TERMINATION OF RESUSCITATION
STATEWIDE ALS GUIDELINE

Purpose:
A. When there is no response to prehospital cardiac arrest treatment, it is acceptable and often preferable to cease futile resuscitation efforts in the field.
   1. In patients with cardiac arrest, prehospital resuscitation is initiated with the goal of returning spontaneous circulation before permanent neurologic damage occurs. Unfortunately, most patients do not respond to an aggressive resuscitation attempt. In most situations ALS providers are capable of performing an initial resuscitation that is equivalent to an in-hospital resuscitation attempt, and there is usually no additional benefit to emergency department resuscitation in most cases.
   2. CPR that is performed during patient packaging and transport is much less effective than CPR done at the scene. Additionally, EMS providers risk physical injury while attempting to perform CPR in a moving ambulance while unrestrained. In addition, continuing resuscitation in futile cases increases the time that EMS crews are not available for another call, impedes emergency department care of other patients, and incurs unnecessary hospital charges.
   3. When cardiac arrest resuscitation becomes futile, the patient’s family should become the focus of the EMS providers. Families need to be informed of what is being done, and transporting all cardiac arrest patients to the hospital is an inconvenience and inconveniences the grieving family by requiring a trip to the hospital where they must begin grieving in an unfamiliar setting. Most families understand the futility of the situation and are accepting of ceasing resuscitation efforts in the field.

Criteria:
A. Any cardiac arrest patient that has received resuscitation in the field but has not responded to treatment, AND a medical command physician has ordered termination of resuscitation efforts.
   1. Consider field termination of resuscitation in the following situations:
      a. There is no response to approximately 20 minutes of ALS care including ventilation with advanced airway and several “rounds” of resuscitation drugs.
      b. During resuscitation, new information related to DNR or terminal medical condition is obtained. If patient has OOH-DNR order, must follow OOH-DNR Protocol #324 before this protocol.
      c. BLS care when AED has advised “no shock” on 3 sequential analyses, and the patient cannot arrive at a hospital or ALS cannot arrive at the patient within 15 minutes.

Exclusion Criteria:
A. Consider continuing resuscitation and transporting patients with the following conditions (although under certain circumstances, a medical command physician may order termination of resuscitation in these conditions also):
   1. Cardiac arrest associated with medical conditions that may have a better outcome despite prolonged resuscitation, including:
      a. Hypothermia
      b. Near-drowning
      c. Lightning strike
      d. Electrocution
      e. Drug overdose
   2. Cardiac arrest in infants and children
   3. Cardiac arrest in a public place
   4. Cardiac arrest in an environment where the bystanders do not accept the idea of ceasing efforts in the field. While most families understand the futility of the situation and are very accepting of field termination, some family members or bystanders can become hostile.
System Requirements:

A. Ideally, the EMS agency medical director should be involved in the decision to begin a program of terminating resuscitation in the field. Each agency should develop policies (e.g. related to transportation of bodies) and should make proactive contacts with key individuals (e.g. the coroner/ medical examiner, local nursing homes). Every ALS provider that participates in this process should have training related to “breaking bad news”, dealing with grieving individuals, and interpersonal skills.

Procedure:

A. All Patients:

1. Follow appropriate resuscitation protocol to the point of “Contact Medical Command” to consider termination of resuscitation. Verify appropriate patient:
   a. No femoral pulse
   b. No respiratory efforts
   c. Aystole or wide complex PEA at < 60 BPM
2. Contact medical command. **EMS providers may terminate resuscitation only after order from a medical command physician.**
3. Terminate resuscitation efforts and document time of death.
4. Consider the possibility of a crime scene. If suspected, restrict access (if possible) and notify law enforcement immediately. See Crime Scene Preservation Guideline #919.
5. Inform any family at the scene of the patient's death and facilitate early grieving.
6. Contact the coroner or medical examiner
   a. Do not move the body or remove any resuscitation adjuncts (e.g. endotracheal tube or IV lines) until given permission by the coroner or medical examiner.
7. Provide for dignity. If the coroner has given permission:
   a. Remove airway devices and IV catheters
   b. Place the patient in a position that appears comfortable
   c. Clean up debris from the resuscitation
8. Assist the family.
   a. Offer to call a friend, pastor, or funeral director.
   b. Consider notifying the patient's primary care physician.
   c. Do not leave the scene until the family has adequate support.
9. Consider calling the local organ donation program [800-DONORS1 (Eastern PA) or 800-DONORS7 (Western PA)] for the family. Many individuals can donate corneas, skin grafts or bone grafts.
10. It is not generally the role of EMS to transport bodies, and this is usually handled by funeral directors or medical examiner offices. In some situations, EMS agencies may have a policy that permits transport of deceased patients to a local morgue for the coroner or to a local funeral director. These arrangements should not take EMS vehicles out of service for an extended time to perform these services.

Notes:

1. In remote or wilderness situations, EMS providers **must** make every effort to contact medical command, but resuscitation may be terminated in the field without medical command when the following have occurred:
   a. There has been no return of pulse despite >30 minutes of CPR (This does not apply in the case of hypothermia)
   b. Transport to an emergency department will take > 30 minutes (This does not apply in the case of hypothermia)
   c. The EMS providers are exhausted and it is physically impossible to continue the resuscitation