6703.02 NON-TRANSPORT / REFUSAL OF CARE

INTRODUCTION

The culture of EMS is embedded in the transport of the sick and injured to the hospital. While this remains the largest portion of EMS calls, patients are increasingly relying on clinicians for health advice rather than transport. To this regard, it is not uncommon for patients to refuse transport or certain treatment options. Though a patient has the right to refuse any level of care they wish, there are professional responsibilities that fall on the clinician to ensure the patient has the ability to refuse and that they have truly made an informed decision.

With increasing health care system pressures such as ED overcrowding, offload delays, hospital bypass, etc., patients and clinicians are seeking alternative solutions to EMS transport. As research demonstrates that it is extremely difficult for EMS providers to independently correctly identify if a patient requires assessment and/or transport to an ED, paramedic initiated non-transport is not supported and unique system designs are being implemented in an effort to assist clinicians when faced with a patient who is refusing or does not require transport to a hospital. Such calls require careful and deliberate collaboration with key stakeholders and support networks to help ensure patient safety.

MEDICAL LEGAL

Patients who refuse transport to the hospital or remain at home after calling 9-1-1 are some of our highest risk calls. On a daily basis, clinicians must find a balance between protecting the patient from harm by providing appropriate care, but at the same time respecting their right to make their own decisions (autonomy). This can be difficult in the pre-hospital setting, and typically hinges on whether the patient possesses the “decision making capacity” to refuse care or transport. Assessment of capacity in the pre-hospital setting is challenging, as there are time constraints, substance use or confusion may alter patient judgment, collateral sources of information may be absent, and most often there is a lack of familiarity with the patient and their values.

Capacity is defined as the “ability to express a reasoned choice”, and is a clinical determination at the time of patient encounter. It should not be confused with patient “competence”, which is a legal standard that is determined by the judicial system.

A patient is not determined to globally possess “decision making capacity” to make all their own decisions; rather this is considered in the context of the specific decision being made (i.e. whether or not to go to hospital). A patient may possess the capacity to make some low risk decisions but not high risk decisions in the same moment. Demonstration of a more sophisticated level of understanding is required for “high stakes” decisions, such as a life or death decision. It should also be stated that the possession of capacity for any given patient is also dynamic. A patient may possess capacity to make several high risk decisions one minute then their condition may change such that they are no longer capable of making the same decisions. See the section below on questions to consider when determining capacity for more specific information.

If a patient is refusing transport but does not display the capacity to make that decision, reasonable attempts must be made to reach a surrogate decision maker. This may be court-appointed decision maker, a designated medical power of attorney, an Advance Directive or a close relative (spouse, adult child, parent, sibling). If a patient lacks capacity in an emergent situation and no surrogate decision maker is available, then emergency treatment without informed consent may be provided for a medically warranted course of action.

PROFESSIONAL RESPONSIBILITIES

There are a number of responsibilities on the part of the clinician when dealing with a patient refusing transport or treatment.

Patient Advocacy and Communication

When a patient refuses care or transport, they are legally and ethically entitled to make an “informed refusal”. It is the obligation of the clinician to clearly explain the reasonably foreseeable consequences of refusing care (disclosure). It is often difficult to delineate any precise risks in the pre-hospital setting, but clinicians must make their best effort to determine the likely risks at play and explain them clearly. Informing the patient as to the benefits of complying with care is also the clinician’s responsibility. If the patient refuses to be transported, they are entitled to an explanation regarding why you feel care is required, the risks of refusing this, and the focus shifts to assessing the capacity of the patient to use this information to make a reasoned decision.

