SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

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PATIENT CONSENT FOR AND PATIENT REFUSAL OF EMERGENCY MEDICAL CARE AND TRANSPORTATION – Public Comment December 4

I. PURPOSE

A. To define who a patient is
B. To specify the requirements for evaluation and documentation of non-transported patients at the scene of a prehospital medical incident.
C. To establish performance and documentation standards for non-transport incidents, including the assessment and release of patients who choose to decline transport or refuse services against medical advice.
D. To establish a process for when prehospital personnel cannot physically access a patient.

II. DEFINITIONS

A. **Adult**: Adult is a:
   1. Individual eighteen (18) years of age or greater
   2. Legally emancipated minor*
   3. Legally married minor*
   4. Individual on-duty with the armed forces;
   5. Self-sufficient minor at least 15 years of age, living apart from parents, and managing their own financial affairs.
   *SFPD should be notified if the Prehospital Provider cannot verify the patient's legal status.

B. **Capacity**: Capacity is the ability to understand, and demonstrate an understanding of, the nature and consequences of refusing medical care. An individual has capacity if they:
   1. Are able to rationally and logically discuss/repeat details of medical need, including benefits, risks, and alternatives and the consequences of refusal; and
   2. Have not been declared to lack capacity to make decisions (as described in Section II C)

C. **Designated Medical Decision Maker or Authorized Legal Representative**: An individual, other than the patient, who has the legal and documented responsibility for making the patient's medical decisions. This individual may be:
   1. A parent or guardian of a minor;

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2. A conservator who presents letters of conservatorship from a court stating that the patient is not competent to give or withhold consent for medical care.
    a) Letters of conservatorship are specific regarding the patient's lack of capacity to give or withhold consent to psychiatric treatment, routine medical care, and necessary/non-routine medical treatment. The letter shall match the conservatee's name, be checked for correct timeframe and signed/dated. An LPS conservator is unlikely to have authority to make non-routine medical treatment decisions, and a court order must be sought for non-routine treatment. Emergent/life-saving treatment may always be provided without consent from the decision-maker. An LPS conservatee cannot refuse transport to a Receiving Facility without the approval of the conservator (Welfare and Institutions Code § 5358.5). Patients may appear to have decision-making capacity but have been legally declared incompetent. Prehospital personnel should contact the conservator when encountering patients known to be conserved. If the court order is silent on a relevant issue, and/or prehospital personnel cannot get a hold of the conservator, contact the Base Hospital.
3. An attorney -in-fact appointed under a durable power of attorney for health care;
4. In the absence of any of the above in no. 1-3, the patient's surrogate decision-maker with Base Hospital consultation.

D. **Gravely disabled**: A condition in which a patient, as a result of a mental health disorder, impairment by chronic alcoholism, severe substance use disorder, or a co-occurring mental health disorder and severe substance use disorder is unable to provide for their basic needs for food, clothing, shelter, personal safety, or necessary medical care.

E. **Patient:** A patient any individual identified by a prehospital provider who meets any of the following descriptions:
1. Has requested medical assistance;
2. For whom medical assistance has been requested by another person and:
    a. Has a complaint suggestive of potential illness or injury, or
    b. Has obvious evidence of illness or injury, or
    c. Has experienced an acute event that could reasonably lead to illness or injury, or
    d. Is in a circumstance or situation that could reasonably lead to illness or injury, or
    e. Is experiencing an apparent medical emergency.
3. If there's any uncertainty about request for medical assistance or emergency medical condition, the prehospital provider shall consider the individual a patient.

F. **Psychiatric/5150 Involuntary Hold**: A patient who is involuntarily detained and transported for evaluation under the authority of Welfare and Institutions Code (e.g. §

5150, § 5585 [minors]) because as a result of a mental health disorder, the patient is a danger to themselves, danger to others, and/or gravely disabled. A law enforcement officer or a provider authorized by the DPH Director of Behavioral Health may detain an individual and place them, using an authorized written application, on an involuntary hold for up to 72 hours for assessment, evaluation, and crisis intervention or placement for evaluation and treatment. The authorized written application must accompany the patient to the facility that they are transported to for further assessment.

