOH DNR per Clinical Standard CS – 09 DNR/Advanced Directive. **If you are unsure whether the patient meets criteria, resuscitate.**

Application:

Resuscitation efforts should not be initiated or continued by an ATCEMS System provider if the patient is **pulseless** and **apneic**, and one or more of the following is present. (Document in the PCR the specific indications for withholding or stopping resuscitation).

1. Signs of obvious death:
 - Rigor mortis and/or dependent lividity;
 - Decomposition;
 - Decapitation;
 - Incineration;
2. Obviously mortal wounds (severe trauma with obvious signs of organ destruction)
3. Patient submersion greater than 20 minutes from arrival of first Public Safety entity until the patient is in a position for effective resuscitative efforts to begin
4. Fetal death with a fetus < 20 weeks by best age determination available at scene (considered products of conception and does not require time of death). Fetal death < 20 weeks may be documented on mothers PCR. If ≥ 20 weeks create separate PCR.

If the patient meets any of the above criteria and bystander resuscitative care was not continued or not initiated by System Credentialed Providers/Responders; the arriving lead paramedic provider, may contact communications for a time of death.

If resuscitation efforts have been initiated or continued by a System Credentialed Provider/Responder; discontinuation is at the discretion of the arriving lead paramedic provider. In this case continue resuscitation and a System Medical Director must be contacted for Termination of Resuscitation (TOR).

Should the on call System Medical Director decline the TOR request; the patient must be treated and/or transported in accordance with online Physician Direction.

Reference: Texas Health and Safety Code Sec.773.016.



MEDICAL ARREST: Termination of Resuscitation (> 30 minutes) Checklist:

- Adequate CPR has been administered
- Airway managed with ET, BIAD, Cric.
- IV/IO Access has been achieved
- Rhythm appropriate meds/treatment administered
- Identified reversible causes have been addressed.
- Failure to establish sustained ROSC at any time
- Failure to establish recurring/persistent v-fib
- Arrest not due to suspected hypothermia
- Providers agree with decision to cease efforts

Contact an on call System Medical Director for TOR.

TRAUMATIC ARREST: Termination of Resuscitation (> 30 minutes) or withholding of Resuscitation Checklist:

- Obvious injuries incompatible with life and/or obvious signs of organ destruction
Clinical Standard CS-06.
- Pt is pulseless and apneic on arrival of first Provider **AND**
- Lacks respiratory effort after basic airway maneuvers **AND**
- Identified reversible causes have been addressed **AND**
- Medical cause of arrest has been considered.

Contact an on call System Medical Director for TOR if CPR started.

In all cases/circumstances continue CPR (if started or continued by System Provider/Responder) while obtaining TOR:

- The lead Paramedic Provider based upon patient presentation, clinical circumstances and their clinical judgement may contact System Medical Director for TOR with < 30 minutes of resuscitation.



BLS Transport Decision Process

Purpose: To define patients that cannot be transferred to a provider other than a Credentialed Paramedic.

Application:

For the purposes of this standard, "Paramedic" refers to an Austin/Travis County EMS System Credentialed Paramedic with no current restrictions on their credential to practice.

All providers on scene are expected to participate in patient care. Both providers are responsible for conducting an initial evaluation to determine a chief complaint, level of distress and initial treatment plan. Stable patients not in need of paramedic level care may be attended by another provider. The Transport Paramedic is responsible for making the decision for which patients can be safely transported by a provider with lower credentials.

The care of the following patients **cannot** be transferred to a lower level of Credential by a Transport Paramedic:

1. Any patient who requires additional or ongoing medications, intervention and/or monitoring beyond the scope of practice of the System Credentialed EMT - B provider refer to OMD Reference OMDR – 03.
2. Any patient that receives medications beyond the scope of practice of the System Credentialed EMT-B provider.
3. Postictal seizure patients who have not returned to baseline mental status.
4. Any patient with the following: Trauma Activation (steps 1 and/or 2), Stroke Alert, STEMI Alert, or Syncope.
5. Any patient for which the transporting providers **do not agree** can be safely transported without a Paramedic attending in the back of the ambulance.
6. Any "High Risk" patient as defined in Clinical Reference CR – 29 must be assessed by a Medic II.

Exceptions to the above listed items:

- Patients listed as "High Risk" in CR-29 may be transported by a Medic I provider if, the Medic II provider completes an assessment and; the patient does not require any care/monitoring beyond the scope of practice of the Medic I.
- Patients who received a **single dose** of intranasal (IN) narcotic for the purpose of pain control in a traumatic injury **not involving** the head, chest, or abdomen.
- Patients having a Syncopal episode, who are < 50 yrs. old, have a normal blood sugar, and a normal ECG.
- Monitor IV Saline Lock.
- Monitor PO route medications administered by a Medic II.



