Northwest Community EMS System			POLICY MANUAL
Policy Title: **DO NOT RESUSCITATE and Advance Directive Guidelines**			**No.** **D - 5**
Board approval: 5-16-13	**Effective:** 3-15-13	**Supersedes:** 10/1/10	**Page:** 1 of 8

References: Public Act 094-0865 that amends the EMS Act and others with respect to DNR orders; EMS Rules; Section 515.380 (Sept 18, 2008); Public Act 096-0765 The Health Care Surrogate Act (1/1/10); IDPH news release March 14, 1013 regarding new IDPH Uniform DNR (POLST) Advance Directive form, IDPH Guidance for Health Care Providers and Professionals Q&A document, and POLST Illinois Task Force documents.

Disclaimer: If Federal or State laws that impact Advance Directives and/or DNR orders change prior to this policy being amended or they appear to be inconsistent or in conflict with any provisions of this policy, the statutory language or State Directives shall prevail.

I. **POLICY**

A. **Resuscitation shall be attempted on all patients in cardiac and/or respiratory arrest, except in those situation described in this policy.**

B. "Emergency medical services should be available to all persons in need, including terminally ill patients who need to be transported to the hospital for palliative care. Prehospital care providers require a means to honor patient directives to limit intubation and avoid application of cardiopulmonary resuscitation (CPR). Requests to limit resuscitation will confront the provider in many forms. Written Do-not-resuscitate (DNR) orders, living wills, clear and unequivocal family requests, and a relative's impulsively expressed reservations about life support will be encountered. Acceptable directives must guarantee that withholding resuscitation would reflect the informed wishes of competent patients" (NAEMSP, 1993).

C. Competent adults have the right to make decisions regarding their healthcare. Illinois courts have ruled that this right should not be lost when a person becomes unable to make their own decisions. Competent adults may accept or refuse medical care after they have been informed about treatment alternatives and the risks and benefits of each alternative. The law requires that they be informed of the availability of advance directives to help assure that their wishes are carried out even if they are no longer capable of making or communicating their decisions.

D. The decision to accept and/or withhold resuscitative and/or life-sustaining interventions is the result of a responsible medical, legal, and ethical process with respect for the patient's right to privacy and self-determination. It is acceptable to withhold or withdraw resuscitative and/or life sustaining interventions in the event a patient is terminally ill, when death will occur in a reasonably short period of time, or for whom treatment would be virtually futile or prolong the act of dying and the patient has a valid IDPH Uniform Do-Not-Resuscitate (DNR) Advance Directive. These patients are in the process of dying and **DO NOT** meet the criteria listed in the Triple Zero Policy.

E. A valid IDPH Uniform DNR Advance Directive should be honored unless compelling circumstances arise and an on-line medical control (OLMC) physician directs EMS personnel to resuscitate.

F. A DNR Order does not mean the abandonment of appropriate care that the patient perceives as desirable. All patients are to receive medical care as indicated on the form, and required by their condition per SOP and/or OLMC.

G. If at any time it is unclear if these policies apply, begin BLS treatment and contact OLMC for orders. If communication with OLMC is impossible, begin treatment per SOPs and transport as soon as possible.

II. **Circumstances under which resuscitation may be WITHHELD and/or WITHDRAWN**

A. The patient has been declared dead by a coroner, medical examiner, or a physician.

B. **There are explicit signs of long-term biological death (Triple zero).**

1. These signs include decapitation, thoracic/abdominal transection, rigor mortis without profound hypothermia, profound dependent lividity, decomposition, frozen state, or other signs that establish long-term biological death.

2. For such patients, follow the Triple Zero policy and thoroughly document both the surrounding circumstances and the signs of biological death on the EMS patient care report.

3. If required, notify the coroner or Medical Examiner's office according to System Policy M-4: Medical Examiner/Coroner Guidelines.

4. If there is any question regarding the appropriateness of withholding or withdrawing medical care in such circumstances, **begin treatment and contact OLMC immediately for orders.**

C. **When instructed by an OLMC physician to withhold or withdraw medical care.**

1. In certain circumstances, a medical control physician can order further treatment to be withdrawn or withheld from a patient. This may occur, for example, when the patient remains in persistent monitored asystole after resuscitation per SOP or a question arises as to whether the patient's care is governed by an IDPH Uniform Do-Not-Resuscitate (DNR) Advance Directive or other valid DNR order. Medical control should be notified and, depending on the circumstances, may order further treatment withheld or withdrawn.

