

WHEN NOT TO START

Resuscitation efforts should be withheld or discontinued under the following circumstances:

- **VALID DO NOT RESUSCITATE ORDER:** Refer to [DNR, POLST & Advanced Directives Protocol 8.8](#).
- **SCENE SAFETY:** The physical environment is not safe for providers.
- **DEAD ON ARRIVAL (DOA):** A person is presumed dead on arrival when all five “Signs of Death” are present **AND** at least one associated “Factor of Death” is present.

Signs of Death (All five signs of death must be present)

- Unresponsiveness.
- Apnea.
- Absence of palpable pulses at carotid, radial, and femoral sites.
- Unresponsive pupils.
- Absence of heart sounds.

Factors of Death (At least one associated factor of death must be present)

- Damage or destruction of the body incompatible with life, such as:
 - ✓ Decapitation.
 - ✓ Decomposition.
 - ✓ Deforming brain injury.
 - ✓ Incineration or extensive full thickness burns.
- Lividity/Rigor mortis of any degree.
- Major blunt or penetrating trauma incompatible with life.



Patients with ventricular assist devices (VAD) should almost never be pronounced dead at the scene, see [VAD Policy 8.20](#).

SUDDEN UNEXPLAINED INFANT DEATH SYNDROME (SUIDS).

- An infant <12 months who is apneic, asystolic (no heartbeat or umbilical cord pulse), and exhibiting lividity and/or rigor mortis should be presumed dead.
- For unexpected, unexplained infant death, record carbon monoxide level in room where infant was found unresponsive, if possible.

NEONATE:

- A neonate who is apneic, asystolic, and exhibits either neonatal **maceration** (softening or degeneration of the tissues after death in utero) or **anencephaly** (absence of a major portion of the brain, skull, and scalp) may be presumed dead.
- Contact **Medical Control** if gestational age is less than 20 weeks and neonate shows signs of obvious **immaturity** (e.g., translucent and gelatinous skin, lack of fingernails, fused eyelids).



NOTE: Infant and/or neonatal resuscitation and transport may be initiated in cases where the family does not accept the idea of nonintervention.

Policy Continues 

8.16 Resuscitation Initiation and Termination

Policy Continued

Resuscitation may be stopped under the following circumstances:

EMT/ADVANCED EMT STANDING ORDERS – ADULT & PEDIATRIC

E/A


- The physical environment becomes unsafe for providers.
- The exhaustion of EMS providers.
- The automatic external defibrillator has advised “no shock” for 20 minutes and Paramedic/hospital care is not available within 20 minutes (hypothermia is an exception) and the ETCO₂ is less than 20 mmHg (if available).
- Extrication is prolonged (>15 minutes) with no resuscitation possible during extrication (hypothermia is an exception).
- If directed to do so by **Medical Control**

PARAMEDIC STANDING ORDER – ADULT & PEDIATRIC

P



- Asystole and slow wide complex PEA
 - If there is no return of spontaneous circulation after 20 minutes in the absence of hypothermia and the ETCO₂ is less than 20 mmHg.
- Narrow complex PEA with a rate above 40 or refractory and recurrent ventricular fibrillation / ventricular tachycardia
 - Consider early expert consultation with **Medical Control**
 - Consider resuscitation for up to 60 minutes from the time of dispatch.
 - Termination efforts may be ceased before 60 minutes based on factors including but not limited to ETCO₂ less than 20 mmHg, age, co-morbidities, distance from, and resources available at the closest hospital.

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- For narrow complex PEA with a rate above 40 or refractory and recurrent ventricular fibrillation / ventricular tachycardia, termination efforts may be ceased before 60 minutes based on factors including but not limited to ETCO₂ less than 20 mmHg, age, co-morbidities, distance from, and resources available at the closest hospital. Consider expert consultation with on-line medical control.
 - EMS providers are not required to transport every victim of cardiac arrest to a hospital. Unless special circumstances are present, it is expected that most resuscitations will be performed on-scene until the return of spontaneous circulation or a decision to cease resuscitation efforts is made based on the criteria listed under “when to stop” (above). Transportation with continuing CPR may be justified if hypothermia is present or suspected. Current AHA guidelines state: “cessation of efforts in the out-of-hospital setting...should be standard practice.”

PEARLS:

- For patients that do not achieve return of spontaneous circulation on scene, termination of resuscitation should be considered before the patient is loaded into the ambulance for transport.

Policy Continues

Policy Continued

DETERMINING DEATH IN THE FIELD

When efforts to resuscitate are not initiated or are terminated under the above provisions, EMS providers shall:

- Document time of death.
- Notify law enforcement.
- Consider possibility of a crime scene and restrict access.
- Any decision to move the body must be made in collaboration with law enforcement and the medical examiner.
- Leave any resuscitation adjuncts such as advanced airway devices, IV/IO access devices, electrode pads, etc., in place.
- Inform family on scene of patient's death and offer to contact family, friends, clergy, or other support systems.

The above requirements apply to situations in which law enforcement or the medical examiner may take jurisdiction. Law enforcement and the medical examiner are not required to take jurisdiction of hospice or other patients who are known to have been terminally ill from natural causes or congenital anomaly, and death was imminent and expected. Where law enforcement is not involved, EMS providers may provide appropriate assistance to families or other caregivers.

Mass Casualty Incident (MCI): [See MCI Protocol 9.1.](#)

Documentation

- Complete a Patient Care Record (PCR) in all cases. If available, include ECG rhythm strips with the patient care report.
- Document special orders including DNR, on-line Medical Control, etc.
- MCI conditions may require a triage tag in addition to an abbreviated PCR.
- Record any special circumstances or events that might impact patient care or forensic issues.