Squad Review

MCEMS

Winter/Spring 2013

Refusals/Non-Transports and MCEMS

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Goals:

1) Discuss important themes and the approach to patients who wish to refuse EMS care or transport.
2) Review guidelines provided to me by my medical-legal defense attorney regarding how EMS should think and document when allowing a Non-Transport/Refusal.
3) Review current MCEMS protocol for Non-Transport/Refusals.
4) Review essential and required charting for Non-Transport/Refusals.
5) Review recent Good, Bad and Ugly MCEMS PCR's.
6) Avoid putting you to sleep.

How it works...EMS that is... theoretically...

- Someone calls for EMS because they are worried.
- EMS responds.
- EMS evaluates, and stabilizes as needed.
- EMS transports to hospital for further evaluation by an advanced level provider.
- The presumption, in the eyes of society and the law, is that if someone was worried enough to call 911, the patient will generally be evaluated at the hospital.
- The presumption, in the eyes of society and the law, is that if the patient will not be taken to the hospital, EMS will do this in a very thorough and careful manner.

A good way to look at Refusals..

- They are deviations from the generally accepted Standard of Care.
- Not quite true, of course...
- But also not untrue, and a good thought-tool for approaching all Refusal cases... as if you are violating SOP.
- When we violate SOP in medicine, for legitimate reasons, we:
  - Think very carefully about this decision.
  - Chart very carefully about this decision.

The C-spine as an analogy

- C-spine thinking and charting is another place where we commonly *"violate"* a standard of care.
- If patient has a MOI that could have injured the spine, the standard is immobilization.
- However, the NEXUS Criteria are a well-studied and clinically proven tool for *modifying the usual standard of care*.
- They are concrete, quite specific, not a lot of grey area.
- IF you *apply* them exactly and completely...
- IF you *chart* them exactly and completely...
- You have actually altered the standard of care in that particular patient...IF

The C-spine as an analogy...

- The beauty of the NEXUS Criteria as a decision-making tool is:
    1. They are very well validated- highly reliable...IF
    2. They are pretty concrete and unambiguous.
- Interestingly the places in the NEXUS criteria where we STILL fall down in MCEMS are:
    1. intoxication
    2. distraction
- These are the 2 most “grey” or ambiguous of the 5 NEXUS Criteria.
    1. You seem to not think about them (per chart review)
    2. You definitely tend to not chart your thinking about them.

The C-spine as an analogy…

- Lessons:
  1. Generally, we tend to NOT apply these sorts of standard-of-care-changing-tools completely to our patients.
  2. Specifically, the less concrete the tool is the more we tend to not use it at all, or apply it only partially to our patients.

- We still "alter the standard of care" in that particular patient, but leave ourselves open to significant error:
  1. The error in our *THINKING* leads to
  2. Errors in our *PATIENT CARE* which risks disaster for our patient, and naturally causes
  3. Substandard *CHARTING* which immortalizes our thought and patient care errors for all time.

?NEXUS Criteria for Refusals?

- How happy I would be if we had them (we sort of do!).
- How thrilled I would be if you actually used them (you sort of don't... at least most of you don't).
- If you were to design some "NEXUS Criteria" for Non-Transport/Refusal patients what would you want them to do?
    1. Accurately identify patients who were safe for Refusal
- If you had to design some "NEXUS Criteria" for Non-Transport/Refusal patients what would they be?
    1. Does patient/guardian have *capacity* to make such a decision?
    2. Does patient have such a "high risk" situation that you feel they are in danger if not transported by you now?

Refusals are all about “Risk”

- You are assessing Risk when you are deciding whether to allow a Refusal or not.
    1. Risk is “grey”, and usually not very concrete.
    2. It is very subjective…hard to formalize
    3. Therefore it deserves careful explanation in your chart as to how you got to the risk-assessment you decided upon.
- You are “violating” the standard of care, and this MUST be adequately explained in your now forever, immortal chart:
    1. You must apply and chart “Refusal NEXUS Criteria”
    2. Does patient have capacity to make an informed decision?
    3. In your opinion is there no evidence that an acute emergency exists requiring transport now?

Refusals are all about “Risk”...

- If you cannot state, for all immortality, that:
  1. In your opinion the patient has the capacity to understand their situation, and make an informed decision; AND
  2. In your opinion, at this moment in time, is there no evidence that an acute emergency exists requiring ambulance care or transport now;
- You have:
  1. Performed an inadequate Risk-Assessment of this patient; AND
  2. Cannot in good conscience, or by protocol, allow their refusal without a lot of EDP involvement.