2. In these situations, thoroughly document the circumstances surrounding the call, describe the treatment withheld or withdrawn, along with the name of the medical control physician, and the time resuscitation was discontinued.

D. **When presented with a valid** IDPH Uniform Do-Not-Resuscitate (DNR) Advance Directive**.**

III. **DNR ORDERS**

A. The following System members are authorized to honor a valid DNR order: EMT; Paramedic; Prehospital RN; ECRN; ED physicians.

B. The IDPH Uniform Do-Not-Resuscitate (DNR) (POLST-compliant) Advance Directive can be used to create a physician order that reflects an individual's wishes about receiving *cardiopulmonary resuscitation (CPR) and life-sustaining treatments such as medical interventions and artificial administered nutrition*. It allows an individual, in consultation with his or her health care professional, to make advance decisions about CPR and other life-sustaining decisions, in the event the individual's breathing and/or heartbeat stop or they are at the end of life.

C. **DNR form**

1. After March 15, 2013, a valid DNR Advance Directive may, but need not, be in the form adopted by the Department of Public Health pursuant to Section 2310-600 of the Department of Public Health Powers and Duties Law (20 ILCS 2310/2310-600) known as the Illinois Department of Public Health Uniform Do-Not-Resuscitate (DNR) Advance Directive. The POLST compliant form is a revised version of the IDPH Uniform DNR Advance Directive.

a. Some patients may still have older versions of the form. A valid, completed form does not expire. When a new form is created, it voids past forms. Follow instructions on the form with the most recent date

b. The person does NOT need the original form – all copies of a valid form are also valid

c. The Form should travel with patient at all times

2. The form is intended to be honored across various settings, including hospitals, nursing homes, licensed long-term care facilities, with hospice and home-care patients, and by EMS personnel in the individual's residence or enroute to or from a health-care facility.

3. The 2013 IDPH DNR Advanced Directive form adds a greater level of specificity when it comes to decisions about cardiopulmonary resuscitation (CPR) and life sustaining and/or comfort measures including being intubated, placed on a ventilator and fed through a tube. The new IDPH DNR Advance Directive meets requirements to nationally be considered a Physician Order for Life-Sustaining Treatment (POLST) form.

   a. A POLST form is a signed medical order for documenting the life-sustaining treatment wishes of seriously ill patients. It travels with the patient to assure that treatment preferences are honored across settings of care.

   b. POLST is designed to honor the freedom of persons with advanced illness or frailty to have or to limit treatment across settings of care. POLST allows patients to choose all possible life-sustaining treatment, limited life sustaining interventions, or comfort care only. Comfort measures are always provided no matter what other choices patients make.

   c. A DNR (POLST) Advance Directive is intended for persons of any age for whom death within the next year would not be unexpected. This includes patients with advanced illness or frailty. POLST is not intended for persons with chronic, stable disability. Such individuals should not be mistaken for having an end-of-life determining illness. POLST would only be appropriate for such persons if their health deteriorates such that death within a year would not be unexpected.

   d. Having a POLST compliant DNR Advance Directive is completely voluntary. POLST orders can be revoked or changed by patients at any time.

   e. POLST compliant DNR Advance Directive forms are completed after patients discuss their preferences with health care professionals who can explain to them what may happen if different treatments are tried. The form serves as a guide for these discussions related to each person's unique medical condition and goals.

   f. The completed form is an actionable medical order.

   g. Health care providers and professionals are required by law to honor treatment choices shown on a POLST complaint DNR Advance Directive form. Because the form travels with the patient, it provides an immediate guide for first responders and emergency department staff about whether to even begin life-supporting care.

4. If presented with a document that contains all mandatory elements, but it is written on other than the IDPH Uniform DNR Advance Directive Form contact OLMC for orders.

