Administrative Policies and Procedures

2013 Edition
Effective August 1, 2013

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

AUTHORIZATION TO PRACTICE IN THE LORD FAIRFAX EMS COUNCIL REGION

The 2013 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 original signature of the Agency Operational Medical Director (OMD).

Authorization to Practice may be withdrawn under such conditions as, but not necessarily limited to, intoxication/substance abuse while on duty, practicing without a valid BLS or ALS certification,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 OMD, LFEMSC Regional OMD, 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 OMD 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 OMD for resolution.

_____
Agency Operational Medical Director

_____
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 *County*

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

1. The Agency OMD is ultimately responsible for all BLS and ALS practiced in this area. Therefore, the Agency OMD 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 the each EMS Agency and Agency OMD 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 OMD and Medical Direction Board, for their respective level of certification (i.e. sedating a patient with Versed and intubating is **NOT** allowed).
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 OMD, 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 OMD, LFEMSC Regional OMD, 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 OMD, LFEMSC Regional OMD, 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 OMD, LFEMSC Regional OMD, 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 OMD 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) Advanced Cardiac Life Support (ACLS) Course to be "Authorized to Practice" within the region. ALS providers at the Intermediate and Paramedic levels are encouraged to be certified in the AHA Pediatric Advanced Life Support (PALS) Course.
12. EMS providers are responsible for meeting their continuing education requirements. All required Category One and Category Two continuing education hours must be completed prior to recertification.
13. Any EMS Agency, Jurisdictional EMS Coordinator, and/or Agency Operational Medical Director 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 Operational Medical Director**.**
15. All EMS providers must complete the mandated skills drill in their local jurisdiction under the auspice of the Agency OMD or designee. Those EMS providers who are employed as a career EMS provider within LFEMSC yet volunteer with a different agency within the LFEMSC region only need to complete their annual skills drill for their career agency. EMS providers employed by agencies outside the LFEMSC region are required to complete LFEMSC mandated skills drill. OMDs have the authority to require EMS providers to demonstrate skill proficiency at any time.
16. If an EMS provider fails to complete his/her **mandated skills drill**, he/she will automatically become ineligible to act as Attendant-In-Charge until he/she has worked with their Jurisdictional EMS Coordinators, Agency Operational Medical Director, or their designee. The suspension of privileges becomes effective 15 days from the final LFEMSC mandated skills drill. Original lists of providers in attendance at all skills drills shall be forwarded to the LFEMS Council for the appropriate OMD within 15 days of their final skills drill.

17. 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.

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:

- Airway and breathing emergencies with an Oxygen Saturation less than 90%
- Systolic BP less than 90 mmHg
- 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) for all other age groups.
- Drowning
- ST-Elevation Myocardial Infarction (STEMI)
- Acute stroke (less than 3 hours from initial onset of systems)

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 July 20, 2011. 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 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.

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 Oder, 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.

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 and benzodiazepines (Fentanyl, Morphine, Valium, and Versed) 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 and benzodiazepines in the drug box in accordance with the Board of Pharmacy regulations and local hospital guidelines.
4. If narcotics or benzodiazepines have been used; any narcotic or benzodiazepines remaining in the opened vial and/or syringe shall be disposed of in accordance with the Administrative Policies and Procedures and shall be documented on the PCR and signed by the EMS provider and appropriate hospital representative. The ALS provider and appropriate hospital representative 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 narcotic and/or benzodiazepines 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 or empty syringe(s) or vial(s) is returned with the narcotic and benzodiazepine drug container. 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.

PEDIATRIC IMMOBILIZATION

Research of current literature does not offer any conclusive information regarding the conditions requiring the removal of a pediatric patient from a child safety seat involved in a motor vehicle crash for immobilization. In consultation by Thomas Jefferson EMS Council with Dr. Pamela Ross, Pediatric Attending Physician with the University of Virginia Medical Center, the following criteria has been developed:

In the event a pediatric patient secured in a child safety seat has been involved in a motor vehicle crash, the patient must be removed from the child safety seat for immobilization on a pediatric immobilization device under the following circumstances:

1. Integrity of the child seat has been violated (seat broken).

2. The patient exhibits a focal neurological deficit. Focal neurologic deficit refers to abnormalities that result in a child not being able to function normally. It can include but is not limited to decreased function/movement of an extremity, eye deviation, and incontinence in a potty-trained child. I understand that a broken arm could present as a "focal deficit". If there is any question or mechanism for potential neurologic/spine injury - then caution should be toward protecting and immobilizing the spine. I.e. a child is ejected from a car. The provider is expected to always err on the side of caution in any situation that is questionable and immobilize the patient.

Note:
Be reminded the smaller child's head is larger proportionately to the remaining torso and therefore requires additional padding to compensate for the space (void) difference to maintain neutrality of the cervical spine and maintain the airway. Because the head is larger and is not "restrained" during a motor vehicle collision, it is important to review the mechanism of injury when deciding to utilize the child safety seat as an immobilization device.

Rolled towels can be utilized to immobilize the pediatric patients within their child safety seat.

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 OMD at least monthly for review. Routine agency reporting shall include the number of refusals, no patient found, and no treatment required with the Agency OMD 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 her self 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 her self

A patient that meets the criteria to be taken into emergency custody by law enforcement and needs transported for evaluation by a designee of a Community Services Board to determine the need for involuntary hospitalization.

Alcoholism and drug abuse may be considered mental illness for the purposes of determining whether or not a person meets the criteria.

An ECO will generally not be issued for a person that you believe is in need of medical treatment but is refusing care, and will certainly not even be considered unless there is an immediate threat to the person's life. 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, and may transport the person for evaluation, or

2. An ECO may be issued by a magistrate on the sworn petition of "any person" if he finds the person to be detained meets the criteria set out above, and law enforcement will serve that order. However, not all magistrates will issue such an order for anyone other than an employee of the Northwestern Community Services or similar agency. Not all magistrates will issue an order for someone other than the Northwestern Community Services or similar agency if law enforcement is present but has declined to take the person into custody.

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 take them into custody. However, because that requires the officer to be out of service for up to four hours, and not all officers may agree that the person meets the criteria, you should attempt to call the on-call person from the Community Services Board and have them decide whether or not to 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.