G. **Routine Medical Treatment:** Includes, but is not limited to, diagnostic tests, physical exams, and for non-life-threatening wound care.

III. POLICY

A. Offer of Transport

1. Prehospital personnel must offer to provide care and transport to a patient unless:
    a. Otherwise provided in EMSA Policy # 4050 (Death in the Field)
    b. Otherwise provided in EMSA Policy # 4051 (Do Not Resuscitate)
    c. There is a declared state of emergency or disaster, as defined in EMSA Policy # 8000 (Multi-Casualty Incident)
    d. Prehospital personnel safety is threatened

B. Documentation

1. Non-transporting prehospital personnel, handing off care to transporting prehospital personnel, must document assessment findings and interventions using an EMS Agency approved form. Non-transporting prehospital personnel shall use dark blue or black ink on written forms to complete the transfer of care report, clearly and legibly, and sign it upon completion.
    a) A copy of this report must be turned into the receiving hospital along with the transport Patient Care Report (PCR).
    b) Provider Agencies shall retain the original copy of the Transfer of Care documentation in compliance with medical record regulations.
2. Transporting prehospital personnel shall complete a (PCR) for each patient contact.
3. All non-transported patient encounters must be documented on a PCR (electronic or paper) to the best effort of the responder and include the following information:
    a) Complete assessment findings;
    b) Medical care and transportation offers;
    c) Any care given;
    d) Explanation to the patient including potential consequences of the patient's actions;
    e) The potential benefits of prehospital care and transportation;
    f) The patient's own words verbalizing an understanding of the event, the refusal of care, and the potential consequences of the refusal of care;

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g) The patient's capacity and criteria of self-determination to make the medical care decision (include name, age, and guardian as appropriate);
h) An assessment of the patient's mental status, including orientation and speech, gait and if able, other physiologic parameters including vital signs;
i) The name and relationship of a parent or guardian to the patient, if the patient is released to that person;
j) The name and badge number of the police officer if the patient is released to the officer;
k) Patient signature acknowledging the availability of ambulance transport and their refusal of services;
l) Witness signature if available (witness is third party who is not the patient or provider);
m) If a patient refuses to sign the form (or electronic equivalent) after having been determined to have decision making capacity, the release shall be documented within, or included with, the PCR after being signed by both members of the EMS crew and a witness (if available).
n) The documentation shall include a description of the circumstances surrounding the refusal to sign including direct quotes of statements made by the patient;
o) Patients declining transport (PDT) with MINOR medical conditions require, at minimum, the signatures of one paramedic + one crew member (EMT or above). Refer to Section IV. A.;
p) Patients refusing transport against medical advice (AMA) with potentially significant or life threatening medical conditions (as defined in Section IV. B. 1.) require, at minimum, one of the following:
   (1) The signatures of one paramedic + one crew member (EMT or above) May consider Base Hospital physician consultation if prehospital personnel feel there is a need, benefit for the patient, or unique/unusual circumstance.
   (2) If the patient is detained by or in custody of law enforcement, and refusing evaluation, treatment, or transport, Base Hospital contact is required.
q) For incidents where the above items a) through q), cannot be performed or completed, refer to Appendix 3 *Prehospital Personnel Resources for Patient Management*.

4. During a declared MCI, documentation shall be in accordance with Policy # 8000.
5. PDT and AMA at special events / mass gatherings approved under EMSA Policy # 7010 (EMS at Special Events) shall follow the guidelines defined in Policy 7010.
6. Prehospital personnel and Provider Agencies shall maintain confidentiality of the verbal and documented patient and medical information in compliance with applicable state and federal law on patient confidentiality.

C. Patient Evaluation

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1. Minimum evaluation for ALL patients is described in EMS Agency Treatment Protocols 1.01 (Primary Survey) and 1.02 (Secondary Survey).

