Protocol G-09

SECTION: Protocol G-09

TITLE: Patient Refusal and Documentation

REVISED: December 01, 2022

Purpose: This document provides direction for patient care refusal documentation for all agencies operating within the Ada County-City Emergency Services System (ACCESS).

Definitions:

- **Against Medical Advice (AMA)** – Any refusal for assessment, treatment or transport deemed necessary by any provider.
- **Assessment** – Physical, visual or verbal assessment of an illness or injury in order to create a treatment plan (e.g., palpation, auscultation, visualization, focused questioning about chief complaint).
- **Consent** – A Patients' authorization or agreement to undergo specific medical assessment, treatment or transport. This can be in the form of actual permission (*informed consent*) or in the form of an assumption that authorization would be given by an incapacitated patient or a minor's legal guardian (*implied consent*).
- **Emergency Health Record (EHR)** – ESO medical documentation that includes patient information, patient history, vital signs, care provided, final disposition, etc.
- **Informed Refusal** – A patient with good mental capacity must be informed of the risks of refusing medical treatment and/or transport using descriptive language that can be understood by the patient. All specific risks that were discussed should be documented thoroughly and a witness should be present.
- **Medical Provider In-Charge of Patient Care** – See *SWO G-06 for guidance on establishing Provider in-Charge.*
- **Refusal** – incidence where the patient no longer desires assessment, treatment or transport once an assessment (including visual/verbal assessment) has begun. Patients may accept parts of the offered services while refusing others (document denials). If the patient's accepts transport but refuses some individual interventions, a written refusal does not need to be completed. Specific refusals of interventions should be thoroughly documented in the narrative**.**

- **Refusal Form** – Legal documentation of a patient who refused initial or on-going medical assessment, treatment, or transport. The patient should be informed of all assessment findings, transport recommendations and interventions recommended by the Medical Provider In-Charge of Patient Care. In addition to completion of this electronic refusal form, a refusing patient shall be offered a physical copy of the 'Notice of Privacy Practices' document.

Patient*:* *

A patient is an individual that:

- has contacted EMS and requested evaluation for a possible injury and/or illness

- has been assessed or examined by another System provider

- Law Enforcement personnel have requested be evaluated by EMS. *Consent to physical assessment or treatment must still be granted by the individual. In the event the individual is in custody, the Officer or Deputy may consent to or refuse evaluation, treatment, and/or transport in-behalf of the individual in custody*

- has requested transport. *Approved courtesy transports and hospital transports of non-injured relatives or friends are excluded from refusal documentation*

- is a minor (< 18 years old or emancipated minor) who is experiencing some type of illness or injury

  - The following person(s) may consent to or refuse the assessment, treatment, and/or transport of a minor:
    - Minor's Parent or Legal Guardian
    - Law Enforcement if in custody

- is ill/injured and mentally disabled or incapacitated where their mental status cannot be verified as normal by someone familiar with the individual

- is not fully conscious, alert, and oriented that presents with illness or injury needing EMS attention

- is a possible victim of intimate partner violence/domestic violence, sexual assault, strangulation or any other form of battery

** These criteria are to be considered in the widest, most inclusive sense. If there is any question or doubt, the individual should be treated as a patient in every respect (assessment, treatment, transport and documentation).*

Refusals
Once patient care has begun (assessment or treatment), a patient deemed capable can allow or refuse further care at any point. If a patient refuses care or continuation of care, an informed refusal process shall be conducted or at least attempted by the Medical Provider In-Charge of Patient Care and thoroughly documented.

Patient dispositions that require refusal documentation:

- **Patient Treated, Released (AMA)** – provider recommends further treatment and/or transport and patient refuses further care.
- **Patient Refused Evaluation/Care (without transport)** – patient refused to give consent to assess/treat or withdrew consent for further assessment/treatment/transport. This may be a consensual decision that further care is not warranted.
- **Patient Treated, Transported by Private Vehicle** – Patient was evaluated and or treatment was provided by your EMS unit however patient or guardian refused ambulance transport in lieu of providing their own transport.

Since refusal charts are the highest liability to provider and agency, a Refusal and/or Treat and Release EHR should be thoroughly documented and with an understanding that each appropriate portion of the chart must be completed with greater detail. Refusals can be written by any ACCESS provider as long as the assessment and care provided are within their scope of practice.

