Davie Fire Rescue
EMS Division
CQI Guide

Refusal Quick Reference

Clinical Impression
This section has critical information that should give you an idea of the call nature and reasonable documentation expectations. Is the clinical impression acceptable to obtain a refusal?

Vital Signs
Minimum of one set shall be obtained on all refusals.
No new abnormal vitals should be listed (O2 Sat below 94%, Bradycardia or Tachycardia, Low GCS, etc.)

Narrative – Refusal

- Did the patient meet "High Risk Refusal" guidelines? If so, did the report writer document the BC was notified and hospital contacted following protocol?
- Did the narrative end with a clear documentation of the risks being explained to the patient regarding signing a refusal?

Signatures (Refusals)

- Notified by section should have the report writers' signature
- Patient signature should be obtained
- Witness should be (in order or preference) Family or Close contact or PD or Partner

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Refusal Patient Care Report Guide

Patient Information

- Last Name, First Name
- Gender, DOB, Address completed
- Phone number (important on refusals)

Clinical Impression

This section has critical information that should give you an idea of the call nature and reasonable documentation expectations. The more details in this section (and others) indicates this report is complete and thorough.

- Primary Impression, Secondary Impression and Chief Complaint are selected accurately
- Duration of symptoms are a logical an accurate description of the injury/illness

Medication/Allergies/History

- Categories are completed thoroughly and without spelling errors. Doses are preferred for all medications when possible.

Vital Signs

Minimum of one set shall be obtained on all refusals.
No new abnormal vitals should be listed (O2 Sat below 94%, Bradycardia or Tachycardia, Low GCS, etc.)

Flow Chart

All treatments and a BLS Assessment should be documented in the flow chart. If any treatment is mentioned in the narrative, it should also be documented in the flow chart (cold pack, bandaging, irrigation, etc.)

- All interventions are documented in a logical sequence and in accordance with protocol

Initial Assessment

There should be documented abnormalities that match the chief complaint/primary impression. An injury to the face should have the category HEENT, abnormality for Head/Face documented. If “No Abnormalities” is selected, this would be a documentation error and an appended narrative should be requested.

- “Not Assessed” is appropriate for multiple categories depending on the complaint. As an example, a localized trauma should not have a Pelvis/GU/GI assessment completed.

Ongoing Assessment

The ongoing assessment should either be more complete than the initial or update the initial findings. Review this section to make sure nothing is selected “No Abnormalities” that contradicts the initial assessment findings. As an example, a fractured extremity should not be marked on an ongoing assessment as No Abnormalities.

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Narrative

SOAP is the preferred narrative style, but some report writers use chronological style. Please review the narrative and confirm:

- All treatments documented are in the flow chart
- All injuries/complaints in this section are accurately documented in the clinical impression section of the report
- Narrative is free of spelling and grammatical errors
- Narrative accurately describes the call based upon the above documented sections

Narrative – Refusal

- Did the patient meet "High Risk Refusal" guidelines (any low-severity under 18, significant risk to patient or agency, not their own legal guardian, any administration of medications)? If so, did the report writer document the BC was notified and hospital contacted following protocol?
- Did the narrative end with a clear documentation of the risks being explained to the patient regarding signing a refusal?

Specialty Patient – Outbreak Screening

If this form is enabled during your review, is it completed accurately? None should not be documented in each section. This form should only be used if a complaint is discovered that matches the outbreak. i.e. COVID-19 if symptoms of SOB, Fever, Cough, Sore Throat, or Diarrhea – the form should be completed. If none of those symptoms exist, "Unable to Obtain and Not Indicated" should be selected.

Incident Details

- Address matches call location, not patient address
- Level of Service is selected appropriately

Incident Times

- Times are all completed accurately.
- Was there any delay in En Route, total response time, or making patient contact?

Crew Members

- Are all crew members involved with patient treatment documented?

Delays

- Based upon the documented times, should there be any delays documented?

Additional Agencies

- Were any additional agencies involved with the patient care?

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Signatures (Refusals)

- Notified by section should have the report writers' signature
- Patient signature should be obtained
- Witness should be (in order or preference) Family or Close contact or PD or Partner

Provider Signatures

- Appear to accurately match all providers signatures along with their badge number.
- Review the certification level of each member to make sure it is accurate (particularly if a firefighter has recently been cleared as a paramedic)