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There may be situations where the paramedic feels transport is not required. In such situations it is important not to dissuade the patient from transport in spite of this. The ability of a clinician in the prehospital setting to safely determine whether further acute care is required is a controversial topic. Some studies have suggested this is not safe, while others have shown that it is possible in specific circumstances. The safety of such practice depends on the clinical scenario, the experience and training of the clinician, and the use of resources to support such decision making (e.g. medical oversight, family, clinical support desk). There are very limited situations in which it is appropriate to treat a patient and then have them remain at home, therefore this should be avoided unless addressed specifically in Clinical Practice Guidelines. For example, a palliative care patient requiring acute symptom relief, or a moderate risk hypoglycemic patient having returned to baseline after treatment are examples where clinicians may safely determine that transport is not indicated, provided the patient is also requesting to stay at home. The Online Medical Oversight Physician (OLMOP) or the Clinical Support Paramedic (CSP) should be involved in such decisions. See **Figure 1** for a general guideline on who to contact in the various situations.

Questions to consider when determining if the patient has the capacity to refuse transport include:

1. Has their condition/clinical situation been clearly explained to them in terms that they understood, and how have they demonstrated this understanding?
2. Does the patient demonstrate an understanding of the risks and consequences of non-transport?
3. Does the patient display age and situation appropriate behaviour?
4. Does the patient appreciate the consequences of a poor outcome?
5. Does the patient verbalize a logical reason for non-transport? If yes, what was it? You need not agree with the logic provided, but the explanation provided must be "reasoned".
    - Alternate transport arranged
    - Cost/financial
    - Did not call/request EHS
    - Felt complaint not serious
    - Social factors
    - Terminal illness
    - Wait time in ED
    - Will seek alternative care
    - Another reason
6. Is there someone that can stay with the patient?
7. Does the patient and/or SDM understand the call back instructions?
    - Callback instructions are critical – ensure the patient understands any serious signs or symptoms to watch for, and feels comfortable that they can call 911 again at any time.

Key Points – Assessing Capacity in Patients Refusing Care: ACDC
Autonomy – Does the patient have the legal right to make the decision?
Comprehension – Does the patient understand the clinical situation?
Disclosure – Have all the risks and consequences been explained to the patient?
Capacity – Does the patient have the capacity to make the decision?

Using resources

Patient's friends and family members can also be valuable in attempting to persuade a patient to go to the hospital. Often they will listen to advice of people who are close to them.

Aside from the patient's family, friends and/or care giver(s), there are a number of other resources available to the clinician if a patient is refusing care. These include:

Law Enforcement: Law enforcement personnel can be requested to help in the assessment of a case (e.g. patient who is intoxicated and refusing transport) and/or management (e.g. a patient with a behavioural emergency refusing transport). The three Acts detailing when a patient can be managed involuntarily are the *Involuntary Psychiatric Treatment Act*, *Adult Protection Act*, and the *Child and Family Services Act.*

Clinical Support Paramedic: The Clinical Support Paramedic can provide support in situations where a patient with capacity is refusing transport however, the clinician is concerned about leaving them on scene. The CSP may have access to different resources that are not available on scene. The CSP must be contacted prior to completing the non-

transport/refusal of care process for the following patients:

- Those in cells or in police custody in any setting
- Those with moderate to high risk hypoglycemia
- Those with abnormal vital signs (see Figure 2 for abnormal vital sign tables)
- Those with chest pain
- Those with shortness of breath/respiratory system complaint
- Those with a head injury
- Suspected abuse
- Age greater than 65 years
- Age less than 5 years

Online Medical Oversight Physician: The Online Medical Oversight Physician (OLMOP) can provide advice regarding any patient. If a patient is refusing care or transport and they do not appear to have the capacity to do so, it is a requirement to contact the OLMOP. It should be noted that the OLMOP consult is not to seek approval of a non-transport, but rather it is to ensure decision-making capacity and that appropriate risks have been discussed. Research also demonstrates that the OLMOP can positively influence the patient's by speaking to the patient. For those patients who continue to refuse transport, the OLMOP can help develop a comprehensive care plan. The OLMOP must be contacted for all patients who are refusing transport and do not appear to have the capacity to do so, for example:

- Patients appearing intoxicated
- Patients with an altered LOC
- Patients with medical conditions that may impair judgement (e.g. dementia, delirium)

Another patient at high risk for adverse outcome if not transported is a patient who is pregnant and has experienced physical trauma. A call to the OLMOP must be made for these situations as well.

