HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Provision of Care		
Document:	Multidisciplinary Policy and Procedure		
Title:	Refusal of Admission or Treatment or Request Discharge Against Medical Advice		
Applies To:	All Healthcare Provider		
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1. PURPOSE:

1.1 Address the patient's rights to refuse or discontinue treatment offered.
1.2 Establish guidelines to handle situations when the patient refuses or discontinue treatment or requests to leave the hospital against medical advice.

2. DEFINITONS:

2.1 **Discharge Against Medical Advice (DAMA)** – is when a patient decides to leave the hospital after an examination has been completed and a treatment plan recommended, whether it is an inpatient or an outpatient.
2.2 **Refusal of Treatment** – refers to a patient's decision to refuse treatment or a procedure recommended by a physician including admission or continued stay in the hospital even when there are risks or potential complications to this refusal.
2.3 **Substitute Decision Maker** – a person with decision making capacity who is authorized to make healthcare decisions for a patient when the patient loses decision making ability.

3. POLICY:

3.1 Maternity and children hospital respects the right of individuals to make decisions regarding their own healthcare.
3.2 A competent adult patient has the right to leave the hospital or refuse any treatment or procedure, including those that may be medically indicated or ordered for the wellbeing or sustain the life of the patient. The patient's relatives or others cannot force the patient to stay or authorize treatments or procedures that he/ she has refused.
3.3 When a competent inpatient or outpatient requests to leave the hospital without medical approval, the physician providing the treatment plan or his/her designee must:
- 3.3.1 Make efforts to identify the reason the patient is choosing to leave against medical advice
- 3.3.2 Explain the medical risks prior to discharge.
- 3.3.3 Inform patient about available care and treatment alternatives.
- 3.3.4 Involve family members whenever appropriate.
- 3.3.5 Respect patient and family choices.
- 3.3.6 Provide normal discharge procedures if the patient allows.
- 3.3.7 Notify the patient's family physician if he/ she is known and has not been involved in the process
- 3.3.8 Report cases of infectious disease to the local authority.
- 3.3.9 Document the relevant discussion in the patient's medical record.

3.4 If the patient is unable to make decision due to physical or mental incapacitation, a substitute decision maker may refuse healthcare services on the patient's behalf if the substitute decision maker feels it is the patient's best interest.

4. PROCEDURE:

4.1 Physician role: if a patient and or his/ her decision maker refuses treatment or decides to leave against medical advice, the attending physician and his/her designee will:

- 4.1.1 Discuss with the patient/ patient's substitute decision maker to determine the reason the patient wishes to leave or refuse treatment and ensure that the patient/ substitute decision maker is making an informed decision. Involve family members whenever appropriate.
- 4.1.2 Explain the benefits of staying in the hospital and potential risks/ dangers that may result from the refusal of treatment or DAMA.
- 4.1.3 Explore possible available care and treatment alternatives with the patient.
- 4.1.4 Attempt the patient/ substitute decision maker to reconsider. Involve the family members whenever possible.
- 4.1.5 Request the social worker to assess if any social problem or worries.
- 4.1.6 Ensure that the patient/ substitute decision maker understands the situation and arrange for translation if any language barrier.
- 4.1.7 Respect patient and family choices.
- 4.1.8 Inform the patient/ substitute decision maker of what to do if their condition worsens or that they can come back to the hospital emergency room or to the emergency room of the nearest hospital to them.
- 4.1.9 Provide the patient/ substitute decision maker with instructions for follow up care.
- 4.1.10 Get the patient/ substitute decision maker to sign the 'Discharge against medical advice (DAMA) form'.
- 4.1.11 Write order of discharge against medical advice in the physician's order sheet.
- 4.1.12 Provide normal discharge procedures if the patient allows.
- 4.1.13 Notify the patient's family physician if he/ she is known and has not been involved in the process.
- 4.1.14 Report cases of infectious disease to the local authority.