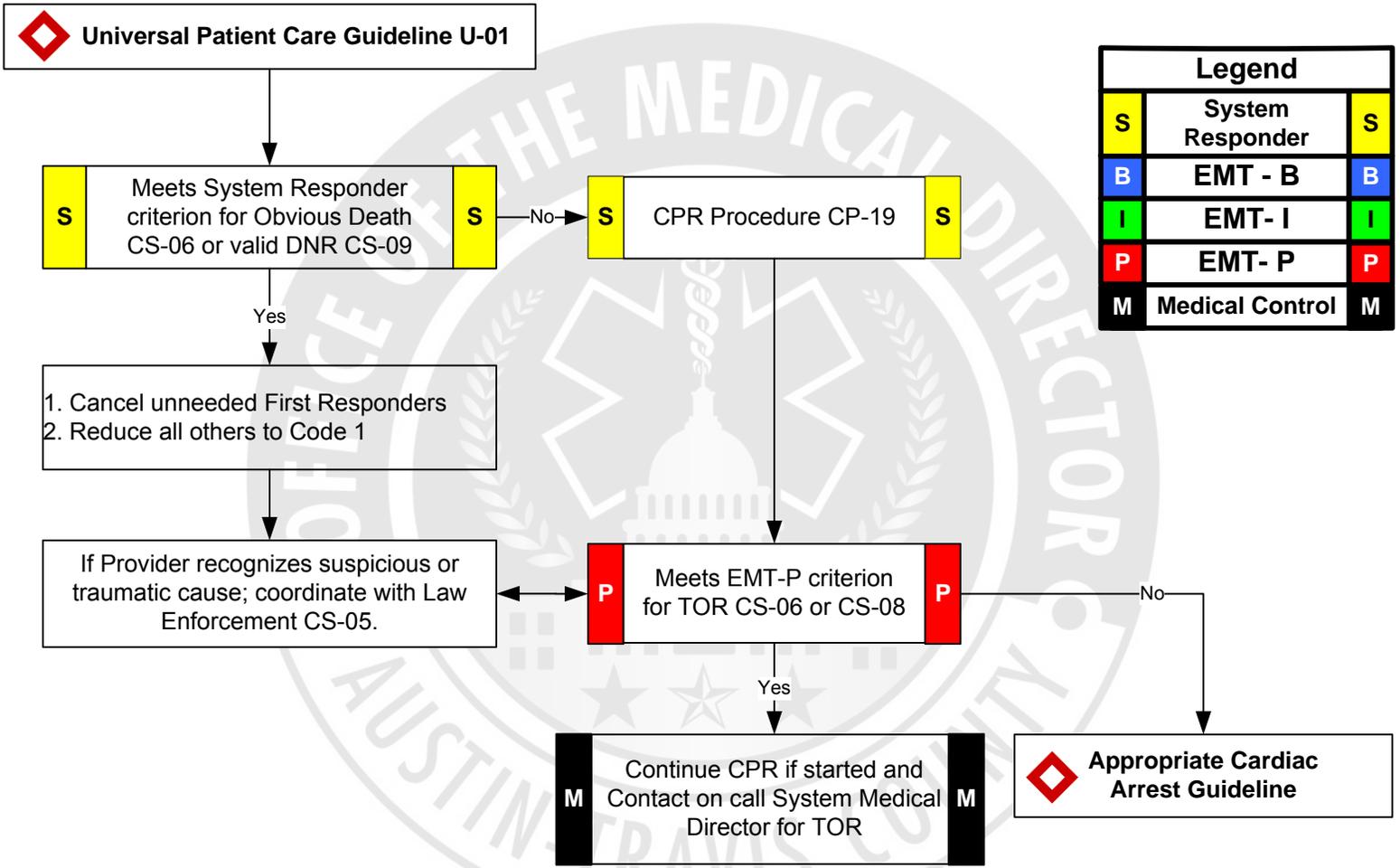
BLS Transport Decision Process

- Any hypoglycemic patient that returns to baseline mental status after treatment.
- A BLS Transport Provider may call and obtain a Termination of Resuscitation (TOR) on behalf of a Paramedic Transport Provider post ALS assessment; for patients that meet the Criteria for Death or Withholding Resuscitation, Clinical Standard CS-06. Patients who fall under the Discontinuation of Prehospital Resuscitation, Clinical Standard CS-08, the decision for TOR must be discussed between the Medic II and the Physician.
- Refer to OMDR-3 for additional Scope of Practice.

The ePCR should reflect the decision making process to determine which provider attends in the back of the ambulance. As with all documentation, both providers are responsible for the content of the ePCR.

Deceased Person

History: Past Medical History Recent Illness Last seen alive Mechanism Trauma/Medical Resuscitation efforts PTA	Signs/Symptoms: Dependent Lividity Pulseless Apneic Decapitation Rigor Mortis	Differential: Primary Cardiac Disease Homicide Diving Trauma Asphyxiation
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Pearls:

