Administrative Policies and Procedures

2022 Edition
Effective October 1, 2022

Lord Fairfax EMS Council, Inc.
180-1 Prosperity Drive
Winchester, Virginia 22602
Phone 540-665-0014 Fax 540-722-0094
www.lfems.vaems.org

TABLE OF CONTENTS

ADMINISTRATIVE POLICIES AND PROCEDURES

REVISION HISTORY

Description of Change	Change Effective Date
Original Document	03/15/2007
Revised and Approved by MDB	08/22/2008
Revised and Approved by MDB	05/08/2009
Approved with no revisions by Board of Directors	06/09/2010
Approved with no revisions by Board of Directors	06/08/2011
Approved with no revisions by Board of Directors	06/12/2013
Revised and Approved by MDB	05/15/2017
Approved with no revisions by Board of Directors	06/21/2017
Approved with no revisions by Board of Directors	04/18/2018
Revised and Approved by MDB	02/14/2019
Approved with no revisions by Board of Directors	08/29/2019
Approved with no revisions by Board of Directors	08/19/2020
Approved with no revisions by Board of Directors	05/17/2021
Revised and Approved by MDB	06/14/2022

AUTHORIZATION

The Lord Fairfax Emergency Medical Services (EMS) Council Pre-Hospital Standard Patient Care Treatment Protocols are developed by the LFEMSC Medical Direction Board (MDB). The mission of the Medical Direction Board, a standing committee, is to delineate medical practice standards for emergency medical services in the Lord Fairfax EMS Council region. The committee provides regular review and revision of these standards. Activities and actions by the committee are reported to the Lord Fairfax EMS Council Board of Directors for their information.

Each Agency EMS Physician must approve the protocols and has the authority to limit or expand implementation of protocols within their agency. Virginia Emergency Medical Services Regulations 12VAC5-31-1890, Responsibilities of Operational Medical Directors, grant authority to establish and enforce protocols, policies, and procedures. All prehospital medical care is carried out with the express written authority of the EMS Physician and under their supervision. Virginia Emergency Medical Services Regulations 12VAC5-31-1040, Operational Medical Director Authorization to Practice, states "EMS personnel may only provide emergency medical care while acting under authority of the operational medical director for the EMS Agency for which they are affiliated and within the scope of the EMS Agency License."

Drugs may be administered by an Emergency Medical Technician upon an oral or written order or standing protocol of an authorized medical practitioner in accordance with §54.1-3408 of the Code of Virginia.

The following LFEMS EMS Physicians approve the use of the Lord Fairfax Emergency Medical Services Council Pre-Hospital Patient Care Treatment Protocols by his / her respective EMS agencies for which he/she serves as an EMS Physician.

_____ _____
C. Christopher Turnbull, MD Date
Clarke County Fire and EMS Department / Winchester Fire and Rescue Department
Valley Medical Transport, Inc. / Regional EMS Physician

_____ _____
John C. Potter, MD Date
Mount Weather Fire and Rescue Department

_____ _____
Joel T. Grant, MD Date
Frederick County Fire and Rescue Department

_____ _____
David A. Rosie, DO Date
Page County Fire and EMS Department

_____ _____
Nazir A. Adam, MD Date
Shenandoah County Department Of Fire and Rescue

_____ _____
T. Preston Bennett, MD Date
Warren County Department Of Fire and Rescue

AUTHORIZATION TO PRACTICE IN THE LORD FAIRFAX EMS COUNCIL REGION

The 2022 Edition of the Pre-Hospital Standard Patient Care Treatment Protocols is to be utilized within the Lord Fairfax EMS Council (LFEMSC) by authorized Basic and Advanced Life Support (BLS and ALS) personnel to provide life-saving treatment.

Authorization to function at the Basic and Advanced Life Support level within the LFEMSC pursuant to these guidelines and standing orders shall not be valid without the endorsement of the Agency EMS Physician.

Authorization to Practice may be withdrawn under such conditions as, but not necessarily limited to, intoxication / substance abuse while on duty, practicing without a valid BLS or ALS certification, failure to comply with LFEMSC BLS and ALS Standards and Regional Protocols or failure to comply with requests / directions of the Agency EMS Physician, LFEMSC Regional EMS Physician, and/or LFEMSC Medical Direction Board.

Any Emergency Department Physician in the LFEMSC Region who feels that there is reasonable cause to immediately, but temporarily withdraw, the Authorization to Practice, may do so according to this policy. In circumstances where it is necessary for an Emergency Department Physician to immediately withdraw the Authorization to Practice, he / she must immediately inform:

1. The BLS or ALS provider's immediate supervisor.
2. The BLS or ALS provider's Jurisdictional EMS Coordinator.
3. The LFEMSC Agency EMS Physician or Chairman of the Medical Direction Board.
4. The Virginia Office of Emergency Medical Services Program Representative.

When an immediate withdrawal of Authorization to Practice occurs, a meeting of the LFEMSC Medical Direction Board shall be called at the earliest possible opportunity to review the circumstances of the case, and shall make recommendations to the LFEMSC Regional EMS Physician for resolution.

****THIS BOX IS TO BE COMPLETED BY THE AGENCY OPERATIONAL MEDICAL DIRECTOR****

*****This provider is authorized to provide care at the _____ level.*****

_____
Agency EMS Physician

_____
Date

THIS IS NOT A CONTRACT

I have attended a Pre-Hospital Standard Patient Care Treatment Protocols session and acknowledge receipt of this authorization.

_____ _____
Provider Signature *Print Name and Certification Number*

_____ _____
Agency Affiliation *City / County*

_____ _____
Instructor, Protocols Class (Signature) *Date of Protocols Class*

1. The Agency EMS Physician is ultimately responsible for all BLS and ALS practiced in this area. Therefore, the Agency EMS Physician has the right to suspend EMS providers who fail to perform his / her duty as trained and/or fail to follow established Pre-Hospital Standard Patient Care Treatment Protocols.
2. The Medical Direction Board (MDB) must approve changes in medical procedures and Pre-Hospital Standard Patient Care Treatment Protocols.
3. In order to practice as an EMS provider, the EMS provider must have the approval of each EMS Agency and Agency EMS Physician to act as an Attendant-In-Charge within the Lord Fairfax EMS Council Region.
4. EMS providers may only provide care that has been approved by the Agency EMS Physician and Medical Direction Board, for their respective level of certification.
5. In special situations, an on-line physician may authorize an EMS provider to perform a procedure outside the Regional Protocols but within their Scope of Practice of the EMS provider's certification level. The physician must sign the Patient Care Report (PCR) indicating authorization to perform a procedure.
6. If it has been determined or alleged that a provider flagrantly exceeds the authority given to him / her by the Agency EMS Physician, Medical Direction Board, LFEMSC Pre-Hospital Standard Patient Care Treatment Protocols, or the Virginia Department of Health, Office of Emergency Medical Services Rules and Regulations, the misconduct shall be reported to the EMS provider's immediate supervisor, Jurisdictional EMS Coordinator, EMS Provider's Agency EMS Physician, LFEMSC Regional EMS Physician, and/or the Virginia Office of Emergency Medical Services Program Representative immediately. A copy of the PCR and written summary of the potential violation shall be completed within 24 hours of occurrence and forwarded to provider's immediate supervisor, Jurisdictional EMS Coordinator, Provider's Agency EMS Physician, LFEMSC Regional EMS Physician, and/or the Virginia Office of Emergency Medical Services Program Representative. If the violation is detrimental to patient care, the provider may be suspended from practicing by their Agency EMS Physician, LFEMSC Regional EMS Physician, or Virginia Office of Emergency Medical Services Program Representative for the LFEMSC region.
7. A formal investigation of the incident shall be conducted and completed within 5 business days of the alleged violation. The investigation team shall consist of a minimum of 3 personnel and a maximum of 5 personnel. The EMS provider's immediate supervisor, Jurisdictional EMS Coordinator, or Agency EMS Physician will select the investigation team members. The investigation team will make recommendations for possible disciplinary measures. Note: (Personnel issues are confidential matters and must be handled with caution.)

