STANDARDS' COMPANION EXAMPLES

NATIONAL INSTITUTE *for* MEDICAL RESPITE CARE

Standard 4: Medical respite program administers high quality post-acute clinical care.

2023

Table of Contents

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Medical Respite Guidelines for RNs and Providers on the Management of Patients Who Decline Recommended Care

Background: Patients have a right to determine whether or not they will agree to and comply with recommended care. This document is intended to provide RNs and Providers with guidance on how to optimize patient safety in these situations.

- If a patient declines medical recommendations:
  - A respite provider should meet to discuss this with the patient.
  - If a respite provider is not on-site, an RN should meet with the patient.
  - Respite RN may contact the on-call provider, if needed, for guidance on patient management.

- If a patient declines medical recommendations:

  - they should be apprised of the risks of declining the treatment.
  - The involved respite RN or provider should obtain confirmation of the patient's understanding of involved risks using the "teach-back" method.
  - If the patient's comprehension is limited, the respite RN should pass this information on to the provider on for the following day-shift (or contact the on-call provider if the recommendations are of an emergent nature) and document the information in a chart note.
  - If a provider is on-site, they should assess whether the patient has decisional capacity (see Table 1). The respite psychiatric provider can assist with assessment of decisional capacity, when needed. The decisional capacity assessment is to be documented in a chart note.

- **Table 1**, at the end of this document, offers guidance on the assessment of Decision-Making Capacity.

- If a patient is assessed to have decisional capacity and declines recommended treatment after receiving education on the associated risks:

  - the involved respite RN or provider should assess whether the patient can safely be managed in the respite setting (RN may consult covering provider as needed).
  - This assessment should take into account the absence of overnight medical staff for clinical monitoring of the patient.
  - This assessment should also take into account the clinical ramifications of the declined treatment.

- If it is determined that the patient can safely be managed in the respite setting, despite their declination of recommended care:

  - the patient should be asked to sign a "Refusal of Treatment" form (U2225)
  - a note should be entered summarizing the discussion and the patient's decision and signature of the form.

- If it is determined that the patient cannot be safely managed in the respite setting (they are or may become clinically unstable):

    - the provider or RN should refer the patient to the appropriate emergency department.
    - If the patient declines emergency department evaluation and it is deemed appropriate, the patient may be informed that they cannot remain at respite as they are beyond the program's scope of care.
    - Medics can be called to assess the patient and offer transport to the emergency department if the patient declines respite staff assistance with transfer to the emergency department.
    - Document information pertinent to the incident in the patient's record.

- If a patient is assessed to be clinically unsafe to remain at respite, they decline transport to the emergency department and choose to leave the program:

    - Offer pertinent information to the patient (e.g., ED options, community resources, crisis clinic telephone, walk-in visit options, list of upcoming appointments)
    - Within the boundaries of confidentiality, notify family, significant other(s), case managers and/or other members of the patient's care team to inform them of the patient's plan and discuss options to monitor and support the patient.
    - Document the circumstances under which the patient decided to leave, who was notified, that the patient was encouraged to seek emergency department evaluation and any other pertinent information.
    - Complete an incident Report on the Patient Safety Net

- If a patient is felt to be of immediate risk of self-harm or harm to others and is unwilling to have an emergency department evaluation, an MHP referral should be placed.

Table 1. Legally Relevant Criteria for Decision-Making Capacity and Approaches to Assessment of the Patient.

Criterion	Patient's Task	Physician's Assessment Approach	Questions for Clinical Assessment*	Comments
Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	Have you decided whether to follow your doctor's [or my] recommendation for treatment? Can you tell me what that decision is? [If no decision] What is making it hard for you to decide?	Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity
Understand the relevant information	Grasp the fundamental meaning of information communicated by physician	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor [or I] told you about: The problem with your health now The recommended treatment The possible benefits and risks (or discomforts) of the treatment Any alternative treatments and their risks and benefits The risks and benefits of no treatment	Information to be understood includes nature of patient's condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment) and their benefits and risks
Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	What do you believe is wrong with your health now? Do you believe that you need some kind of treatment? What is treatment likely to do for you? What makes you believe it will have that effect? What do you believe will happen if you are not treated? Why do you think your doctor has [or I have] recommended this treatment?	Courts have recognized that patients who do not acknowledge their illnesses (often referred to as "lack of insight") cannot make valid decisions about treatment Delusions or pathologic levels of distortion or denial are the most common causes of impairment
Reason about treatment options	Engage in a rational process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	How did you decide to accept or reject the recommended treatment? What makes [chosen option] better than [alternative option]?	This criterion focuses on the process by which a decision is reached, not the outcome of the patient's choice, since patients have the right to make "unreasonable" choices

* Questions are adapted from Grisso and Appelbaum.[31] Patients' responses to these questions need not be verbal.

Medical Respite

RN Protocol for Over-Sedated Patients

Department: Medical Respite
Effective Date: July 2019
Revision Dates:

POLICY PURPOSE

To describe Registered Nurse (RN) actions when Medical Respite patients are found over-sedated.

DEFINITIONS

- Naloxone (e.g. brand name Narcan) is a medication which reverses opioid drug overdose by temporarily blocking the drug effects.

- Opioid Emergency occurs when an excessive quantity of a recreational or prescribed opioid drug prevents an individual from responding appropriately to their environment. It is a medical emergency that includes symptoms such as:
    - Unconsciousness/Unresponsiveness
    - Severe sleepiness
    - Slowed heartbeat
    - Difficulty breathing (or slowed breathing)
    - Snoring or gurgling sound
    - Difficulty walking or talking
    - Pale or blue skin, feels cold
    - Pinpoint pupils or eyes rolled back

POLICY

- Registered Nurses (RNs) at Medical Respite who encounter over-sedated patients should utilize the Sedation Protocol Algorithm (attachment) for this opioid emergency.

