

INSTRUCTOR GUIDE

COURSE: DISPOSITION OF PATIENTS REFUSING TREATMENT

SESSION REFERENCE: 1

TOPIC: HANDLING REFUSALS USING THE “N.O.T.O.S” METHOD

LEVEL OF INSTRUCTION: LEVEL 3- APPLICATION

TIME REQUIRED: TWO HOURS

MATERIALS: WORKSHIEETS

PREREQUISITE KNOWLEDGE: ANY APPLICABLE TREATMENT

PREREQUISITE SKILLS: EMT-B, EMT-I, EMT-P

REFERENCES: EMT-BASIC: NATIONAL STANDARD CURRICULUM, MODULE 1,
LESSON 3-1, “MEDICAL/LEGAL AND ETHICAL ISSUES”.

BRADY, EMERGENCY CARE, 9th EDITION, CHAPTER 3

PREPARATION:

MOTIVATION: To ensure technicians are acting in the best interest of the patient and to reduce the number of potential lawsuits against the agency and the technicians.

OBJECTIVE (SPO):

1. Given a patient scenario, the student shall describe the steps required to acquire information needed to perform an ample refusal interview that fulfills the N.O.T.O.S. method

Enabling Objectives

- 1-1-1 The technician will describe factors that affect patient interviews
- 1-1-2 The technician shall describe gathering information from scene survey
- 1-1-3 The technician will describe gathering information from subjective sources
- 1-1-4 The technician will describe gathering information from objective sources

2. Given information included in (S.O.A.) of an appropriate S.O.A.P.E. note, the technician shall describe the steps of conducting a refusal interview required to fulfill the N.O.T.O.S. method.

Enabling Objectives

- 1-2-1 The technician will describe notifying a patient of the situation and possible outcomes if when refusing treatment.
- 1-2-2 The technician will describe to a patient treatment per protocols and training and possible outcomes of treatment.
- 1-2-3 The technician will describe repeating possible outcomes to patients refusing treatment
- 1-2-4 The technician will describe reading and explaining a refusal statement to a patient

3. Given the components of a refusal interview, the technician will be able to document a patient using the N.O.T.O.S method.

Enabling Objectives

- 1-3-1 The technician will describe how refusals are signed
- 1-3-2 The technician will document a patient's wishes to refuse
- 1-3-3 The technician will document on health issues and possible outcomes on patients refusing treatment
- 1-3-4 The technician will document on treatment told to the patient and possible outcomes
- 1-3-5 The technician will document the signing of a refusal

OVERVIEW: DISPOSITION OF PATIENTS REFUSING TREATMENT

- * Factors that affect interviews
- * Gathering information from scene survey
- * Gathering information from subjective source
- * Gathering information from objective sources
- * Notify patient of situation and possible outcomes to patient
- * Describing treatment per protocols and training and possible outcomes
- * Repeating possible outcomes to patients refusing treatment
- * Describing reading and explaining a refusal to the patient
- * Describing how refusals are signed
- * Documenting how refusals are signed
- * Documenting a patient's wish to refuse
- * Documenting on notification of health issues and possible outcomes on patient's refusing treatment
- * Documenting on treatment told to the patient and possible outcome
- * Documenting the signing of a refusal

I. GATHERING INFORMATION

A. Factors that affect interviews

1. Personal appearance
2. Attitude
3. Language

B. Gathering information from scene survey

1. Safety
2. Environment
3. Bystanders

C. Gathering information from subjective sources

1. Bystanders
2. Public safety officers
3. Patient

D. Gathering information from objective sources

1. Physical exam
2. Scene

NOTES:

Professionalism,
Building trust, establishing a
relationship with patients
Knowing Resources to overcome
any barriers

Examples:
Domestic Situations

Medicine Bottles

Attitudes of significant others
Examples:

Bystander motives

Safety officer training, motives, obligation,
attitude etc.

Use of exam techniques taught during
training: BTLS, PALS, GEMS, etc.