D. Patient Decision-Making Capacity and Self-Determination for Treatment Purposes

1. The law presumes an individual has capacity to consent or refuse care. Pre-hospital personnel alleging a lack of capacity must thoroughly document the reasons why the patient lacks capacity. The mere presence of a psychiatric illness, drug and/or alcohol use, or physical/mental impairment may impair patient decision-making capacity but are not sufficient on their own to eliminate decision-making capacity. Any patient who meets the self-determination criteria below shall be allowed to make decisions regarding their medical care, including the refusal of evaluation, treatment and/or transport. The criteria for allowing self-determination of medical care include:
   - a) Having capacity (as defined in Section II. B.); and
     - i. Being an adult (as defined in Section II. C.); or
     - ii. Pregnant minors if related to self-determination for the medical treatment of their pregnancy or reproductive health.
2. Any patient who presents with one or more of the following conditions shall be considered as lacking decision-making capacity, in the opinion of the prehospital provider, regarding refusal of medical care. When safe to do so, the individual shall be transported to the appropriate Receiving Facility for further evaluation. (Patient consent in these circumstances is implied, meaning that a reasonable and competent adult would allow the appropriate medical treatment under similar circumstances):
   - a) Altered mental status. Causes of altered mental status may include, but not limited to:
     - i. Abnormal vital signs
     - ii. Influence of drugs and/or alcohol
     - iii. Psychiatric illness
     - iv. Metabolic or infectious causes (e.g. CNS infection or hypoglycemia)
     - v. Dementia
     - vi. Head trauma
   - b) Minors (as defined above) with no parent or legal guardian available;
   - c) Legally incompetent adult without legal guardian or DPOA available;
   - d) Patients who are conserved (under a probate or LPS, temporary, or permanent conservatorship) may have capacity to make certain health care decisions.
     1) The prehospital provider must review the Letters of Conservatorship to determine whether the person lacks capacity to make decisions regarding psychiatric treatment, routine medical treatment, or necessary/non-routine treatment. Emergent/life-saving treatment may always be

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provided without consent from the conservator. Non-emergent treatment may qualify as routine or non-routine medical treatment, depending on the treatment. See Section II for definitions.

2) An LPS conservatee cannot refuse transport to a Receiving Facility without the approval of the conservator (Welfare and Institutions Code § 5358.5).

e) If special circumstances or uncertainty exists as to the presence of one of the above conditions and patient decision-making capacity is thought to be intact, the base hospital may be contacted for consultation and recommendations.

E. 5150 Involuntary Holds

1. Patients who as a result of a mental disorder have been determined to be a danger to themselves, danger to others, or are gravely disabled, and are refusing voluntary transport must be placed on a 5150 involuntary hold in order to transport them to a Receiving Facility for further assessment and treatment or placement for evaluation and treatment. Any person who wants to be transported who has expressed danger to self, danger to others, or are gravely disabled but has not received an assessment for 5150 hold criteria, may be transported without a 5150 hold.
2. Patients who are detained under a 5150 involuntary hold by law enforcement or an authorized prehospital provider can refuse non-emergent medical treatment.
3. Pre-hospital providers have authority to transport patients to a Receiving Facility detained on a 5150 involuntary hold for assessment, evaluation, and crisis intervention or placement for evaluation and treatment to an authorized facility, even if the patient refuses treatment or refuses transport.
4. Patients who are on an LPS Conservatorship (temporary or permanent pursuant to Welfare and Institutions Code § 5350 or § 5352.1) are on an involuntary hold and can be transported to a Receiving Facility, even if the patient refuses treatment or refuses transport. Contact the Conservator in these situations.

IV. PATIENT RELEASE AND NON-TRANSPORT PROCESS

A. Patient Refusals with Minor Medical Conditions – Patient Declines Transport (PDT)

1. Patients who meet self-determination criteria and who have been evaluated by a paramedic and determined to have a minor medical condition that requires prehospital care and/or transportation to an Emergency Department may request a release from further treatment and transport to an Emergency Department only after being advised of the following:
   a) That Advanced Life Support (ALS) assessment is available and being offered; and
   b) That ambulance transportation to an Emergency Department and prehospital care are available and being offered; and

c) The nature of the condition and the risks associated with refusal of prehospital care and transportation to an Emergency Department; and
d) The benefits of prehospital care and transportation to an Emergency Department; and
e) The patient should seek medical attention from a private physician or clinic as indicated; and
f) That EMS may be reactivated if they should change their mind.

2. The attending prehospital provider will review the form (or electronic equivalent) with the patient and ensure that they understand its content (with appropriate use of interpreter services if necessary).