Meet my Attorney

- What they did for me (other than save me last time I was sued):
  1. Reviewed our Non-Transport/Refusal protocol in detail.
  2. Compared our protocol and "way" with several other major Colorado EMS systems.
  3. Reviewed a large cohort of your Refusal charts from 2012 with an eye to how they would stand up in court.
  4. Provided observations and recommendations for a MCEMS Standard of Care process for which you "can't get any more authoritative than in Colorado".
  5. "You'll be proud to know that your protocol matches what they do almost exactly, as far as I can tell".

Meet my Attorney…

- <u>What they concluded:</u>
  1. Most EMS Systems use their Non-Transport protocol to divide all patients into “High Risk” and “Low Risk” in the field. (ours does this- page Treatment P&P 20).
  2. Most “define “High Risk” as any ETOH or drug intoxication, all pediatrics, high-energy MOI, chest pain, etc (“your criteria are eminently reasonable”).
  3. “That categorization is based entirely on the EMS responders clinical judgment”.
  4. “The criteria and thought process for this division between “high” and “low” is charted by EMS”.

Meet my Attorney…

- Conclusions…
  5. “If a high risk category patient wants to refuse, EMS must call base. These calls are recorded”.
  6. “The presumption is that all high risk patients are going to be transported”.
  7. “Certainly any patient whom the EMS personnel believe is intoxicated, or doesn’t have the appropriate decision-making capacity or ability to understand the import of their decisions, will be transported”.
  8. “As I said, the paramedic also charts his/her thought process both about the “high” vs. “low” risk, and the basis for their assessment of the competency issue”.

Meet my Attorney...

- Conclusions...
  9. "With all of that, I don't think you can manage this risk any better".

All what?:

- ...based entirely on EMS responders clinical judgment
- ...thought process... is charted by EMS
- ...any patient...EMS believe is intoxicated...doesn't have the appropriate decision-making capacity...will be transported
- ...charts his/her thought process about
  - risk, and
  - the basis for their assessment of the competency (capacity) issue

Meet my Attorney…

MCEMS Chart Review:

- Reviewed Refusal charts which I felt ran the spectrum of what I see from you.
- Documentation of capacity, risk-assessment, patient understanding, and EMT thought-process were inadequate in most PCR's.
- It was pointed out the large difference between having a solid protocol (we do), and actually following it (we don't).

Our protocol (page Treatment P&P 19)

1. You must determine if the patient/guardian has the **capacity** to understand the situation and the risks of refusing EMS transport.
2. You must clearly inform the patient of your medical opinion, and your assessment of what is in their best interests.
3. The EMT is responsible for a reasonable assessment of the patient to determine if there is an injury/illness or reason for transport or treatment- only then is a patient's refusal informed.
4. **If any medications are administered to the patient (albuterol, D50, etc.) you MUST discuss the case with the EDP before allowing a refusal.**

Our protocol (page Treatment P&P 20)

7. For the patient who refuses treatment, providing the patient with clear instructions and warnings is imperative (use of an agency-approved Information Sheet is recommended).

8. Providers should be very vigilant for the following which should **NOT** be considered minor illness or injury:

- Significant mechanism of injury
- Chest pain
- Shortness of breath
- Abdominal pain
- Headache
- Altered mentation/intoxication of **any** degree.
- Pediatric patient.

Our protocol (page Treatment P&P 21)

DOCUMENTATION FOR REFUSALS

1. **YOU MUST** document:
   Your opinion of the patient/guardians **capacity** and ability to make an **informed decision**; **AND**
   Your opinion of their ability to understand the risks of the condition/situation they are in- which may include death or significant morbidity- and of their decision to refuse care/transport.
2. **YOU MUST** document your medical opinion that **at this moment in time** no evidence of an acute emergency condition exists which requires further care or transport by EMS.

Our protocol (page Treatment P&P 21)

3. <u>If you cannot document that:</u>

a. In your opinion the patient/guardian has informed decision-making capacity,

AND

b. that in your medical opinion no evidence of a high-risk emergency condition requiring EMS transport exists at this moment in time,

<u>then you cannot allow the patient to refuse transport without active EDP involvement</u>

“Provider Impressions” for Refusals

- There is no Non-Transport/Refusal PI.
- Refusal patients should be given ALL PI’s which apply: headache, pain, vomiting, diabetic problem, etc.
- Just because they are refusing does NOT mean there is no problem- make your chart accurate.
- Just notice that if honesty compels you to give them PI(s) which seem inconsistent with a refusal (AMS, CP, SOB, ingestion, intoxication, multiple trauma, etc):
  - rethink things,
  - chart carefully.