8. All issues that cannot be resolved locally to the satisfaction of all those concerned should be reported to the LFEMSC to bring before the Medical Direction Board for recommendation.
9. If ALS care is initiated, an ALS provider who can provide care equal or higher to that initiated **must** accompany the patient in the patient compartment.
10. All EMS personnel are highly encouraged to attend all meetings where EMS calls run by their agency are discussed, and where both practical and lecture materials are reviewed.
11. ALS providers at the Intermediate and Paramedic levels are required to be certified in and maintain certification in the American Heart Association (AHA) or American Safety and Health Institute (ASHI) Advanced Cardiac Life Support (ACLS) Course to be "Authorized to Practice" within the region. ALS providers at the Intermediate and Paramedic levels are required to be certified in the American Heart Association (AHA) or American Safety and Health Institute (ASHI) Pediatric Advanced Life Support (PALS) Course to be "Authorized to Practice" within the region.
12. EMS providers are responsible for meeting their continuing education requirements. All required National Core Curriculum Requirements-NCCR (old Category One), Local Core Curriculum Requirements-LCCR (old Category Two), and Individual Core Curriculum Requirements-ICCR (old Category Three) continuing education hours must be completed prior to recertification.
13. Any EMS Agency, Jurisdictional EMS Coordinator, and/or Agency EMS Physician has the authority to implement more stringent processes than listed in these Administrative Policies and Procedures.
14. All EMS providers must demonstrate skill proficiency to their Jurisdictional EMS Coordinators or their designee in the setting of a skills drill as required by Agency EMS Physician**.**
15. EMS providers who are trained outside the LFEMSC region must complete the requirements established by the LFEMSC and any additional requirements by the provider's agency regardless of prior experience.

PRE-HOSPITAL TERMINATION OF RESUSCITATION EFFORTS

Research has shown that in certain instances resuscitation efforts are futile or become futile. It is well documented that most crashes involving emergency vehicles occur while the vehicle is in an emergency response mode (e.g., lights and siren). In order to decrease the chances of a crash occurring while transporting a futile case, BLS and ALS providers in the Lord Fairfax EMS Council Region may ask Medical Control for permission to cease resuscitation efforts under the following conditions:

1. The patient has received full ACLS treatment and has remained in **asystole**. This means that the patient has had vascular access established, received ACLS medications, and has had adequate ventilations, and has not had a Return of Spontaneous Circulation (ROSC) **after twenty (20) minutes of therapy.**

2. If all of #1 applies but the patient has **Pulseless Electrical Activity (PEA)** and has not had any period of ROSC **after twenty (20) minutes of therapy**.

3. If the patient is discovered to be a DNR, with appropriate documentation, after resuscitation has begun.

4. When resuscitation was begun inappropriately by the first responding units / those with a lower level of training, e.g., CPR begun on a patient that meets no resuscitation criteria: decapitation, rigor mortis, etc.

5. Multi-system trauma victim(s) without vital signs on the scene **should not** have CPR started. Adult and pediatric patients found dead at the scene of a trauma are not to be resuscitated unless they have a viable ECG rhythm (INT, PM), are hypothermic, recently drowned, or electrocuted.

6. When there is no available ALS provider available, and CPR has continued for at least twenty (20) minutes per AHA guidelines.

If any of the above situations apply, then resuscitation will continue until the physician at Medical Control gives permission to stop. **You should speak directly to the physician**. Note on the Patient Care Report the date and time resuscitations efforts were stopped. After resuscitation efforts have ceased, the patient may need to be transported to the hospital if required by Medical Control and/or Medical Examiner. The need for transportation should be decided between the provider and Medical Control and/or Medical Examiner. If EMS transports the patient, this should be **in a non-emergency mode.**

REMEMBER, THIS IS NOT A STANDING ORDER, BUT IS UP TO THE PHYSICIAN AT MEDICAL CONTROL.

PRE-HOSPITAL AIR MEDICAL GUIDELINES

PURPOSE

To provide Pre-Hospital Emergency Medical Service (EMS) personnel with a uniform method of accessing and using Pre-Hospital Air Medical Transport, within the Lord Fairfax EMS Council region.

SCOPE AND INTENT

This procedure applies to patient care situations where Air Medical Transport would be used for medical care and/or transportation of a patient or patients to the most appropriate medical facility.

DECISION MAKING PROCESS FOR USING Air Medical Transport

1. EMS providers should pre-alert helicopters in advance of scene arrival due to dispatch information received per criteria listed below.
2. If the ground-based EMS unit is uncertain as to the appropriate transport form, you should contact the nearest Medical Control Center.
3. If a ground-based EMS unit determines that a need exists for the use of Air Medical Transport, the requesting EMS unit will contact the appropriate 9-1-1 / Emergency Communications Center to request the appropriate service.

CRITERIA INDICATING CONSIDERATION / NEED FOR AIR MEDICAL TRANSPORT

Any of the following:

- Paralysis
- Major amputations
- Acute trauma with a GCS less than or equal to 12
- Penetrating injury of the head / neck / torso / upper thighs
- Crush injury to torso / upper thighs
- Two or more long bone fractures
- Burns – 10% Body Surface Area (BSA) for 10 years of age and under or 50 years of age and over, 20% Body Surface Area (BSA) with suspected airway involvement for all other age groups. Consider early contact with **[Medical Control]** for consultation regarding patient status and transport considerations.
- Drowning
- ST-Elevation Myocardial Infarction (STEMI) – with extended ground transport times greater than 30 minutes.
- Acute stroke (less than 6 hours from initial onset of symptoms) – with extended ground transport times greater than 30 minutes.
- Provider discretion

EMS Providers should use the helicopter for the above criteria when ground transport times are longer than air transportation to the appropriate medical facility (i.e., Trauma Center, STEMI Center, Stroke Center).

