NWC EMSS DECISIONAL CAPACITY/RISK CHECKLIST (Rev. 1-27-22)

Pt. name		DOB		Gender	
Witness name		Has pt been declared legally incompetent? ☐ Yes ☐ No			
Chief complaint		Has pt been declared an emancipated minor? ☐ Yes ☐ No			
Law enforcement	☐ Requested & provided assistance ☐ Requested; denied assistance ☐ Not requested	Did EMS have access to the patient? ☐ Yes ☐ No; pt. refused ☐ No; scene deemed unsafe for EMS			

Decisional capacity assessment: If *any* of these are abnormal or impaired the pt may lack capacity. Attempt to assess & document if changes are new (acute) or features of chronic dx and how grossly abnormal EMS interprets the exam findings to be. ☐ No pt. access	WNL	Abn./ impaired new	Abn./ Impaired chronic
Alertness (Abn. GCS 13 or less): E (3 or 4 OK): V (5): M (6) Total:			
Orientation X 4: Answers accurately person, place, time, and situation (Abn. X 3 or less / 4)			
Speech: Rate, volume, articulation, content (Note abnormality in narrative)			
Affect: Mood/emotional response (sad, depressed, flat, anxious, irritable, angry, elated, inappropriate, and incongruent with speech content) (Note abnormality in narrative)			
Behavior: Quiet, restless, inattention, hyperactivity, compulsions, agitated, violent? (Note abnormality)			
Cognition: Thought processes - Confusion, delirium, delusions, hallucinations, phobias? (Note abnormality)			
Memory: Immediate, recent, remote (amnesia/dementia?) (Note abnormality in narrative)			
Insight: Can pt articulate lucid and logical implications and consequences to their choices? (Note abnormality)			
EMS personnel impression of decisional capacity based on their assessment:			
Physical exam findings (Consider usual baseline state and normal ranges for pt)			
☐ VS - BP: ☐ SpO_2 ☐ $ETCO_2$ ☐ Glucose ☐ ECG			
BALANCE/Coordination – Ataxia (upper or lower extremities); tremors EYES: Nystagmus			

	Y	N
Based on the suicide screen; does the patient pose an imminent risk to self?	Y	N
Based on the EMS risk assessment; does the pt pose an imminent risk to others?	Y	N

HPI/ PMH

☐ Denies PMH ☐ Unable to obtain PMH
☐ **A**: **Alcohol and drugs/toxins (substance use disorder);** ACS/HF, arrhythmias, anticoagulation
☐ **E**: Endocrine/exocrine, particularly thyroid/liver/adrenal dx; electrolyte/fluid imbalances; ECG: dysrhythmias/prolonged QT
☐ **I**: Insulin disorders: **hypoglycemia;** DKA/HHNS
☐ **O**: O_2 deficit (**hypoxia**), **opiates, overdose,** occult blood loss (GI/GU)
☐ **U**: Uremia; other renal causes including hypertensive problems
☐ **T**: (recent) Trauma, temperature changes
☐ **I**: Infections, neurologic and systemic (**sepsis**); infarction
☐ **P**: Psychological*; massive pulmonary embolism
☐ **S**: Space occupying lesions (epi or subdural, subarachnoid hemorrhage, tumors); stroke, shock **(hypotension),** seizures
☐ Neuro: delirium, dementia (Alzheimer's dx), developmental impairment, autism, Parkinson's disease; migraine or other headaches
☐ Metabolic: acidosis (✓ $ETCO_2$), vitamin/dietary deficiencies; eating disorders
*Psych/behavioral: anxiety disorders, mood disorder; PTSD, mental health crisis; personality and bipolar disorders; psychosis.

EMS CARE

Did patient receive any of the following from EMS?
☐ Verbal de-escalation ☐ Physical restraint ☐ Medication sedation If yes, explain in narrative.
☐ Ongoing monitoring of VS and oximetry every 5 minutes after EMS interventions
☐ Any untoward events after restraint or sedation? If yes, explain in narrative.

Pts may not dissent to care/transport IF: EMS has **access to the pt + they lack legal or decisional capacity;** and/or **pose an imminent risk to self, others, or is unable to care for self;** and/or remains acutely & severely **hypoxic** (SpO_2 < 90%), **hypoglycemic, hypotensive, or hypercarbic with AMS after care**. Transport under **implied consent**.

Disposition

☐ Treat/transport w/ express consent ☐ Treat/transport w/ implied consent ☐ Decisional pt refused care/transport ☐ No care d/t EMS safety concerns

Caveats on contested collaborative care decisions/EMS safety issues:

- Non-medical persons cannot compel EMS practitioners to provide or withhold any EMS care.
- EMS personnel have no duty to place themselves at risk of bodily harm in the absence of law enforcement assistance and protection.
- OLMC cannot compel EMS to act in a way that subjects them to risk of harm – which may mean leaving a high risk patient at the scene when EMS access has been denied, law enforcement declines to assist, and/or there is reason to believe the pt may have access to lethal weapons.

EMS shall not seek OLMC approval of a refusal in these instances. Rather, they shall report the following:

We are on scene with a person who has denied us access to provide a reasonable assessment and law enforcement has declined to intervene; OR we have determined that this person has legal and decisional capacity and they appear to pose no imminent risk to self or others and declines to be transported at the present time. They have been informed of the benefits of Rx/transport, given disclosure of the risks of dissenting, alternatives for care, and they demonstrate appropriate insight. They persist in declining our assistance. We are therefore leaving them in their current environment.