If non-transport is being considered for a patient with a suspected Public Health reportable infectious disease (e.g. SARS, TB, bacterial meningitis, etc.), contact the OLMOP to determine next steps. The clinician does not need to contact Public Health directly, as notifications are generally made once an infectious disease has been confirmed through testing. For a complete list of reportable diseases, visit this website: https://www.cdha.nshealth.ca/public-health/communicable-disease/fact-sheets-communicable-diseases

For the most up-to-date list of mandatory CSP or OLMOP contacts, see relevant policies.

Mental Health Crisis Line: This is a provincial line within the province of Nova Scotia to provide 24/7 support for the patient in mental health crises. The number is 1-888-429-8167.

Mental Health Mobile Crisis Team: This is a crisis support service of Capital Health, IWK Health Centre, Halifax Regional Police and Nova Scotia Department of Health and Wellness. The team provides support for people in most communities of Halifax Regional Municipality with any mental health crisis. This team can be reached at the Mental Health Crisis Line as indicated above.

Adult Protection Services: Adult Protection Services should be contacted for adults 16 years of age and older who are living in a situation of significant risk of self-neglect, or experiencing abuse or neglect by others, which results in serious harm to the person and their inability to protect themselves from abuse or neglect by reason of mental and/or physical incapacity. Adult Protection Services has the authority to intervene based on the following:

- The person is living at an immediate and significant level of risk and does not understand or appreciate the level of risk they are living in.
- The person does not have the physical capacity to protect themselves from the assessed risk.
- The person has a permanent, irreversible condition that affects their physical or mental ability to protect themselves.

If a clinician notes that an adult is in need of protection for the above reasons, it is their moral, ethical and legal responsibility to report observations by calling 1-800-225-7225.

When determining if a patient may need help in caring for themselves, consider the Clinical Frailty Scale (**Figure 3**) and activities of daily living (ADLs). These can include items such as:

- Ability to cook and feed themselves
- Mobility (inside and outside the home)
- Ability to wash and use the bathroom
- Ability to use the telephone
- Presence of a medical alarm

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Developing a care plan

The clinician, in conjunction with clinical support (e.g. OLMOP or CSP), must develop a care plan for the patient to follow that is relevant to their chief complaint of situation. A care plan should include the following:

[1] Signs and symptoms to be aware of

[2] Direction to call 9-1-1 if priority symptoms occur

[3] Direct to call 8-1-1 if there are any follow-up questions

[4] Development of a safe follow-up plan, which may include any of the following:

- Have someone else take the patient to the ED
- Direction to follow up with a healthcare provider within 24 hours
- Seek primary care
- Provide a scheduled appointment
- Provide a referral to a community program (e.g. Falls Prevention)
- Referral to EHS program

[5] Recommended self-care (e.g. ice, meals, home medications, etc.)

[6] Ensure any patient with a condition that could affect their level of consciousness agrees not to drive or engage in other activity that could put themselves or others at risk. For example, a patient with concerning chest pain or recent seizure should be advised not to drive. This may include the OLMOP sending notification to the department of motor vehicles.

This plan should be documented in the PCR and written down and left with the patient, family, and/or caregiver.

Documentation

Patients who are not transported constitute one of the highest risk calls a clinician is involved in. Because there is no formal transfer of care, documentation for these patients must be comprehensive, including all aspects of patient and clinician decisions, as it is the only medical record of that patient interaction. To ensure accurate representation and documentation of the call, it is important to select the response outcome that most accurately reflects the situation. It is commonly quoted in CQI systems that “if it is not documented, it never happened.” This highlights the importance of the integrity of the medical record accurately reflecting the events of the patient interaction. The EHS Clinical Documentation Standards Guide provides details on documentation of situations in which a patient is not transported. In general, the chart needs to include:

- a detailed account of the explanation/rationale leading to the non-transport, including the details of the capacity assessment
- any physical findings
- the mental status of the patient (GCS and orientation to person, place, time, and event)
- the patients speech, behaviour, affect, and thought form and content the reason for refusal
- the disclosure and patient acknowledgement/comprehension of risks/consequences, benefits and alternatives
- the risks explained to the patient
- any advice given to the patient
- clinical consult details
- any witness information
- the refusal of care signature form

KNOWLEDGE GAPS

Literature suggests that paramedics are currently not proficient at determining need for transport in the out-of-hospital setting. The more resources the paramedic uses, the more likely it is that adverse outcomes will be avoided.