Other considerations for Pre-Hospital Air Medical Transport:

- Vehicle rollover in which there are unrestrained passengers
- Pedestrian struck by a car going greater than 20 mph
- Falls – Adults > 20 feet (one story equals 10 feet); Children > 10 feet or 2 to 3 times the height of the child
- Motorcyclist thrown from the motorcycle at speed over 10 mph
- Collision causing death of an occupant in same vehicle
- Ejection of a patient from the vehicle

- Ground transport time more than 15 minutes when trauma center needed
- Entrapped patient where extrication time is > 15 minutes
- Limited ground resources and their use would take away available EMT's for the area
- Chest tube or needle chest decompression required
- Multiple trauma
- Neonatal or pediatric intensive care needed
- Burn center treatment needed
- Limb reimplantation / amputation

The ground transport unit shall provide the following information when requesting Pre-Hospital Air Medical Transport:

1. The EMS Agency Name, Unit Number, and the name of the person communicating with the 9-1-1 / Emergency Communications Center.
2. The number of patients requiring Pre-Hospital Air Ambulance Transport.
3. General information concerning the condition of the patient(s). Include Glasgow Coma Scale and Trauma Scores when applicable.
4. Report on the location of the incident (route numbers, cross streets, mile markers, etc.), time needed to extricate patient, estimated transport time to hospital, landing zone location and availability, and environmental conditions.

Regulations governing the Durable Do Not Resuscitate (DDNR) program, adopted by the Virginia State Board of Health, became effective November 19, 2016. These regulations amend the original EMS Durable Do Not Resuscitate (DDNR) regulations and establish a DDNR order that follows the patient throughout the entire health care setting. Once issued by a physician, with whom the patient has an established bona fide physician / patient relationship, as defined by the Virginia Board of Medicine in their current guidelines, only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf.

> **Note:** Licensed Nurse Practitioners have authority to write Do Not Resuscitate (DNR) Orders in accordance with §§ 54.1-2957.02 and 54.1-2987.1 of the Code of Virginia and 18VAC90-30-120 of the Virginia Administrative Code. The authority for a Licensed Nurse Practitioner to write DNR orders must be included in the written or electronic practice agreement as a delegated act by the collaborating patient care team physician and must be performed in consultation with the physician unless the Licensed Nurse Practitioner has been authorized by the board for autonomous practice.
>
> **Note:** Physician Assistants have authority to write Do Not Resuscitate (DNR) Orders in accordance with §§ 54.1-2952.2 and 54.1-2987.1 of the Code of Virginia and 18VAC85-50-101 of the Virginia Administrative Code. The authority for a Physician Assistant to write DNR orders must be included in the written protocol as a delegated act by the supervising physician and must be performed in consultation with the physician.

Durable Do Not Resuscitate (DDNR) orders or "other" orders regarding life-prolonging procedures executed in accordance with the laws of "another state" shall be deemed valid and given effect.

Qualified EMS Personnel shall comply with the following general procedures and published Virginia Durable Do Not Resuscitate Order Implementation Protocols when caring for a patient who is in cardiac or respiratory arrest and who is known or suspected to have a DDNR Order in effect.

Initial assessment and intervention. Perform routine patient assessment and resuscitation or intervention until a valid DDNR Order, Alternate DNR Jewelry, or Other DNR Order can be confirmed as follows:

1. Determine the presence of the a Durable Do Not Resuscitate Order, approved Alternate DNR Jewelry, or Other DNR Order.

2. If the patient is within a qualified health care facility or in transit between qualified health care facilities, EMS Personnel may honor an Other DNR Order as set for in the Code of Virginia § 12VAC5-66-60.

3. Determine that the Durable DNR form or Alternate DNR Jewelry is not altered.

4. Verify, through driver's license or other identification with photograph and signature or by positive identification by a family member or other person who knows the patient, that the patient in question is the one for whom the Durable DNR Order, Alternate DNR Jewelry, or Other DNR Order was issued.

5. If the Durable DNR Order, Alternate DNR Jewelry, or Other DNR Order is intact, unaltered, and verified as issued for the patient, EMS Personnel may consider the Durable DNR Order to be valid.

Resuscitative measures to be withheld or withdrawn. In the event of cardiac or respiratory arrest of a patient with a valid Durable DNR Order, Alternate DNR Jewelry, or Other DNR Order under the criteria set forth in the above section, EMS Personnel shall withhold or withdraw cardiopulmonary resuscitation (CPR) unless otherwise directed by a physician physically present at the patient location, CPR shall include:

1. Cardiac compression;

2. Artificial ventilation;

3. Defibrillation;

4. Endotracheal intubation or other advanced airway management including supra-glottic devices such as the LMA, or other airway devices that pass beyond the oral pharynx, such as the Combitube, PTL, King Airway, etc.

5. Administration of related procedures or cardiac resuscitation medications as prescribed by the patient's physician or medical protocols.

Procedures to provide comfort care or to alleviate pain. In order to provide comfort care or to alleviate pain for a patient with a valid Durable DNR Order of any type or Other DNR Order the following interventions may be provided, depending on the needs of the particular patient:

1. Airway management, including positioning, nasal or pharyngeal airway placement;

2. Suctioning;

3. Supplemental oxygen delivery devices;

4. Pain medications or intravenous fluids;

5. Bleeding control;

6. Patient positioning; or

7. Other therapies deemed necessary to provide comfort care or to alleviate pain.

Revocation.

1. If a patient is able to, and does, express to EMS Personnel the desire to be resuscitated in the event of cardiac or respiratory arrest, such expression shall revoke the EMS Personnel authority to follow a Durable DNR Order or Other DNR Order. In no case shall any person other than the patient have authority to revoke a Durable DNR Order or Other DNR Order executed upon the request of and with the consent of the patient himself.

   If the patient is a minor or is otherwise incapable of making an informed decision and the Durable DNR Order or Other DNR Order was issued upon the request and with the consent of the person authorized to consent on the patient's behalf, then the expression by said person to EMS Personnel of the desire that the patient be resuscitated shall so revoke the EMS Personnel's authority to follow a Durable DNR Order or Other DNR Order.

2. The expression of such desire to be resuscitated prior to cardiac or respiratory arrest shall constitute revocation of the order; however, a new order may be issued upon consent of the patient or the person authorized to consent on the patient's behalf.

3. The provisions of this section shall not authorize any qualified EMS Personnel who is attending the patient at the time of the cardiac or respiratory arrest to provide, continue, withhold or withdraw treatment if such provider knows that taking such action is protested by the patient incapable of making an informed decision. No person shall authorize providing, continuing, withholding or withdrawing treatment pursuant to this section that such person knows, or upon reasonable inquiry ought to know, is contrary to the religious beliefs or basic values of a patient incapable of making an informed when the patient was capable of making an informed decision.