D. **COMPONENTS OF A VALID DNR ORDER**

1. Name of the patient
2. Resuscitation orders (Section "A") must have one of the boxes selected.
3. Name, signature of the attending physician and date. Verbal orders signed by an RN are acceptable.
4. Date signed by physician (effective date). The validity of an order will not expire unless modified or revoked at any time by the maker.
5. Consent from Patient or Legal Representative Evidence of consent by one of the following:
   a. Signature of the patient
   b. Signature of another person legally authorized to act on that person's behalf such the individual's legal guardian, agent under a power of attorney for health care or a surrogate decision maker. *Priority order under Surrogate Act*
      (1) Patient's guardian of person
      (2) Patient's spouse or partner of a registered civil union
      (3) Adult child
      (4) Parent
      (5) Adult sibling
      (6) Adult grandchild
      (7) A close friend of the patient
      (8) Patient's guardian of the estate
   c. A parent or legal guardian typically may consent to a DNR order for a minor. Emancipated minors may consent to a DNR order.
6. Signature of **ONE** witness 18 years of age or older, who attests that the individual, other person, guardian, agent, or surrogate (1) has had an opportunity to read the form; and (2) has signed the form or acknowledged his or her signature or mark on the form in the witness's presence.. There are no limitations on who may be a witness. The witness may be a family member, friend, health-care worker or other competent adult.
7. All other information is optional.

E. **If any of the required elements are not completed in compliance with the Act, the order IS NOT VALID for EMS use.** The order is valid if the back or second page of the form has not been completed.

F. No verbal DNR orders will be honored by EMS personnel unless the patient's personal physician or coroner/medical examiner is present and has declared the patient dead. Document this information in the comments section on the patient care report.

G. **Implementing a DNR Advance Directive order**

1. Assess the patient's condition to determine whether or not they are in the process of dying from the condition that prompted the DNR Advance Directive Order and need to have the Order invoked. If the patient has an intervening condition causing death that is not related to the terminal illness or condition, e.g., choking or trauma, begin care per SOP.
2. Make a reasonable attempt to verify the identity of the patient named in the DNR Advanced Directive, e.g., identification by another person or an I.D. bracelet.

3. Determine if the DNR Advance Directive order contains all of the required elements as listed above. If not, begin resuscitation. "A health care provider may presume, in the absence of knowledge to the contrary, that a completed IDPH Uniform DNR Advance Directive or a copy of that form is a valid DNR Order" [Health Care Surrogate Act, 755 ILCS 40/65 Section 65, subsection (d)]. If there is any doubt as to the validity of a DNR order, begin BLS treatment and contact OLMC as soon as possible.

4. Check the form to determine the care to be given or withheld. There are three categories of instructions on the 2013 form: **CARDIOPULMONARY RESUSCITATION (CPR) if the patient has no pulse *and* is not breathing; MEDICAL INTERVENTIONS if the patient has a pulse and/or is breathing; and ARTIFICIALLY ADMINISTERED NUTRITION.** Follow orders on the form.

   a. **Section A:** Applies if patient is found in respiratory/cardiac arrest

      (1) If "Attempt Resuscitation" box is checked, EMS does **NOT** need to look at any other parts of the form. Initiate Resuscitation per SOP.

      (2) If "DNR" box is checked, do not begin CPR.

   b. **Section B**: Three categories explain the intensity of emergency treatment desired by patients who are still breathing or have a pulse

      (1) **Comfort Measures Only**: Maximize comfort; treat pain/distress per form options. If a patient selects this option, they generally prefer not to be transported. Once EMS is called, transport may be indicated. Consult w/ OLMC to determine appropriate actions. Maximize comfort in existing location and transport only if comfort needs cannot be met where found.

      (2) **Limited Additional Interventions:** Provide comfort measures plus CPAP, IV fluids, and ECG monitor as needed. Transport if indicated. Do not insert an advanced airway or provide mechanical ventilation.

      (3) **Intubation and Mechanical Ventilation**: provide full treatment

         (a) If the "Attempt CPR" box is checked in Section A, treat fully per SOP and ignore Section B.

         (b) The patient may not wish to be resuscitated if they experience a cardiorespiratory arrest, but still want everything done if they are breathing or have a pulse. Transport patient if indicated.

   c. Additional Orders is used to customize the form for individual medical conditions when necessary. Follow instructions listed here.

   d. EMS personnel can ignore Section C: Artificially administered nutrition.