PROCEDURE

- RN should initiate Respite RN Sedation Protocol if patient presents with decreased level of consciousness, pulse present and patient is breathing.
- Patients being monitored on the over-sedation protocol should self-transfer to a recliner chair that is placed in a readily visible location. One staff should be assigned to remain with the patient.

- If there are greater than 2 over-sedated patients requiring RN protocol monitoring, the patient(s) determined to be the most over-sedated should be referred to the ED.
- MHS or Medical Assistant (MA) staff may collect vital signs and report these to an RN. Responsiveness and level of arousal is to be assessed by RN staff.
- A note detailing the over-sedation event, vital signs and O2 saturations should be charted in ORCA and forwarded to Medical Respite providers.
- If an over-sedated patient is enrolled in a methadone maintenance program, the over-sedation documentation should be faxed to the appropriate methadone program facility.

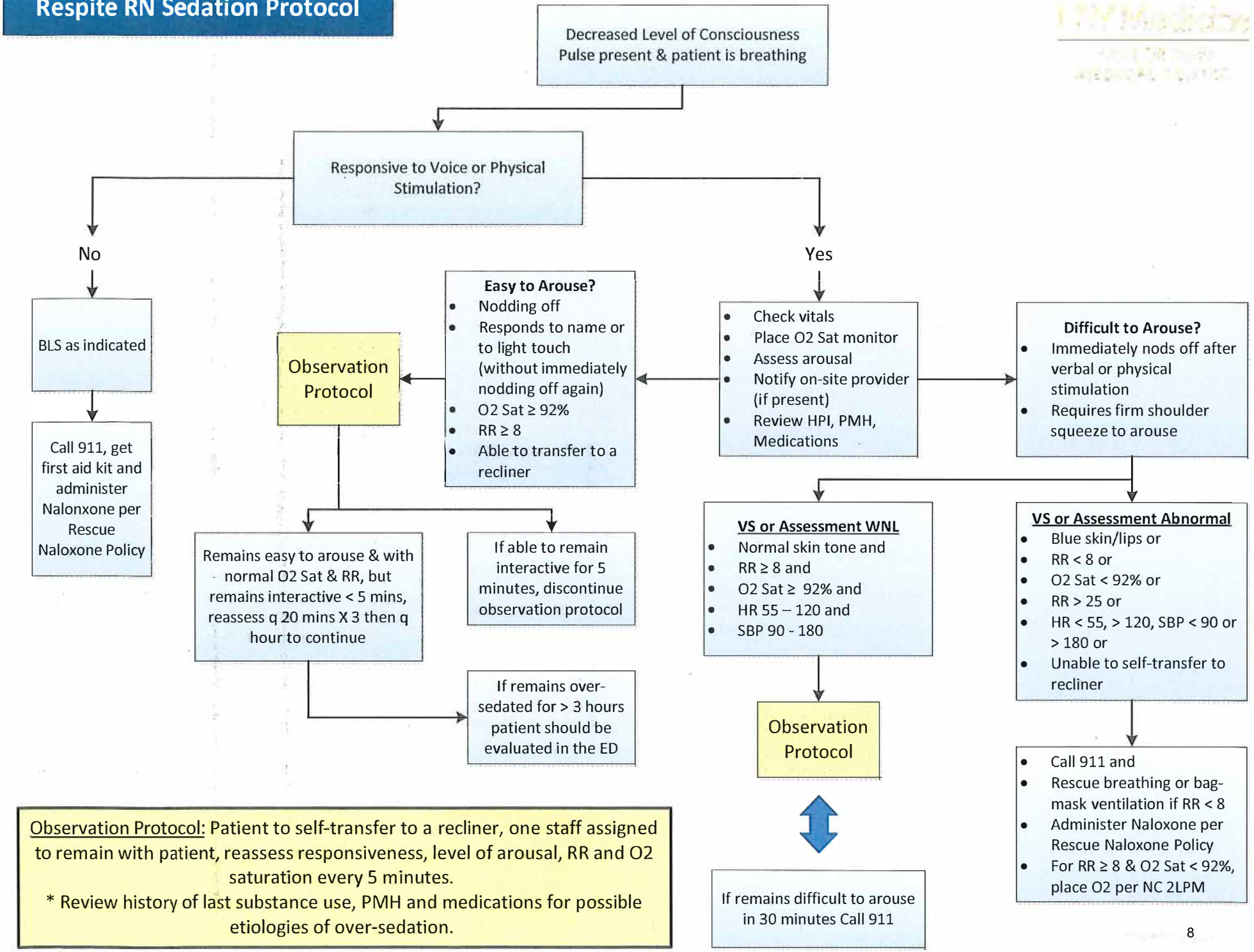
CROSS REFERENCE
County's Opioid Overdose and Naloxone Training Guide How to use Narcan
Rescue Naloxone (APOP 5.103)

ATTACHMENTS
Respite RN – Sedation Protocol Algorithm

REVIEW/REVISION DATES:
7/2019

SIGNATURE:

Respite RN Sedation Protocol



Observation Protocol: Patient to self-transfer to a recliner, one staff assigned to remain with patient, reassess responsiveness, level of arousal, RR and O2 saturation every 5 minutes.

* Review history of last substance use, PMH and medications for possible etiologies of over-sedation.

Revised 7/11/19