“Disposition” for Refusals

- There are basically 4 refusal choices for “Disposition” in HP.
- As with all things medical, and particularly where you are “deviating from standard of care”, the details matter…a lot.
  1. Non-transport/Patient refused treatment AMA
  2. Non-transport/Patient refused treatment
  3. Treated and released
  4. POV
- AMA intimates you did not feel they should have refused, and did so Against your Medical Advice.
- This is a much different Disposition choice than #2 above. I suggest you get the EDP’s opinion on all AMA cases.

EDP's and Refusals

- Realize that the EDP does not "give permission" for a refusal. The refusal is yours, and will stand or fall based on YOUR thinking and charting.
- The smart EDP's will ask you, on the recorded line: if you feel the patient has capacity, is sober, understands the implications of refusing; and if you feel this is a good plan and that the patient is low risk.
  - If your answer is yes, the refusal lands squarely back in your lap- you are there, the EDP is not.
  - We know of NO case law where an EDP was successfully litigated against in these situations, but the EMT, Agency and EMSMD have been.
- This is <u>YOUR</u> Refusal, not the EDP's. Yours. Think and chart as if your license is on the line...it is. The EDP's is not.

EDP's and Refusals

- There are two particular instances where the EDP can likely really help you:
- When you are unsure if the patient is appropriate for refusal, and want to run the case by another brain and see what their vibe is.
- When you feel the patient needs to be transported, but they are refusing. The EDP's are usually pretty effective at getting your plan to happen.
- Realize that the EDP's are happy to hear your cases and try to be of assistance to you with refusals, but:
  1. They are biased by the words and "vibe" you give of the patient/scenario, and
  2. It is your refusal- you are responsible for all decisions.

Charting EDP contacted

- If you speak to the EDP for any reason (med. order, refusal, advice, etc.):
  - In “This Encounter” tab, check “Hospital Contacted” box at bottom of page.
  - This allows you to open drop-down menu with all hospital and EDP names.
  - Click who you talked with- this formally puts that EDP’s name in your PCR.
- Your SOAP Plan needs to give the details of that discussion in narrative form.

Pitfalls and Pearls

1. Non-Transport/Refusal patients are "*high-risk" patients for you* (even though most are not in danger) as you are the only one with "fingerprints" on the case.
2. Approach them in your mind as if they are *deviations from the generally accepted Standard of Care.*
3. You should think and chart on EVERY Non-Transport/ Refusal patient *as if they have the terrible thing you are sure they don't*... eventually one will...your chart will save you.
4. The best "NEXUS Criteria" we have for refusals are:
    1. Does patient/guardian have *capacity* to make such a decision?
    2. Does patient have such a *"high risk" situation* that you feel they are in danger if not transported by you now?

Pitfalls and Pearls...

5. "As I said, the paramedic also **charts** his/her **thought process** both about the "high" vs. "low" **risk**, and the basis for their assessment of the **competency** issue" (capacity).
6. Refusal patients should be given ALL PI's which apply: headache, pain, vomiting, diabetic problem, etc.
7. Disposition details matter...a lot.
    1. Non-transport/Patient refused treatment AMA
    2. Non-transport/Patient refused treatment
    3. Treated and released
    4. POV
8. Realize that the EDP is generally going to agree with what you are selling over the phone. So choose your words carefully. It is YOUR refusal, not the EDP's.

Pitfalls and Pearls...

9. ALL calls for Refusals should be on the recorded line- no exceptions.
10. Document EDP spoken to for all Refusals via the Hospital Contacted checkbox in This Encounter tab.

Ok, so...

Non-Transport/Refusal CQI/QAChart Review

- Vitals, physical exam, GCS, BG, ETOH, etc. all appropriate?;
- Proper documentation of EMT thought-process?;
- Proper documentation of capacity?;
- Proper documentation of patient understanding?;
- Proper documentation of “risk” assessment by EMT?;
- P.I.’s make sense?;
- Disposition makes sense?;
- Proper documentation of EDP contact (if any)?;
- Agency Release Form signed and added to PCR?.

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