5. Document the circumstances surrounding the use of the form and attach a copy to the EMS patient care report if possible. If impossible, record the following information from the DNR Advance Directive in the comments section of the EMS patient care report: physician's name; the effective date of the order; the name of the one giving consent and their relationship to the patient, if known; and the name of the witness. Include the nature of the terminal illness and the person who presented the order to EMS responders.

6. If resuscitation is already in process when a DNR order is produced, continue resuscitation, confirm the validity of the DNR order, and contact OLMC for instructions. Medical control should authorize cessation of all resuscitation.

7. If death occurs during transport and a valid DNR Advance Directive was produced, honor the DNR Order and contact OLMC for further orders.

8. If a person on the scene disputes a written DNR order, determine if they have durable power of attorney for healthcare for the individual or if they had provided consent to the DNR order as the designated surrogate. If yes, this person has a duty to base decisions on the patient's values and wishes and they may revoke the order. If no, contact OLMC immediately and inform them of the dispute. Family members or significant others who do not have the designation of agent or surrogate have no standing to overrule the DNR Order. Follow the direction of OLMC in situations of dispute.

9. If appropriate, notify the coroner/medical examiner according to System Policy M-5.

H. **Voiding or revoking a** DNR Advance Directive

1. A patient with decisional capacity can void or revoke the form, and/or request alternative treatment.

2. Changing, modifying or revising a DNR form requires completion of a new form.

3. Draw a line through sections A through E and write "VOID" in large letters if any DNR form is replaced or becomes invalid.

4. Beneath the written "VOID" write in the date of change and re-sign.

5. If included in an electronic medical record, follow all voiding procedures of the facility.

I. **Professional immunity for implementing a DNR order:**

Subsection (d) of Section 65 of the Health Care Surrogate Act, 755 ILCS 40/65, provides:

"A health care professional or health care provider may presume, in the absence of knowledge to the contrary, that a completed Department of Public Health Uniform DNR Order or a copy of that form is a valid DNR Order. A health care professional or health care provider, or an employee of a health care professional or health care provider, who in good faith complies with a do-not-resuscitate order made in accordance with this Act is not, as a result of that compliance, subject to any criminal or civil liability, except for willful and wanton misconduct, and may not be found to have committed an act of unprofessional conduct."

IV. **Durable Power of Attorney for Health Care Designation**

A. Since 1987, Illinois law has allowed persons to appoint an "agent" or "attorney in fact" to act on their behalf in making medical care decisions for them (principal) in the event that they are unable to make their own medical decisions.

B. An agent can be anyone other than the patient's physician and is appointed by the patient via a document called a **"Durable Power of Attorney for Health Care"**. One does not need an attorney to execute this form, nor does it have to be notarized. The Illinois Durable Power of Attorney Act recognizes the right of individuals to control all aspect of their personal care and medical treatment including the right to decline medical treatment or to direct that it be withdrawn, even if refusal of care will result in death.

C. The Act states that the right of an individual to decide about their personal care overrides the obligation of the physician and other health care providers to render care or to preserve life and health. The power given to the agent may be as broad or narrow as the patient wishes. The standard form grants the agent broad medical decision-making power that the patient may limit. The law does not, however, require that this particular form be used.

D. Other than withholding resuscitation, choices such as refusal of treatment or hospital preference can be verbally made on behalf of the patient by authorized persons within the relationship created by the Power of Attorney. The Agent's ability to make decisions can be designated to begin at any time the patient chooses. They do not have to be in a terminal condition, unlike a Living Will.

E. If both documents are executed, a Durable Power of Attorney supersedes a Living Will.

F. **A health care agent has no authority if the patient is alert and is able to communicate.** If the patient is alert and consents to treatment, continue to treat them, even if thereafter they are unable to communicate with you. In such situations, the health care agent has no authority over the treatment of the patient.

G. **If someone claims to have Power of Attorney to make healthcare decisions for the patient, follow these guidelines**:

1. Begin treatment of the patient per SOPs. Immediately inform OLMC that a health care agent for the patient is present. Follow all orders of the OLMC physician, even if such orders contradict the instructions being given by the "agent".