Documentation. When following a Durable DNR Order or Other DNR Order for a particular patient admitted to a qualified health care facility, EMS Personnel shall document care rendered or withheld as required by facility policies and procedures. When following a Durable DNR Order or Other DNR Order for a particular patient who is not admitted to a qualified health care facility or who is in transit from a health care facility, EMS Personnel shall document in the patient's medical record the care rendered or withheld in the following manner:

1. Use standard patient care reporting documents (i.e. Patient Care Report, patient chart).

2. Describe assessment of patient's cardiac or respiratory arrest status.

3. Document which identification (Durable DNR Order, Alternate Durable DNR Jewelry, or Other DNR Order or alternate form of identification) was used to confirm Durable DNR status and that it was intact, not altered, not canceled, or not officially revoked.

   Note: EMS Personnel may honor a legible photocopy of a Durable DNR Form or Other Durable DNR Order as if it were an original.

4. Record the name of the patient's physician who issued the Durable DNR Order, or Other DNR Order.

5. If the patient is being transported, keep the Durable DNR Order, Alternate Durable DNR Jewelry, or Other DNR Order with the patient.

General considerations. The following general principles shall apply to implementation of all Durable DNR Orders.

1. If there is misunderstanding with family members or others present at the patient's location or if there are other concerns about following the Durable DNR Order or Other DNR Order, contact the patient's physician or EMS Medical Control for guidance.

2. If there is any question about the validity of a Durable DNR Order, resuscitative measures should be administered until the validity of the Durable DNR Order or Other DNR Order is established.

Note: Do Not Resuscitate (DNR) Orders from any commonwealth or state within the United States and its associated territories are authorized to be followed as long as the EMS Providers follows the procedures outlined in these regulations.

See Appendices for Virginia and West Virginia document examples!

1. The EMS providers who exchange drug boxes or performing one-for-one drug exchanges at the local hospital are responsible for accounting for all drugs in the box, including narcotics, whether or not they were **used** on the PCR.
2. All narcotics (Fentanyl, Ketamine, and Morphine), benzodiazepines (Valium and Versed), and neuromuscular blocking agents (NMBA) (Rocuronium) remaining in the LFEMSC approved drug box shall be listed on the PCR or agency run sheet before the appropriate hospital representative signs the patient care report.
3. The EMS provider will verify, by physical inventory, all narcotics, benzodiazepines, and neuromuscular blocking agents (NMBA) in the drug box in accordance with the Board of Pharmacy regulations and local hospital guidelines.
4. If narcotics, benzodiazepines, and neuromuscular blocking agents have been used; any narcotic, benzodiazepine, and/or neuromuscular blocking agent (NMBA) remaining in the opened vial and/or syringe shall be disposed of in accordance with the Board of Pharmacy (BOP) regulation, §18VAC110-20-500 (A) (6) Licensed Emergency Medical Services (EMS) Agencies Program (see below) and shall be documented on the PCR and signed by the EMS provider and other designated person. The ALS provider and other designated person must sign the PCR witnessing the amount of drug disposed.** The pharmacy cannot legally dispose of unused narcotics, so it is incumbent on the ALS provider to follow the proper procedure.
5. The amount of narcotics, benzodiazepines, and/or neuromuscular blocking agents (NMBA) administered, and the amount (if any) disposed of shall be recorded by the ALS provider in the appropriate location on the PCR. The ALS provider shall ensure the used and/or empty syringe(s) or vial(s) are returned with the narcotics, benzodiazepines, and neuromuscular blocking agents (NMBA) drug pack. Empty syringe(s) and/or vial(s) shall be made safe by removing the needles and then retained until all narcotics are accounted for by the appropriate hospital representative, then at that time they will be disposed of in an appropriate hazardous waste container.

§18VAC110-20-500 (A) (6) Licensed Emergency Medical Services (EMS) Agencies Program,

6. ***Destruction of partially used Schedules II, III, IV, and V drugs shall be accomplished by two persons, one of whom shall be the EMS provider and the other shall be a pharmacist, nurse, prescriber, pharmacy technician, or a second EMS provider. Documentation shall be maintained in the pharmacy for a period of two years from the date of destruction.***

** Preference is given to the wasting of narcotics, benzodiazepines, and neuromuscular blocking agents (NMBA) in front of someone other than the second EMS provider, such as a hospital representative. This is considered BEST PRACTICES and only covers and protects the EMS providers from a diversion standpoint.

REFUSALS AND DOCUMENTATION

Anytime a patient refuses treatment and transport, an “EMS Informed Consent To Refuse” statement should be attained. Patient Care Reports (PCR's) that do not have the standardized "Informed Consent to Refuse" will have to write the refusal out on the PCR and then have the patient sign. The Virginia OEMS PCR has the standardized format on the back of the original copy. Please make sure you are documenting refusals properly, this includes any procedures deemed necessary by the Attendant-In-Charge (AIC), but refused by the patient, (i.e., spinal immobilization, intravenous cannulation, etc.).

For any refusal of treatment and/or transportation by or for a pediatric patient (14 years of age and below) or any patient with a potentially life-threatening condition, EMS providers are encouraged to call Medical Direction who can provide assistance.

Refusals and no treatment required shall be completely documented. Each agency shall submit all refusals, no patient found, and no treatment required to the Agency EMS Physician at least monthly for review. Routine agency reporting shall include the number of refusals, no patient found, and no treatment required with the Agency EMS Physician report.

Documentation of refusals must include the following:

- Decision made is from a patient / guardian of sound mind and not under the impairment of any alcohol or substance (legal or illegal) and/or disease process.
- The patient / guardian has been informed of potential need for further evaluation.
- Further medical diagnostic test (x-ray, lab, etc.) may be needed to confirm lack of injury.
- Further injury / illness care or management may be required.
- Further medical evaluation by a health care professional is recommended.
- Other:

AND

- Been informed of the potential risks associated with the refusal of service.
- Potential risk associated may include, but not limited to:
    - Undiagnosed injury or illness.
    - Improper healing of injury.
    - Worsening of injury or illness with or without changing signs or symptoms.
    - Subsequent changes in condition including unconsciousness (coma) shock or death.

AND

- Understand this refusal in no way reduces my ability to recall EMS services in the future.

Witness signatures for patient refusals may be a by-stander, law enforcement, family member, etc. The use of response personnel as witnesses to refusals should be avoided, if at all possible.

Contact Medical Control for Further Guidance!

Emergency Custody Orders (ECO)

A person who is:

1. Mentally ill, **and**
2. In need of hospitalization, **and**
3. Who is incapable of volunteering or unwilling to volunteer for treatment, **and**
4. Is either:
    a. An imminent danger to his or herself or others as a result of mental illness, or

    or

    b. Is so seriously mentally ill as to be substantially unable to care for his or herself or to provide for his or her basic needs.

When a law enforcement officer determines that an individual may meet the criteria, the officer may then take the individual into emergency custody. The law enforcement officer will transport the individual to the nearest hospital emergency department for evaluation by a qualified employee of a Community Services Board. The evaluation will determine whether or not there is a need for involuntary hospitalization (or a Temporary Detention Order).