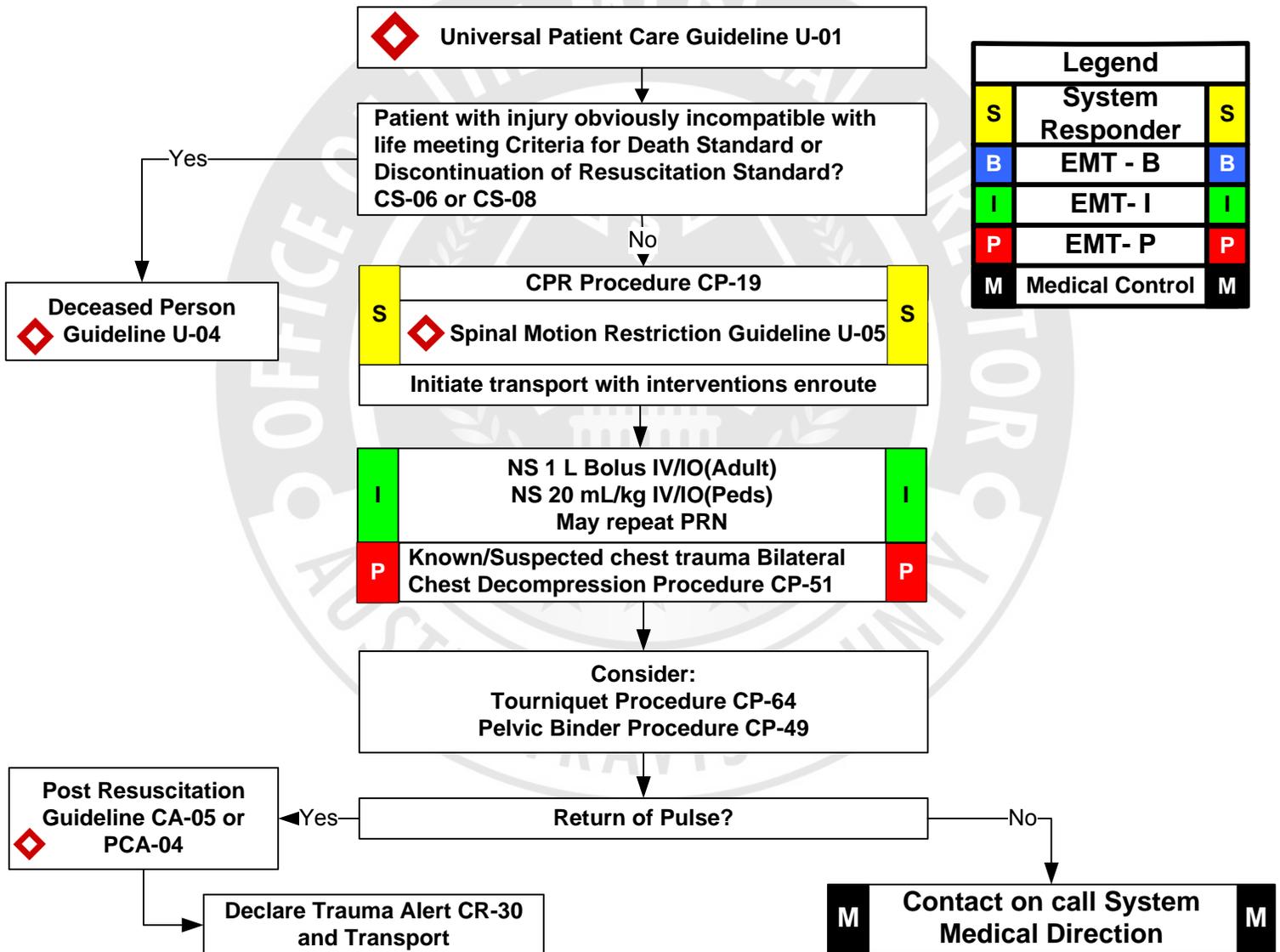
- Anytime a provider feels the need to have Law Enforcement on the scene they should make the request via EMS Communications (suspicious death or assistance with family/bystanders).
- Victim Services should be requested via EMS Communications as soon as possible for deceased person with family members present.

Criteria for withholding resuscitation; one or more of the following is present Clinical Standard CS-06:

- Valid DNR
- Rigor mortis and/or dependent lividity;
- Decomposition, Decapitation, Incineration;
- Obvious mortal wounds (severe trauma with obvious signs of organ destruction)
- Patient submersion > 20 minutes from arrival first Public Safety to patient positioned for resuscitation.
- Fetal death with a fetus < 20 weeks by best age determination available at scene

Trauma Arrest Adult/Pedi

History: <ul style="list-style-type: none"> • Patient who has suffered traumatic injury and is now pulseless 	Signs and Symptoms: <ul style="list-style-type: none"> • Evidence of penetrating trauma • Evidence of blunt trauma 	Differential: <ul style="list-style-type: none"> • Medical condition preceding traumatic event as cause of arrest. • Tension Pneumothorax • Hypovolemic Shock <ul style="list-style-type: none"> • External hemorrhage • Unstable pelvic fracture • Displaced long bone fracture(s) • Hemothorax • Intra-abdominal hemorrhage • Retroperitoneal hemorrhage
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Pearls:

- Discontinuation/No initiation of Resuscitation Clinical Standards CS-06 and CS-08:
 1. Injuries obviously incompatible with life (decapitation, incineration, obvious destruction of vital organs of torso/head)
 2. Drowning with submersion > 20 minutes from arrival of first Public Safety entity to patient in position for resuscitation.
- Consider using medical cardiac arrest guidelines if uncertainty exists regarding medical or traumatic cause of arrest.