2. As soon as is practical, ask the agent for the Illinois Statutory Power of Attorney for Health Care form. The form should be complete, including:

   a. Patient's (principal's) name and address;
   b. Agent's name and address;
   c. Date of execution;
   d. Effective date of Power of Attorney (may not be mandated by Ill. law);
   e. Powers granted to the agent;
   f. Date Power of Attorney terminates (may not be mandated);
   g. Signature of the patient (principal);
   h. Signature of a witness; and
   i. Specimen signatures of the agent (not mandated by Illinois Law).

3. Examine the form to see if it is complete. Ask the agent to verify his/her signature. Review the form to **see what medical authority has been given to the agent**. Ask the agent to point out the language that confirms that the Power is in effect and that it covers the situation at hand.

   a. If form is incomplete, agent's authority to make decisions is not recognized.

   b. If the form is complete, notify OLMC about the presence of a health care agent on scene and **follow the instructions of the agent unless instructed otherwise by medical control**.

   c. **EXCEPTION: EMS cannot honor a verbal or written DNR request or order made directly by a surrogate decision maker or healthcare power of attorney agent**. Agents can provide consent to a DNR order, but the order, itself, must be signed by a physician. The physician is responsible for determining if a power of attorney agent, surrogate decision maker or other person has proper authority to give consent to the DNR.

4. Document the names of the patient and agent and powers given to the agent on the patient care report. Bring the Power of Attorney form to the hospital.

5. If there is any doubt as to the identity of the agent, the validity of the document, the extent of the authority of the agent, or if communications with OLMC cannot be established, **continue treatment per SOP and/or OLMC and transport ASAP**.

V. **LIVING WILLS AND PATIENT SURROGATES**

A. Illinois law has allowed terminally ill patients to instruct their physician, either directly with a Living Will (since 1983), or indirectly through a patient surrogate (since 1991), on their treatment in near-death situations.

B. A **Living Will** is a declaration to a physician and does not go into effect until the person who makes it is in a terminal condition. A terminal condition is defined as "an incurable and irreversible condition which is such that death is imminent and the application of death delaying procedures serves only to prolong the dying process." In order to create a Living Will, the author must be a competent adult and the document must be witnessed.

C. **The Health Care Surrogate Act** is enacted when an adult or minor: (1) lacks decisional capacity; (2) has a qualifying condition; and (3) has no Living Will or Power of Attorney for Health Care.

1. Implementation of this act falls on the physician who must declare that the patient lacks decision-making capacity. The attending physician needs at least one physician consult who agrees that the patient has a qualifying condition. The surrogate is then nominated by the primary physician in the order of priority set by the law.

2. **Prehospital providers shall not follow the instructions contained in a Living Will or given by any person purporting to be a surrogate** for the patient unless affirmed by a medical control physician.

VI. **MINORS**: Minors (unless emancipated) cannot execute advance directives. The parent or guardian "stands in place" at all times and can provide consent to written DNR orders executed by a physician. **Unless there is a valid written DNR Order, all minors should be resuscitated**.

VII. **QUALITY IMPROVEMENT:** The System will review patient care reports where medical care has been withheld or withdrawn pursuant to a DNR order through the PBPI process. The System shall submit an annual report to IDPH if requested indicating issues or opportunities for improvement that have been identified and the System's responses to those issues or opportunities.

VIII. **EDUCATION:** System personnel will receive continuing education concerning the provision of these policies as changes in the law or System policy require or in response to sentinel events which reveal learning opportunities. Information shall be disseminated through the In-Station continuing education program and to ECRNs through EMS CE at their hospitals.

IX. **Other resources relative to the governing provisions of law:**

Nursing Home Care Act	Emergency Medical Services (EMS) Systems Act
Hospital Licensing Act	Illinois Living Will Act
Health Care Surrogate Act	Mental Health Treatment Preference Declaration Act
Illinois Power of Attorney Act	

For more information about the IDPH Uniform Do Not Resuscitate Advance Directive, or to download a Form, log onto http://www.idph.state.il.us/public/books/advin.htm

The POLST Illinois Task Force is a volunteer coalition of doctors, nurses, clergy, social workers, attorneys, paramedics, and administrators from hospitals, emergency medical systems, hospices, and long term care facilities. The Task Force supports every person in exercising his or her right to accept or decline medical treatment. For more information, go to: www.polst.org or www.cecc.info .

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