The ECO criteria is based, first and foremost, on whether the individual is exhibiting signs or symptoms of mental illness. When there are indications that an individual may be actively using alcohol or drugs, it is often difficult to determine whether the signs or symptoms are due to mental illness or substance abuse. A law enforcement officer may determine that the signs and symptoms observed in an individual who is actively using substances is enough for the purposes of deciding whether or not a person meets the criteria for an Emergency Custody Order (ECO).

A magistrate can issue an ECO for individuals who are in need of medical treatment and refusing care, but only when there is an immediate threat to the person's life. This would require the sworn petition of a responsible person (a medical professional, for example). However, a law enforcement officer that has taken a person into custody may seek medical evaluation and treatment of the person if necessary.

A person meeting the criteria may be taken into emergency custody in two ways:

1. A law enforcement officer may take the person into custody without an order being issued by a magistrate. This is often referred to as a "paperless" ECO, or

2. An ECO may be issued by a magistrate on the sworn petition of "any responsible person" if he finds the person to be detained meets the criteria set out above. In such cases, the magistrate will issue an order directing law enforcement to take the individual into custody and transport to the nearest hospital emergency department for evaluation.

There are many variables involved in this process. The fastest way for a person that meets the criteria to be taken into custody is to have a law enforcement officer to enact a "paperless ECO". In such cases, it is the law enforcement officer who must make this determination based upon his or her own experience and training. You can also attempt to call the on-call person from the Community Services Board and have them advise you as to whether or not a "responsible person" should seek an order from the magistrate.

TREATMENT FOR PATIENTS UNDER AGE 18

1. **Persons Subject to this Policy**: This Policy applies to persons under the age of 18 (except those that have an Order of Emancipation from a Juvenile and Domestics Relations District Court) who are in need of medical or surgical treatment, including such person who report being sick or injured; who have obvious injury; and/or have a significant mechanism of injury which suggests the need for medical evaluation.

2. **Authority of Parents, Guardians or Others**: Parents have the authority to direct or refuse to allow treatment of their children. A court appointed guardian, and any adult person standing *in loco parentis*, also has the same authority. "In loco parentis" is defined as "in the place of a parent; instead of a parent; charged, fictitiously, with a parent's rights, duties, and responsibilities." Black's Law Dictionary, 708 (5th ed. 1979). 1987-88 Va. Op. Atty. Gen. 617 "Furthermore, I would point out that §54-325.2(6) allows any person standing "in locos parentis" to consent to medical treatment for a minor child. This signifies, in my judgment, an intent to allow any responsible adult person, who acts in the place of a parent, to consent to the treatment of a minor child, particularly in emergency situations." 1983-84 VA. Op. Atty. Gen. 219. Such a person may be a relative, schoolteacher or principle, school bus driver, baby-sitter, neighbor, or other adult person in whose care of the child has been entrusted.

3. **Persons Subject to Policy with Altered Mental Status:** A person meeting the criteria of paragraph 1 that is unconscious, has an altered mental status, signs of alcohol or substance abuse or head injury shall be treated under implied consent and transported, unless a parent or guardian advises otherwise. Medical control must be consulted if a parent or guardian or person *in loco parentis* refuses to allow treatment or transport.

4. **Persons Subject to Policy Under Age 14:** A person meeting the criteria of paragraph 1 that is under the age of 14 shall be treated and transported unless a parent or guardian or person *in locos parentis* advises otherwise. Do not delay treatment or transport for extended periods simply trying to contact a parent or guardian. If you believe that treatment is necessary, but the parent or guardian or person *in loco parentis* refuses to allow treatment, medical control should be consulted.

5. **Persons Subject to Policy Aged 14-17**: A person meeting the criteria of paragraph 1 who is between the ages 14 and 17 may refuse treatment and transport for themselves, unless a parent, guardian, or person in loco parentis advises otherwise. If you believe that treatment is necessary, and the patient refuses an attempt should be made to contact a parent, guardian, or person in loco p*arentis to obtai*n consent for treatment. If unable to contact a parent, guardian, or person in loco parentis, medical control should be contacted. If you believe that treatment is necessary and the parent, guardian, or person in loco parentis refuses treatment then medical control should be contacted.

6. **Persons Subject to Policy Married or Previously Married:** A person meeting the criteria of paragraph 1 who is, or has been married, shall be deemed an adult for purposes of consenting or refusing medical treatment. Code of Virginia § 54.1-2969.

7. **Persons Subject to Policy that are Pregnant:** A person subject to this policy that is pregnant shall be deemed an adult for the sole purpose of giving consent for herself and her child to medical treatment relating to the delivery of her child; thereafter, the minor mother of such child shall also be deemed an adult for the purpose of giving consent to medical treatment for her child. Code of Virginia § 54.1-2969.

8. **Pediatric Non-Transport:** When a pediatric patient seventeen (17) years of age or younger is not going to be transported after 911 access has been made, the provider will need to document all pertinent information including EMS physician's name if involved with a consultation. The documentation shall be completed by the EMS AIC of the unit.

PURPOSE

To identify and comply with mandatory reporting requirements of the Commonwealth of Virginia to the degree they impose regulations on EMS Providers to report specific situations or circumstances.

GUIDELINES

- Child abuse and/or neglect (§ 63.2-1509) – **(800) 552-7096**
- Elder abuse / neglect / exploitation ((§ 63.2-1606(A)) – **(888) 83-ADULT or (888) 832-3858**
- Hunting Accidents (§ 29.1-100 and § 29.1-530.4) – **(804) 367-1258 or (804) 367-2251**

CHILD ABUSE OR NEGLECT

Virginia EMS Providers are identified as mandated reporters. Mandated reporters must report the situation immediately to the local department of social services in the locality where the child resides or where the abuse is believed to have occurred or make reports to the 24-hour, toll free Virginia Department of Social Services (VDSS) Child Protective Services (CPS) hotline. Failure to do so shall lead to monetary penalties. If transporting the child in question it is also acceptable to report to the attending physician at the hospital. Provide appropriate documentation on the Patient Care Report (PCR) "made notification to Dr. _____." For more details, see *§ 63.2-1509*.

- Physical abuse – the use of physical force that may result in bodily injury, physical pain, or impairment.
- Neglect – the refusal or failure to fulfill any part of a person's obligations or duties to a child such as abusing dependence
    - Neglect may also include failure of a person who has fiscal responsibilities to provide care for a child (e.g., pay for necessary home care services).
    - The failure on the part of an in-home service provider to provide necessary care.
- Sexual abuse – non-consensual sexual contact of any kind; sexual contact with any person incapable of giving consent is also considered sexual abuse.
- Sexual exploitation – can involve the following: possession, manufacture, and distribution of child pornography, online enticement of children for sexual acts, child prostitution, child sex tourism, and child sexual molestation.
- Emotional / mental injury – the infliction of anguish, pain, or distress through verbal or nonverbal acts such as ridiculing values or spiritual beliefs, threats, intimidation, guilt, and blame.
- Abandonment – the desertion of a minor child by an individual who has assumed responsibility for providing care for the child, or by a person with physical custody of the child.