B. Patients Refusals with Potentially Significant or Life Threatening Medical Conditions - Against Medical Advice (AMA)

1. Patients who meet self-determination criteria and either (1) have been evaluated by a paramedic and determined to have a significant or potentially life-threatening medical condition that requires prehospital care and / or transportation to an Emergency Department or (2) cannot be evaluated due to an unsafe scene (e.g. non-criminal barricade situation), may request a release from further treatment and transport to an Emergency Department. Potentially significant or life-threatening medical conditions include the following:
   a) Chest pain
   b) Shortness of Breath/Dyspnea
   c) Syncope
   d) Seizure
   e) Severe headache
   f) Pregnancy-related complaints
   g) Patients meeting Trauma Center Criteria (including mechanism, see EMSA Policy # 5001 (Trauma Triage Criteria))
   h) Suspected Gastrointestinal bleed
   i) Markedly abnormal vital signs
   j) Signs and symptoms of Stroke/Transient Ischemic Attack
   k) Dizziness
   l) Any patient for whom an ALS intervention has been performed on-scene
2. Every effort should be made to convince the patient to accept treatment and/or transport. Be persuasive and use family members or friends if available.
3. The attending prehospital provider will review the form (or electronic equivalent) with the patient and ensure that they understand its content (with appropriate use of interpreter services if necessary).

V. BASE HOSPITAL PHYSICIAN CONTACT

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A. Prehospital providers may contact the Base Hospital physician for consultation for any patient.
   1. Base Hospital Physician name must be documented by Prehospital Provider in PCR.
B. If the treating paramedic is fulfilling Continuous Quality Improvement (CQI) requirements or is doing their first 5 non-transport EMS calls in the San Francisco EMS System, Base Hospital physician contact must be obtained for all patients who are not transported.
C. Every effort should be made to contact the Base Hospital while the prehospital provider is still with the patient.
D. Base Hospital physician report should use this format:
   1. Ambulance Company name and unit ID number
   2. Prehospital provider ID
   3. Incident number
   4. Purpose of the consultation
   5. Patient age and gender
   6. Location found
   7. Patient chief complaint
   8. Vital signs
   9. Blood glucose and ECG findings if relevant
   10. Patient assessment, pertinent physical exam
   11. Pertinent past medical history
   12. Capacity assessment findings
   13. Patient's plan for care if any
   14. Prehospital provider's opinion for disposition

VI. LAW ENFORCEMENT

A. Prehospital Personnel must evaluate patients who are in law enforcement custody (defined as "under arrest", "detained", or "incarcerated"), for whom prehospital personnel are called to the scene to evaluate, for potential medical care needs.
   1. A patient in law enforcement custody maintains the right of self-determination for medical care decisions, including refusals and AMA refusals, and must be treated in accordance with this policy and applicable EMS Agency treatment procedures.
   2. Prehospital Personnel must contact a Base Hospital physician before releasing an in-custody patient who is refusing treatment and/or transport to law enforcement. The paramedic and Base Hospital physicians shall follow all procedures as outlined in Section V of this policy.

VII. SITUATIONS WHERE PREHOSPITAL PERSONNEL SAFETY IS THREATENED

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A. Prehospital Providers shall make every attempt to not put themselves in harm's way to treat or transport a patient.
B. In instances where the safety of the prehospital personnel is in jeopardy and all reasonable and prudent attempts to mitigate the threat, including law enforcement involvement, have failed, prehospital personnel may withdraw from the immediate danger area and wait for the scene to be secure prior to evaluating the patient. In all cases where this provision is implemented:
   1. The EMS Provider's Paramedic Supervisor shall be notified immediately and shall, within 24 hours, submit documentation to the EMS agency regarding the circumstances surrounding the decision; and
   2. The Paramedic Supervisor shall notify the Department of Emergency Management Duty Officer within 60 minutes of the incident; and
   3. The EMS Agency shall treat all such incidents as a Sentinel Event.

