



## EMERGENCY CARE GUIDELINES FOR RESUSCITATION

**RATIONALE FOR THIS DOCUMENT** - The existing standard of emergency care involves aggressive resuscitation including CPR as defined below. The purpose of this document is to allow an individual the option of limiting emergency care when appropriate. Our goal is to provide consistent language and documentation between a hospital, long-term care facility, home health care setting, other setting and emergency providers. The document may be used in any setting where emergency care is needed. A legal document, with physician involvement, directs health care providers in responding to emergency calls. If the document is appropriately completed and signed, emergency care can be provided at the level determined by the patient and physician. The patient has the right to revoke these restrictions at any time.

A. **DEFINITIONS** - The following terms are used in the chart and defined briefly below:

1. **CPR (Cardiopulmonary Resuscitation)** - This is the process of chest compression and artificial breathing in the event of cardiopulmonary arrest as defined by the American Heart Association. Advanced levels of CPR mandate airway management, ventilatory assistance, chest compressions, defibrillation and use of appropriate drugs. The category of CPR implies full resuscitation, using any or all of the above techniques as appropriate.
2. **DNR (Do Not Resuscitate) (No CPR)** - This category does involve active and aggressive medical treatment intended to sustain life up to the point of beginning CPR. If a person is found in full cardiopulmonary arrest, no treatment would be provided. If the first person finding the patient has a question about whether or not a pulse or spontaneous breathing exists, 911 should be called and the paramedics summoned to determine the patient's status.
3. **HOSPICE OR COMFORT CARE INCLUDING DNR** - This category is appropriate for patients who request death-allowing care, knowing that death is expected and prolongation of life is not a goal. Care is intended to provide comfort and attention to basic human needs, allowing life to continue "as is," without medical intervention to sustain or prolong life beyond the natural course of events. In general, calling 911 is not appropriate for patients in this category. In situations where there are immediate needs for choking, pain relief or comfort, 911 may be called.

B. **SPECIFIC GUIDELINES FOR FORM COMPLETION:** After discussing the treatment options, one of the three categories should be checked. The levels of care are to be explained to the patient and/or family/loved ones by the physician or his/her designee. The definitions are to remain consistent, and are indicated above. Documentation by the physician is important in the patient's permanent record and should include:

1. the rationale for DNR or comfort care, including DNR;
2. the basis of determining patient competency; and
3. the significant parties involved in the decision, and their relationship to the patient.

The original form should remain with the patient, with copies to the permanent record and physician's office.

**THREE SIGNATURES AND THREE DATES ARE REQUIRED FOR THIS DOCUMENT TO BE VALID AND ITS INTENT CARRIED OUT.**

1. **PATIENT/CLIENT or AUTHORIZED SIGNATURE:**

- a. The Patient, when of sound mind, may knowingly limit his/her own care.
- b. A Proxy pursuant to Minnesota Statutes, Chapter 145 B, an Agent pursuant to Minnesota Statutes, Chapter 145 C, a Court Appointed Guardian or Conservator (with specific powers to make health care decisions) may sign on behalf of a legally incompetent person.
- c. Next of Kin or Knowledgeable Loved One(s) may sign in consultation with the physician using the concept of "substituted judgment" whereby the above individuals decide what the patient would want were he or she able to express himself or herself.

2. **WITNESS:** This signature is to be obtained at the time a third party witnesses the signature of the patient, proxy, agent, court appointed guardian or conservator, or next of kin or loved one. If a physician designee is involved in the actual discussion and form completion, that person should sign as witness.

3. **PHYSICIAN'S SIGNATURE:** This signature is required, but may be completed at a later date if a physician designee is involved in the actual discussion and form completion.

It is recommended that this document be reviewed periodically; however, the document remains valid indefinitely unless revoked by the individual.