ASSESSMENT GUIDELINES

- Assess for and document psychological characteristics of abuse, including excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, fussy behavior, hyperactivity, or other behavioral disorders.
- Assess for and document physical signs of abuse, including any injuries inconsistent with the reported mechanism of injury, or due to non-age-appropriate activities.
- Assess for and document symptoms or signs of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregivers, or indications of malnutrition.

ELDER ABUSE OR NEGLECT

Virginia EMS Providers are identified as mandated reporters. For more details, see *§ 63.2-1606(A)*. Mandated reporters must report the following to Adult Protective Services (APS) and law enforcement:

- Physical abuse – the use of physical force that may result in bodily injury, physical pain, or impairment.
- Sexual abuse – non-consensual sexual contact of any kind. Sexual contact with any person incapable of giving consent is also considered sexual abuse.
- Emotional or psychological abuse – the infliction of anguish, pain, or distress through verbal or nonverbal acts such as ridiculing values or spiritual beliefs, threats, intimidation, guilt, and blame.

- Neglect – the refusal or failure to fulfill any part of a person's obligations or duties to an elder such as abusing dependence.
    - Neglect may also include failure of a person who has fiscal responsibilities to provide care for an elder (e.g., pay for necessary home care services).
    - The failure on the part of an in-home service provider to provide necessary care.
- Abandonment – the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.
- Financial or material exploitation – the illegal or improper use of an elder's funds, property, or assets.
- Self-neglect – the behavior of an elderly person that threatens his / her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself / herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

Suspected sexual abuse, death, serious bodily injury, or disease believed to be the result of abuse or neglect; applies to an adult 60 years of age or older or an adult 18 years of age or older who is incapacitated and is being abused, neglected, or exploited.

- Mandated reporters must report the situation immediately to the local department of social services in the locality where the adult resides or where the abuse is believed to have occurred.
- Report to the 24-hour, toll-free Virginia Department of Social Services (VDSS) Adult Protective Services (APS) hotline.

Any other criminal activity involving abuse or neglect that places the adult in imminent danger of death or serious bodily injury.

- Mandated reporters must report to the appropriate medical examiner and law enforcement agency when there is reason to suspect that a vulnerable adult died as a result of abuse or neglect.

ASSESSMENT GUIDELINES

- Assess for and document psychological characteristics of abuse, including excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, fussy behavior, hyperactivity, or other behavioral disorders.
- Assess for and document physical signs of abuse, including any injuries inconsistent with the reported mechanism of injury.
- Assess for and document symptoms or signs of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregivers, or indications of malnutrition.

MANDATED REPORTING OF HUNTING ACCIDENTS

§ 29.1-530.4 requires "that any emergency medical service provider that receives a report [that a person engaged in hunting] as defined in § 29.1-100 has suffered serious bodily injury or death, shall immediately give notice of the incident to the Department of Game and Inland Fisheries."

- EMS Providers are required to report the event to the Department of Game and Inland Fisheries within five days of the incident.
- It is a Class 4 misdemeanor to fail to report this information.
- Call the Department of Game and Inland Fisheries 24-hour law enforcement dispatch center.

APPENDIX A

VIRGINIA DURABLE DO NOT RESUSCITATE (DDNR) ORDER FORM

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ **Date** _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

_____	_____	_____
Physician's Printed Name	Physician's Signature	Emergency Phone Number

_____	_____
Patient's Signature	Signature of Person Authorized to Consent on the Patient's Behalf

Copy 1 – To be kept by patient

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ **Date** _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

Physician's Printed Name	Physician's Signature	Emergency Phone Number

Patient's Signature	Signature of Person Authorized to Consent on the Patient's Behalf

Copy 2 – To be kept in patient's permanent medical record

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ **Date** _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

Physician's Printed Name	Physician's Signature	Emergency Phone Number

Patient's Signature	Signature of Person Authorized to Consent on the Patient's Behalf

Copy 3 – Used to order DDNR jewelry EMS – 7105 6/2011

APPENDIX B

VIRGINIA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST) FORM

HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

Virginia Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the patient's current medical condition and wishes. Any section not completed creates no presumption about the patient's preferences for treatment.

Name Last / First / M.I.

Address

City / State / Zip

Date of Birth (mm/dd/yyyy) | Last 4 Digits of SSN ☐☐☐☐

A ✓one only

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ Attempt Resuscitation ☐ Do Not Attempt Resuscitation (DDNR/DNR/No CPR)

If "Do Not Attempt Resuscitation" is checked, this is a DDNR order. See Page 2 for instructions for use.

If a previous Durable Do Not Resuscitate form or POST form indicating Do Not Attempt Resuscitation was signed by the patient, only the patient can consent to reversing such a Durable DNR Order.

When not in cardiopulmonary arrest, follow orders in B & C

B ✓one only

If "Attempt Resuscitation" is checked in Section A, Virginia EMS protocol includes intubation when needed.

MEDICAL INTERVENTIONS: Patient has pulse and / or is breathing.

☐ **Comfort Measures:** Treat with dignity and respect. Keep warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital *only* if comfort needs cannot be met in current location. Also see "Other Orders" if indicated below.

☐ **Limited Additional Interventions:** Includes comfort measures described above. Do not use intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP or BiPAP). Use additional medical treatment, antibiotics, and cardiac monitoring as indicated. Hospital transfer if indicated. Avoid intensive care unit if possible. Also see "Other Orders" if indicated below.

☐ **Full Interventions:** In addition to Comfort Measures above, use intubation, mechanical ventilation, cardioversion as indicated. Transfer to hospital if indicated. Include intensive care unit. Also see "Other Orders" if indicated below.

Other Orders: _____

C ✓one only

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluids by mouth if feasible.

☐ **NO** feeding tube (Not consistent with patient's goals given current medical condition)

☐ Feeding tube for a defined trial period (specific goal to be determined in consultation with treating physician)

☐ Feeding tube long-term if indicated

Other Orders: _____

D

Must be signed by a physician, nurse practitioner or physician assistant

PROVIDER SIGNATURE: My signature below indicates that I have discussed the decisions documented herein with the patient or the person legally authorized to consent on the patient's behalf and have considered the patient's goals for treatment to the best of my knowledge.

DISCUSSED WITH (Required):

☐Patient ☐Agent named on Advance Directive ☐Other person legally authorized ☐Court appointed guardian

SIGNATURE (REQUIRED): _____ **DATE (REQUIRED):** _____

PROVIDER NAME (REQUIRED): _____ **PHONE:** _____

Signature of Patient or Authorized Person (Required)

Signature: _____ **Date:** _____

If the patient signs and Do Not Attempt Resuscitation is checked in Section A, only the patient can revoke consent for the Do Not Resuscitate Order.