VIII. AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.204, 1798, 1798.6, and 1799.106

California Code of Regulations, Title 22, Sections 100147, 100172 – 100175

APPENDIX 1: PATIENT DECLINING TRANSPORT FORM

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<table>
<tr><td colspan="3">Patient Declines Transport
I acknowledge that I have a medical problem, which requires additional medical attention, and that an ambulance is available to transport me to the hospital. Instead, I elect to seek alternative medical care and refuse further treatment and/or transport. I hereby release, discharge and waive any and all claims and demands arising out of or in connection with my refusal to accept transport against (1) the City and County of San Francisco, its officers, agents and employees and (2) the ambulance service provider.</td></tr>
<tr><td>Patient Name (Print):</td><td>Patient Signature:</td><td>Date:</td></tr>
<tr><td>Witness Name (Print):</td><td>Witness Signature:</td><td>Date:</td></tr>
<tr><td>Paramedic or EMT Name (Print):</td><td>Paramedic or EMT Signature:</td><td>Date:</td></tr>
<tr><td>Paramedic or EMT Name (Print):</td><td>Paramedic or EMT Signature:</td><td>Date:</td></tr>
<tr><td colspan="3">Ambulance Company Name:</td></tr>
<tr><td colspan="3">Circumstances/Reasons for Declining Transport:</td></tr>
<tr><td colspan="3">Advice given/Alternatives discussed:</td></tr>
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APPENDIX 2: REFUSALS AGAINST MEDICAL ADVICE FORM

Against Medical Advice (AMA)

I, the undersigned, have been advised that I need medical assistance, and that refusal of this medical assistance and transport to a hospital may result in my death, or imperil my health. Nevertheless, I refuse to accept treatment or transport. I assume all risks and consequences of my decision to refuse treatment or transport. I hereby release, discharge and waive any and all claims and demands arising out of or in connection with my refusal to accept treatment or transport against (1) the City and County of San Francisco, its officers, agents and employees and (2) the ambulance service provider.

<table>
<tr><td>Patient Name (Print):</td><td>Patient Signature:</td><td>Date:</td></tr>
<tr><td>Witness Name (Print):</td><td>Witness Signature:</td><td>Date:</td></tr>
<tr><td>Paramedic or EMT Name (Print):</td><td>Paramedic or EMT Signature:</td><td>Date:</td></tr>
<tr><td>Paramedic or EMT Name (Print):</td><td>Paramedic or EMT Signature:</td><td>Date:</td></tr>
<tr><td colspan="3">Ambulance Company Name:</td></tr>
</table>

<table>
<tr><td>Risks of Refusal Discussed with Patient:</td><td rowspan="2">Reasons stated by patient for refusing care:</td></tr>
<tr><td>Benefits of Care/Transport Discussed with Patient:</td></tr>
</table>

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Safety is paramount for our EMS crews and patients. To determine the best approach to ensure both the needs of the patient are met and the resources prehospital personnel may need to provide patient care safely, consider the following steps and actions when evaluating each call or scenario. This is not a comprehensive list of steps for all circumstances and is listed in no particular order. EMS clinicians shall use sound clinical judgment and scene management skills.

Steps:	Notes:	Policy Reference and Link:
Ensure Provider Safety and Scene Security	Scene safety is paramount for EMS crews and patients. If the scene cannot be made safe or the scene becomes unsafe, then document, in detail, what was not safe about the scene and what steps were taken to try to mitigate scene safety. Document what happened to the patient prior to leaving a scene. Employ the following options to best mitigate safety concerns: • Verbal De-escalation • Utilize responder with the best rapport for communication with the patient • If appropriate, utilize bystanders to communicate with the patient • Request Law Enforcement • Request Engine or Truck • Request EMS Supervisor	**1.01 Patient Assessment** **4041 Scene Management** **4043 EMS Use of Physical Restraints** **4040 VII. B Prehospital Personnel Safety Threatened**
Call Supervisor	Escalate difficult situations/unsecure scenes for review by an EMS Supervisor by calling the EMS Supervisor to the scene.	**2052 Paramedic Field Supervisor** **4041 Scene Management**
Call Law Enforcement	Request law enforcement to the scene. If law enforcement does not respond, intervene, nor assist, make sure to document what happened when law enforcement arrived, their level of involvement, and the outcome.	**4041 Scene Management** **4043 EMS Use of Physical Restraints**
Request Base Hospital Physician in the Field (if available)	Request a Base Hospital Physician, assigned to the field rotation, to respond to the scene. This physician can speak with the patient or provide medical advice while on scene. Document all interactions with a physician who arrives on scene.	**EMSA Memo-New EMS/Base Hospital Physician in the Field Program**
Call Community Paramedic Captain (e.g. EMS6, CP5, CP7)	Request the appropriate Community Paramedic Captain to the scene to assist. The Captain can consult and decide if it is an appropriate response for Street Crisis Response Team or Street Wellness Response Team and/or respond to the scene directly. A member of the unit may have specialized training to assist with a patient especially if there are medical, behavioral health, or	**4041 Scene Management**