It is important to support any research in this area in order to increase patient safety.

EDUCATION

Further education in terms of safe non-transport options is being explored.

QUALITY IMPROVEMENT

Non-transports with bounce back calls will be reviewed as part of the prospective CQI program.

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Figure 1: Clinical Consults for Refusal of Care

	Patient wants transport	Patient does not want transport
Clinician feels transport is warranted	None (Transport)	Contact OLMOP
Clinician does not feel transport is warranted	Contact OLMOP	Situation dependent (no call, call CSP or call OLMOP)

Figure 2: Abnormal Vital Signs

Adult

Vital Sign	Parameter
Heart rate	Less than 60 or greater than 100 beats per minute
Systolic blood pressure	Less than 90 or greater than 140 mmHg
Respiratory rate	Less than 10 or greater than 22 breaths per minute
Blood glucose level	Less than 4 or greater than 8 mmol/L*
Temperature	Less than 36 or greater than 38°C*
Oxygen saturation	Less than 94% (or outside of targeted COPD range)*

*These particular values are considered abnormal and require a clinical consult for pediatric patients as well

Pediatric

Heart Rate

Age	Low	Normal	High
0 to <3 mo	<95	110 - 160	>180
3 to <6 mo	<105	120 - 160	>180
6 to <12 mo	<100	110 - 150	>160
1 to <4 y	<75	85 - 140	>145
4 to <10y	<60	70 - 115	>125
≥ 10y	<45	60 - 100	>105

Respiratory Rate

Age	Low	Normal	High
0 to <3 mo	<25	35 - 55	>60
3 to <6 mo	<25	30 - 50	>60
6 to <12 mo	<20	30 - 50	>60
1 to <4 y	<17	20 - 45	>50
4 to <10y	<15	17 - 27	>30
≥ 10y	<10	13 - 22	>25

Pediatric Definition of Hypotension*

*Defined as <5th percentile for age

Age	Systolic BP (mmHg)
Term neonate (0-28 days)	<60
Infants (29 days - <12 mo)	<70
Children (1 - <10 years)	<70 + (age in years x 2)
Children (>10 years)	<90

Source: American Heart Association Inc.

Figure 3: Clinical Frailty Scale

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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PEP 3x3 TABLES for NON-TRANSPORT/REFUSAL OF CARE

Throughout the EHS Guidelines, you will see notations after clinical interventions (e.g.: **PEP 2 neutral**). PEP stands for: the Canadian **P**rehospital **E**vidence-based **P**rotocols Project.

The number indicates the Strength of cumulative evidence for the intervention:
1 = strong evidence exists, usually from randomized controlled trials;
2 = fair evidence exists, usually from non-randomized studies with a comparison group; and
3 = weak evidence exists, usually from studies without a comparison group, or from simulation or animal studies.

The coloured word indicates the direction of the evidence for the intervention:
Green = the evidence is supportive for the use of the intervention;
Yellow = the evidence is neutral;
Red = the evidence opposes use of the intervention;
White = there is no evidence available for the intervention, or located evidence is currently under review.

As of 2021/10/14 there are no PEP Recommendations for Non-Transport/Refusal of Care Interventions. PEP is continuously updated. See: https://emspep.cdha.nshealth.ca/ for latest recommendations, and for individual appraised articles.

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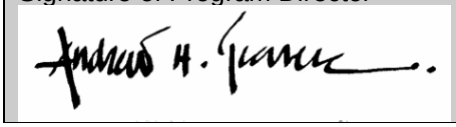
Signature of Program Director 		Signature of program Document Coordinator *Tanya Fraser* *Electronically Signed to Expedite Transfer*