4.2 Assigned nurse role: If the nurse is the first healthcare provider who becomes aware of the patient's/ substitute decision maker decision to refuse treatment or DAMA, she will:

- 4.2.1 Determine the reason the patient/ substitute decision maker wishes to leave or refuse treatment and answer any questions that can help in making an informed decision.
- 4.2.2 Notify the assigned patient's physician and document notification in the progress notes of the patient medical record.
- 4.2.3 Delay the patient until the physician meets him/her, determines his/ her current status and take the above steps (physician role).
- 4.2.4 Witness the signature of the refusal of treatment form if refusal or DAMA is decided.
- 4.2.5 If the patient is leaving DAMA, the nurse will:
  - 4.2.5.1 Document the time of departure, condition of the patient and the care given
  - 4.2.5.2 Communicate any instructions as ordered by the attending physician.
  - 4.2.5.3 Inform the patient to go the nearest emergency department if their condition worsens.
  - 4.2.5.4 Process normal discharge procedure, with medications and appointments.

4.3 If the patient/ substitute decision maker refuse to sign the DAMA form: if the patient/ substitute decision maker refuses to sign the refusal of treatment DAMA form, the attending physician/ his/her designee will:

- 4.3.1 Contact the assigned on duty executive manager to assist and or witness the refusal.
- 4.3.2 Document the refusal to sign on the DAMA form and on the multidisciplinary progress notes of the patient's medical record authenticate it with sign, date and time.

5. MATERIALS AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurse
6.3 Admission Department

7. APPENDICES:

7.1 DAMA Form
7.2 Patient Refusal Form

8. REFERENCES:

8.1 MCH, Directorate of Health Affairs Holy Capital.

9. APPROVALS:

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KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____ / ____ / 14____ H ____ / ____ / 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

PATIENT REFUSAL FORM نموذج رفض المريض لإجراء طبي أو علاج

I, the undersigned, _____ in my

Capacity as ☐ Patient ☐ Legal Guardian ☐ Relative

(Specify: _____) of

(Patient's Name: _____)

أنا الموقع أدناه: _____ بصفتي

☐ المريض/ ☐ ولي الأمر/ ☐ القريب

(_____) :صلة القرابة

(_____) :اسم المريض

I accept to take complete responsibility of refusing the treatment and risks associated with it for the medical procedure

أتحمل كامل المسؤلية والنتائج المترتبة على رفضي للإجراء الطبي أو العلاج التالي

That was explained to me by the Physician / Dr. .....

.....

وقد تم الشرح لي من قبل الطبيب المعالج: .....

.....

I was informed as well as about the Medical alternatives – if present- and the complications and associated risks that might happen, And for that I signed.

واخباري بالبدائل الطبية المقترحة, في حال وجودها, والمضاعفات والمخاطر التي قد تحدث, وعليه أوقع.

Signature of Patient / Guardian: .....

توقيع المريض/ولي الأمر : .....

Relationship to patient: .....

صلة القرابة: .....

Date: ..... / ..... / ..... Time: .....

التاريخ: ..... / ..... / ..... الوقت: .....

Nurse Witness / Name and Signature:

اسم الممرض/ الممرضة الشاهد والتوقيع:

Date: ..... / ..... / ..... Time: .....

التاريخ: ..... / ..... / ..... الوقت: .....

Head Nurse of Department / Name and Signature:

اسم رئيس التمريض في القسم والتوقيع:

Date: ..... / ..... / ..... Time: .....

التاريخ: ..... / ..... / ..... الوقت: .....

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KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____ / ____ / 14____ H ____ / ____ / 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

DISCHARGE AGAINST MEDICAL ADVICE (DAMA)

I, the undersigned, _____ in my

Capacity as ☐ Patient ☐ Legal Guardian ☐ Relative

(Specify: _____) of

(Patient's Name: _____)

Hereby, I confirm that I have been advised by

Dr. _____ for the need to

Continue treatment at this hospital for myself / the patient and I also admit to the fact that the Doctor has explained to me the risks and the potential harms that may happen as a result of not continuing treatment or taking up the advice.