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	social needs. The Community Paramedic team may be able to develop a back-up strategy such as re-engaging with the patient a few hours later or offering other social resources.	
Documentation	Write a full Patient Care Report (PCR), even if a first response form would be indicated. Include which of the steps in this Appendix 3 were taken, why the steps were taken, and the outcome of each step. If a step did not apply to the situation or was not taken, document the rationale. Document quotes from individuals on scene. Any phone calls/radio communications to dispatch, physicians, and supervisors should be on a recorded line if possible. Document the following as applicable: **PDT** • Patient did not activate 911 • Patient does not consent to evaluation • Patient does not consent to demographic information • Patient has no obvious signs of trauma • Patient has no obvious signs of drug or alcohol intoxication • Patient is speaking in clear speech • Patient has no obvious medical complaint or signs of distress • Patient self-ambulates from scene with a steady gait • Patient is offered evaluation, treatment, and transport • Patient advised to activate 911 if any change of decision **AMA** • Multiple attempts at de-escalation • Law enforcement contacted for scene management per Policy 4041 • Community Paramedic Captain Contacted • Law enforcement denies request to assist physical restraint of patient • Community Paramedic Captain or Field RC to assist crew filling out Sentinel Event • Request Base Hospital Physician in the Field through the DEC if available and the patient is still on scene	**4040 Procedure and Documentation for Non-Transported Patients** **6020 Incident Reporting** **4040 VII B Prehospital Personnel Safety Threatened**

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APPENDIX 4: ALS Assessment Criteria

An ALS Assessment shall occur for the following clinical indications. The following list is a guide and is not comprehensive. If in doubt or unsure whether patient needs an ALS assessment, care and/or transport, call for an ALS resource to respond.

A. Abdominal Pain
   1. Discomfort, pain, unusual sensations if patient is > 40 years old and has cardiac history
   2. Severe generalized abdominal pain

B. Breathing
   1. Respirations > 30 min, abnormal respiratory patterns, patient in tripod position
   2. Audible wheezing
   3. Need for inhaler or no improvement after self-administration
   4. Asthma attack or medical history with need for intubation

C. Burns
   1. All thermal burns except minor heat-related, superficial burns
   2. Chemical and/or electrical burns

D. Cardiac
   1. Suspected acute coronary symptoms
   2. Irregular heart rate
   3. Chest pain

E. CVA/Stroke
   1. Suspected stroke with associated symptoms

F. Diabetic
   1. Patient with history of diabetes with decreased mental status, is unable to swallow, has rapid respirations, fails to respond to oral glucose, suspected ketoacidosis

G. Environmental
   1. Hypothermia or Hyperthermia with co-morbidities (i.e. elderly, illness, trauma, alcohol and/or drug-use)
   2. Suspected drug-induced hyperthermia

H. Mental Status
   1. Glasgow Coma Score less than or equal to 13
   2. Abnormal behavior with unstable vital signs
   3. Abnormal behavior with suspected drug or alcohol intoxication
   4. Sobering patients that do not meet Policy 5000 “Sobering Services” criteria

I. Vital Signs
   1. Hypotension (Systolic < 90)
   2. Signs of shock (Systolic < 90, Pulse > 120)
   3. Sustained tachycardia
   4. Hypotension and severe bradycardia

J. OB/GYN
   1. All patients with known or suspected pregnancy with an OB/GYN complaint

K. Seizure
   1. Any seizure or seizure-like activity reported prior to arrival

L. Trauma

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1. All patients meeting Policy 5001 Trauma Triage Criteria and/or patients meeting base hospital contact criteria within Policy 5001

Patients with moderate to severe pain requiring pain control

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