Elements of an informed refusal that should be included in EHR:

- Pertinent denials – what the patient denied or refused
- Offer of transport (witness present)
- Outline of the discussion about the patient's refusal (witness present)
    - Was the decision mutual or against medical advice (AMA)?
    - Was Medical Direction contacted?
        - Any Medical Control contact should be documented and include the name of the MD, facility contacted, and summary of the discussion
    - Was the patient offered other transportation/assistance options?
    - What were the circumstances of the refusal?
    - What were the risks of refusal that were discussed (witness present)?
    - Was the patient offered further assistance by calling 911 again?
    - Document mental status of the patient
    - Signature of the patient and witness (who was present during above discussions) on the refusal paperwork
    - Thoroughly documented explanation of any refusal to sign

Refusal Procedure: *(see Refusal Form in EHR under signatures)*

Refusal documentation and signatures shall be obtained on the tablet of the Medical Provider In-Charge of Patient Care. This will be the provider who completes the refusal chart.

The patient assessment is the foundation for treatment and other considerations. However, not all individuals desire assessment, treatment or transport to a medical facility. An assessment can be done visually. Therefore, the assessment will always serve as the basis for determining medical capacity as it relates to that patient's ability to refuse care.

To provide appropriate care, providers shall attempt to determine:

- **Legal capacity** – patient is > 18yrs old and/or has the legal capacity to make their own decisions (emancipated, been pregnant, married, military)
- **Mental capacity** – patient is in a good mental state and has acceptable **decision-making** ability
- In order to determine good mental capacity, at a minimum, a patient must be alert and oriented to person, place, time and purpose; must not be a danger to themselves or others; understands risks presented; have no signs of mental incapacity, drug/alcohol intoxication, unsteady gait, slurred speech, etc.
- **Medical capacity** – patient must be free from any medical conditions that may impair their ability to make informed decisions for themselves.
- Rule-out: head injury, hypoxia, head trauma, metabolic issues (ie: diabetes), environmental issues (ie: heat/cold injury), or any other mind-altering emergencies or recent unexplained loss of consciousness.

All patients deemed alert and oriented and who have capacity for decision making, will receive a comprehensive assessment (including a complete set of vitals). In the event a comprehensive assessment is refused or is not possible, this will be explained in detail in the narrative.

- **Medical Direction** (called **Medical Command** in EHR) shall be contacted for any question arising outside normal SWOs and operational standards. If Medical Direction is contacted, details including physician contacted, orders received, and time of contact will be recorded in the Refusal Form in the EHR.

- Patients/Guardians shall be informed of assessment findings and provided with recommendations that include treatment and transport options (i.e. ACP, personal vehicle, etc.).

- Patients are to be advised of the risks and possible consequences of refusing care which could include the risk of death (if appropriate). In the case of a refusal on behalf of a minor, the parent or guardian must take responsibility for care of that patient. *Conversation details should be clearly articulated in written narrative section of Narrative tab on the EHR.*

- The Patient or Guardian must sign the refusal form. Refusal to sign must be detailed in the written narrative of the chart.

- The refusal shall be signed by a witness that was present during the discussion of treatment/transport options and witnessed the patient or guardian refuse further care. In order of preference, witness signatures may be obtained from:
    - a patient’s family member or someone with the patient
    - law enforcement
    - crew member of another agency
    - crew member of same agency
    - provider cannot sign refusal as witness

- If a patient refuses to sign the refusal form, a witness signature should be obtained, if possible.

- The provider should advise the patient they may re-request assistance at any time. In the event a confirmed guardian is not on location (ie: at a school), a verbal/phone refusal may be considered if all parties are in agreement. Details must be thoroughly documented in the written narrative.

This SWO is intended to support not replace good judgment that will inevitably be required given the wide variety of situations that may be encountered.

Further Assistance:

Providers are encouraged to contact the EMS Battalion Chiefs or utilize on-line Medical Direction in the event questions arise.

Field providers are directed to always hold a potential patient’s best interest in mind regardless of considerations for cost, insurance, childcare, or any other patient-perceived obstacle which would prevent that patient being evaluated at a definitive care facility.

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