In spite of the above mentioned statement, I decided to discharge myself / the patient, on my responsibility and against the doctor's advice, decline his/her said treatment advice.

Therefore, I accept the full responsibility for my action and I release the hospital, the treating physician and other medical and nursing staff of any liability related to my action and to that effect I sign this consent in the presence of witness named below:

Patient Name/Legal Guardian/The Next of Kin:

_____

Signature: _____ **Date & Time:** _____

I, Dr. _____ confirm that I have advised the (Patient/Legal Guardian/Next of Kin) the need to continue treatment or taking the medical advice seriously.

Also the Health Care Practitioners and I tried the maximum efforts to convince the patient/legal guardian, and a next of kin to continue the treatment in another hospital or with another doctor of the same specialty to ensure a safe FOLLOW UP for medical condition for the patient. And I have explained the risk and potential harms and morbidity that may result from not continuing treatment or taking up the medical advice.

Physician Name: _____

ID No.: _____ **Signature:** _____

Date: ____ / ____ / ____ **Time:** _____

Nurse/Witness Name: _____

ID No.: _____ **Date & Time:** _____

Administration On-Duty / Patient's Affairs Officer:

Name: _____ **ID No.:** _____

Signature: _____ **Date & Time:** _____

أنا الموقع أدناه: _____ بصفتي

☐ المريض/ ☐ ولي الأمر/ ☐ القريب

(_____):صلة القرابة

(_____):اسم المريض

أقر بأن

الطبيب: _____ قد أبلغني إحتياجي / إحتياج المريض إلى ضرورة متابعة العلاج في هذا المستشفى وأقر كذلك بحقيقة أن الطبيب قد شرح لي خطورة عدم الاستمرار في العلاج أو عدم الإنقياد للنصيحة الطبية والمخاطر الطبية المحتملة التي قد تنتج عن هذا الفعل.

وعلى الرغم مما ورد أعلاه فقد قررت الخروج/ إخراج المريض على مسئوليتي الخاصة ضد رغبة الطبيب معرضاً عن نصيحته الطبية.

وعلى ذلك أتحمل كامل المسؤولية عن تصرفي هذا , وأقر بأن المستشفى والطبيب المعالج وبقية أعضاء الفريق الطبي والتمريض المعنيين بحالتي معفيون من أية إلتزامات قانونية مترتبة على قراري هذا وعليه تم توقيعي على الإقرار في حضور الشاهد المذكور أدناه.

إسم المريض/ولي الأمر/القريب:

_____

التوقيع: _____ **التاريخ والوقت:** _____

أنا, الطبيب: _____ أؤكد بأني قد قمت بالنصيحة الطبية لـ (المريض) (ولي الأمر/ القريب) بضرورة إستمرار المريض في العلاج أو أخذ النصيحة الطبية بجدية.

كما قمت وقادر المستشفى بأقصى جهد ممكن لإقناع المريض/ ولي أمره أحد أفراد العائلة، من أجل متابعة العلاج في أية مؤسسة طبية أخرى أو عند طبيب مختص آخر لضمان سلامة الحالة ولقد وضحت الخطورة والمضاعفات الصحية المحتملة التي قد تنتج عن عدم استمرارية العلاج أو العمل بالنصيحة الطبية.

اسم الطبيب: _____

رقم الطبيب: _____ **التوقيع:** _____

التاريخ: ____ / ____ / ____ **الوقت:** _____

إسم الممرض / الشاهد: _____

الرقم الوظيفي: _____ **التاريخ والوقت:** _____

المدير المناوب / موظف شؤون المرضى:

الإسم: _____ **الرقم الوظيفي:** _____

التوقيع: _____ **التاريخ و الوقت:** _____

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