General Observation

II. CONDUCTING A REFUSAL INTERVIEW

- A. **Notifying** patient of situation and possible **outcomes** to patient
1. Tell patient situation
 2. Tell patient possible health outcomes
- B. Describing treatment per protocols and training and possible outcomes
1. Tell patient of planned **treatment**
 2. Tell patient possible **outcomes**
- C. Repeating possible outcomes to patients refusing treatments
1. Give possible outcomes
 2. Give possible choice of treatments
- D. Reading and explaining refusals
1. Read refusal to the patient
 2. Explain the refusal
 3. Witness

III. DOCUMENTATION OF PATIENT REFUSAL

- A. How refusals are **signed**
1. Patient **signs** refusal
 2. Witness records / relationship
 3. Witness **signs** refusal

NOTES:

Initiate N.O.T.O.S when / if patient refuses

N and O of N.O.T.O.S
N=Notified of Situation
O=Possible Outcomes
Include:
Chief Complaint
Contributing factors

T and O of N.O.T.O.S
T=Tell Treatment Modalities

Give examples: i.e. Motor Vehicle Accident / Chest Pain
Give examples per audience-- Advanced Life Support or Basic Life Support

Continued O of N.O.T.O.S
O=Possible outcome with treatment
****Note****Repeat possible outcome without treatment
Give examples: i.e. MVA / Chest Pain Give examples per audience-- Advanced Life Support or Basic Life Support

Read and explain refusal to witness if necessary

S of N.O.T.O.S
S=Signing of refusal statements

Procure name of witness if not readable
Clarify witness's relationship with the patient if necessary

B. Documenting a patients wish to refuse

1. Record wish to refuse
2. Record reason why, if given
3. Record patients plan, if any

Give examples of patient's plans, ie. Will seek treatment on own
Patient thinks they are ok.

C. Documenting on health issues and possible outcomes on patients refusing treatment.

1. Record that patient was advised of information.
2. Record health outcomes told to patient.

N and O of N.O.T.O.S
Apply to previous examples

D. Documentation of treatments explained to the patient

1. Record treatment modalities told to the patient
2. Record possible health outcomes told to patient

T and O of N.O.T.O.S

Continue with previous
Examples

E. Documentation of the signing of a refusal.

1. Record the patient's desire.
2. Record that the patient read and was given verbal explanation of the refusal.
3. Record the name and relationship of witnesses.

S of N.O.T.O.S
Continued desire to refuse

Record witness and explained refusal

REVIEW:

DISPOSITION OF PATIENTS REFUSING TREATMENT

- * Factors that affect interviews
- * Gathering information from scene survey
- * Gathering information from subjective source
- * Gathering information from objective sources
- * Notify patient of situation and possible outcomes to patient
- * Describing treatment per protocols and training and possible outcomes
- * Repeating possible outcomes to patients refusing treatment
- * Describing reading and explaining a refusal to the patient
- * Describing how refusals are signed
- * Documenting how refusals are signed
- * Documenting a patient's wish to refuse
- * Documenting on notification of health issues and possible outcomes on patient's refusing treatment
- * Documenting on treatment told to the patient and possible outcome
- * Documenting the signing of a refusal

REMOTIVATION:

ASSIGNMENT:

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EVALUATION: See Scenarios

SCENARIO Work Sheet:

You respond to an office building to assist a 26-year-old male who had a syncope episode. Bystanders say the patient was telling a joke while he organizing and filing papers. The patient accidentally stapled his thumb. After pulling the staple out, the patient lost consciousness. The patient is currently alert with minimal bleeding from his thumb. He appears embarrassed and refusing treatment.

Scene Survey: a. d.
b. e.
c.

Objective: a. d.
b. e.
c.

Objective: a. d.
b. e.
c.

N.O.T.O.S.

- N – Notification of Situation**
- O - Possible Outcome:**
- T - Told Treatment Modalities:**
- O - Possible Outcome with treatment / Repeat possible outcome without treatment**
- S - Signing Refusal**

DOCUMENT REFUSAL USING N.O.T.O.S. SYSTEM