Print Name: _____

If patient lacks capacity, describe authority to consent on the patient's behalf: _____

If the patient has no Advance Directive, the following persons may consent for the patient in this order: Guardian, Spouse, Adult Children, Parents, Adult Siblings, Other Relative in descending order of blood relationship (Code of Virginia §54.1-2986)

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

www.virginiapost.org

patient label

HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

NAME: _____ **Date of Birth:** _____

CARE SETTING WHERE POST WAS COMPLETED

☐ Long-Term Care ☐ Hospital ☐ Home ☐ Hospice Facility ☐ Outpatient Practice ☐ Other _____

Name of Care Setting: _____

Name of Healthcare Professional Preparing Form:

Print Name: _____ Date: _____ Organization: _____

This form is meant to reflect decisions for treatment based on the patient's current medical condition. It should be reviewed periodically and updated as needed with changes in condition, patient preferences, or setting.

Instructions for Use of This Form

Completing POST

- POST is not valid until signed by a physician, nurse practitioner or physician assistant who has a bona fide relationship with the patient. Nurse practitioners and physician assistants are authorized to sign POST forms under the Code of Virginia §54.1-2957.02 and §54.1-2952.2 respectively. Health care organizations may have policies that impose limitations on this authority based on the provider's individual scope of practice.
- Use of the original form is encouraged. A photocopy, fax or electronic version should be honored as if it were an original.

Using POST

- Patients may choose Full Interventions to authorize ventilation/intubation as a treatment for respiratory distress and still choose Do Not Attempt Resuscitation in the event of a full cardio-pulmonary arrest.
- When comfort cannot be achieved in the current setting, the patient, including someone who has chosen "Comfort Measures," should be transferred to a setting able to provide comfort (e.g. treatment of a hip fracture).
- Review POST periodically and update if needed with changes in condition, patient preferences or setting.

Revoking/Making Changes to Section A

- Administrative Code of Virginia §12VAC5-66-10 states "Durable DNR order shall also include a Physician Orders for Scope of Treatment (POST) form." Therefore, provisions under Code of Virginia §54.1-2987.1 apply to POST Section A.
- If "Do Not Attempt Resuscitation" is checked in Section A, and Section D is completed, and the patient has signed this form, no one has the authority to revoke consent for the DDNR order other than the patient as stated in the Code of Virginia §54.1-2987.1.
- If "Attempt Resuscitation" is checked in Section A, a legally authorized decision maker may make changes to carry out the patient's preferences in light of the patient's changing condition.

Making Changes to Sections B and C

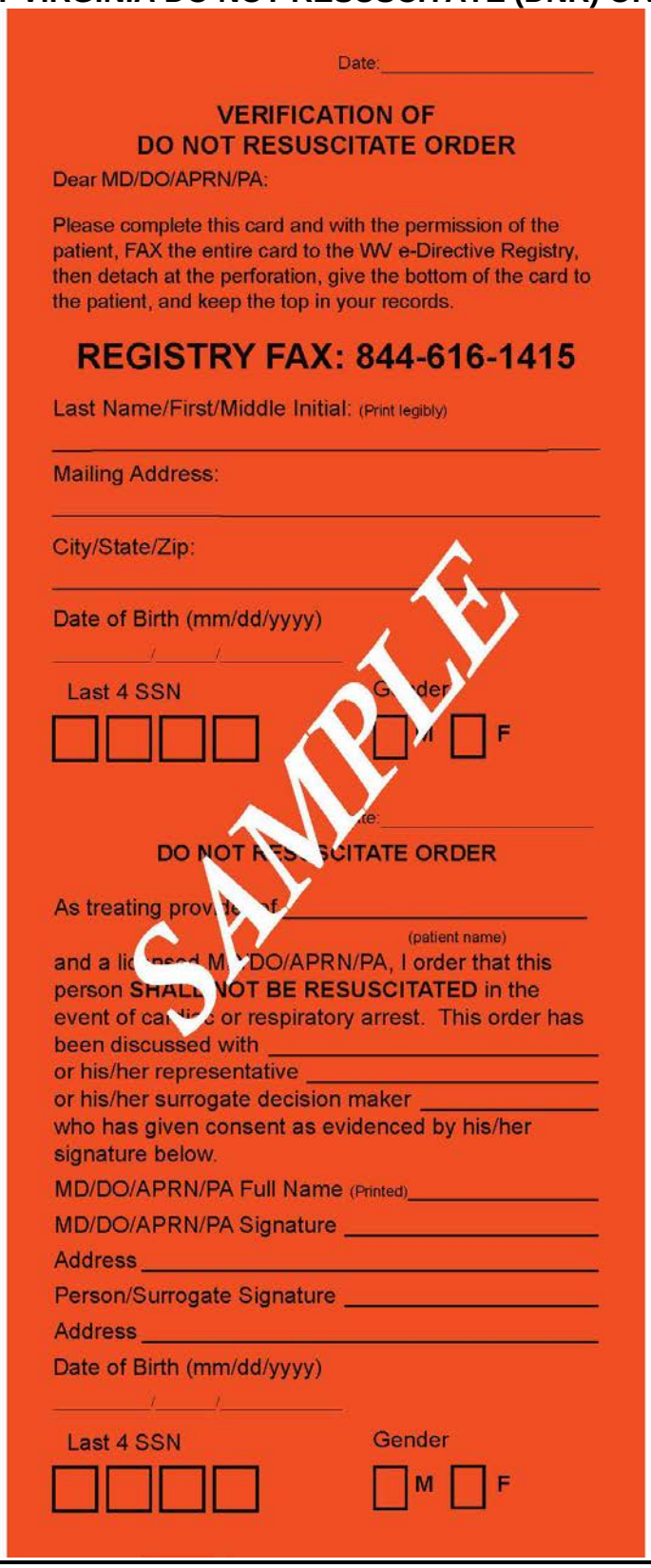
- To change any orders in these sections, the current POST form must be voided and a new POST form completed.
- If the POST is revoked and no new POST form is completed, full treatment and resuscitation may be initiated.
- If a patient tells a healthcare professional that they wish to revoke their consent to POST or change POST, the healthcare professional caring for the patient should draw a line through the front of the form and write "VOID" on the original, date and sign, and notify the patient's physician. A new POST form then may be completed if desired by the patient.
- If not in a healthcare facility, the patient (or person authorized to make decisions on the patient's behalf, in keeping with the patient's goals for treatment) may revoke consent for POST orders by voiding the form as described above and informing a healthcare professional. The healthcare professional must then notify the patient's physician so that appropriate orders may be written and a new POST form created if desired by the patient.
- If the patient signs this form and becomes unable to make healthcare decisions, a legally authorized decision maker may continue carrying out the patient's preferences in light of the patient's changing condition, and in consultation with the treating physician, may sign, revoke consent to, or request changes to the POST orders (except in Section A as noted above).

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

POST forms are available to medical providers and organizations that have agreed to the standards set forth by the Virginia POST Collaborative. Contact: program.coordinator@virginiapost.org

APPENDIX C

WEST VIRGINIA DO NOT RESUSCITATE (DNR) ORDER



Date: _____

VERIFICATION OF
DO NOT RESUSCITATE ORDER

Dear MD/DO/APRN/PA:

Please complete this card and with the permission of the patient, FAX the entire card to the WV e-Directive Registry, then detach at the perforation, give the bottom of the card to the patient, and keep the top in your records.

REGISTRY FAX: 844-616-1415

Last Name/First/Middle Initial: (Print legibly)

_____

Mailing Address:

_____

City/State/Zip:

_____

Date of Birth (mm/dd/yyyy)

____/____/____

Last 4 SSN

☐☐☐☐

Gender

☐ M ☐ F

SAMPLE

Date: _____

DO NOT RESUSCITATE ORDER

As treating provider of _____
(patient name)

and a licensed MD/DO/APRN/PA, I order that this person **SHALL NOT BE RESUSCITATED** in the event of cardiac or respiratory arrest. This order has been discussed with _____
or his/her representative _____
or his/her surrogate decision maker _____
who has given consent as evidenced by his/her signature below.

MD/DO/APRN/PA Full Name (Printed)_____

MD/DO/APRN/PA Signature _____

Address _____

Person/Surrogate Signature _____

Address _____

Date of Birth (mm/dd/yyyy)

____/____/____

Last 4 SSN

☐☐☐☐

Gender

☐ M ☐ F

APPENDIX D

WEST VIRGINIA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST) FORM

West Virginia POST

HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

West Virginia POST Form

Adapted from the National POLST form and in compliance with WV Code §16-30-1 *et seq.*

Health care providers should complete this form only after a conversation with the patient or the patient's Medical Power of Attorney (MPOA) representative or surrogate. The POST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. https://polst.org/guidance-appropriate-patients-pdf

Patient Information. **Having a POST form is always voluntary.**

THIS IS A MEDICAL ORDER, NOT AN ADVANCE DIRECTIVE.
Review and revise advance directives to be consistent with POST.

Patient First Name:_____ Middle Initial:_____

Last Name:_____ Suffix (Jr, Sr, etc.): _____

Preferred Name:_____ DOB (mm/dd/yyyy): _____/_____/_____

Last 4 Social Security Number: xxx-xx-_____ _____ _____ _____ Gender (circle one): M F X

Address: _____ Zip code: _____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.
(Requires choosing Full Treatments in Section B)

☐ NO CPR: Do Not Attempt Resuscitation.
(May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and is breathing.

Reassess and discuss interventions with patient or MPOA representative/surrogate regularly to ensure treatments are meeting patient's care goals. Consider a time-limited trial of interventions based on goals.

Pick 1

☐ Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
EMS protocols may limit emergency responder ability to act on orders in this section.

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe, and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes
☐ Time-limited trial of _____ days but no surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Discussed but no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative/Surrogate/Guardian (eSigned documents are valid)

Authorization ☐	Indicate in this box if you agree with the following statement: If I lose decision-making capacity and my condition significantly deteriorates, I give permission to my MPOA representative/surrogate to make decisions and to complete a new POST form in accordance with my expressed wishes for such a condition or if these wishes are unknown or not reasonably ascertainable, my best interests.
Opt-In ☐	Indicate in this box if you agree to have your POST and other forms submitted to the WV e-Directive Registry and released to treating health care providers to ensure your wishes are known. **FAX 844-616-1415**

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's MPOA representative/surrogate, the treatments are consistent with the patient's expressed wishes or, if unknown, their best interests.

Patient/Patient MPOA representative/surrogate signature (required)	**Date** (mm/dd/yyyy)	**The most recently completed, valid POST form supersedes all previously completed POST forms.**

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or the patient's MPOA representative/surrogate. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only providers with MD, DO, APRN, or PA license may sign this order]

MD/DO/APRN/PA signature (required)	**Date** (mm/dd/yyyy): Required / /	**Phone # :**

Send original form with patient. A copied, faxed, or electronic version of this form is a valid medical order. This form does not expire.

WV Center for End-of-Life Care: 1-877-209-8086. **WV e-Directive Registry FAX: 844-616-1415** 2021

West Virginia POST
Physician Orders for Scope of Treatment
A Participating Program of National POLST

HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

WV POST form: A Portable Medical Order

Consistent with the National POLST form and in compliance with WV Code §16-30-1 *et seq.*

Printed Full Name: required		License/Cert. #:

Patient Full Name:

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative.)

Full Name:	☐ MPOA Representative/surrogate ☐ Other emergency contact	Phone #:

Primary Care Provider Name: Phone: ( )

☐ Patient is enrolled in hospice — Name of Agency: Agency Phone: ( )

Reviewed patient's advance directive to confirm no conflict with POST orders:
(A POST form does not replace an advance directive or living will)

☐ Yes; date of the document reviewed:_____
☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart)
☐ Advance directive not available
☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court-Appointed Guardian ☐ Parent of Minor ☐ MPOA representative/Surrogate ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - MPOA representative/surrogate may be able to execute or void this POST form only if the patient lacks decision-making capacity.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - If a translated POST form is used during conversation, attach the translation to the signed English form.
  - **FAX completed form to the WV e-Directive Registry at 844-616-1415 so it may be available to health care providers in emergencies.**
- **Using a POST form:**
  - Any incomplete section of POST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care, and other measures to relieve pain and suffering.
- **Reviewing a POST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes their treatment preferences or goals of care.
- **Modifying a POST form:** This form cannot be modified. If changes are needed, void form (see below) and complete a new POST form. **FAX new POST form to the WV e-Directive Registry at 844-616-1415 so it may be available to health care providers in emergencies.**
- **Voiding a POST form:**
  - **If a patient or MPOA representative/surrogate (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider and the WV e-Directive Registry to void orders in patient's medical record and the Registry.
  - **For health care providers**: destroy copy (if possible), note in patient record form is voided and notify the WV e-Directive Registry.
  - *If no new form is completed, note that full treatment and resuscitation may be provided*.
- **Additional Forms.** Can be obtained by going to www.wvendoflife.org/ or by calling 877-209-8086.
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.
- **Submitting a POST form (or any form) to the WV e-Directive Registry (if Opt-In Box is initialed)**
  - With the permission of patients or their legal agents, the WV e-Directive Registry houses and makes available to treating health care providers advance directive forms, do not resuscitate (DNR) cards, Physician Orders for Scope of Treatment (POST) forms, etc. The Registry makes patients' treatment wishes known to their physicians so that they can be respected. By submitting forms to the e-Directive Registry, the patient can ensure their forms are available in the event of a health care emergency in order for medical wishes to be translated into patient care. More information is available at www.wvendoflife.org/wv-e-directive-registry. FAX a copy of the POST form to the WV e-Directive Registry at 844-616-1415. Ensure the form is readable prior to faxing the form to the Registry. For questions, call 877-209-8086.