Government of Western Australia
Department of Health

Consent to Treatment Procedure

1. Purpose

The purpose of the *Consent to Treatment Procedure* is to outline the steps and processes that must be followed to meet the mandatory requirements of the *Consent to Treatment Policy.*

2. Applicability

This Procedure does not cover consent relating to matters other than treatment (e.g. consent to clinical research, collecting or disclosing information or photography or filming).

Informed financial consent is also not covered in this Procedure. Please see *NSQHS Advisory 18/10 Informed Financial Consent*.

This Procedure applies to all Health Service Providers that provide clinical treatment, as well as health practitioners that provide treatment on behalf of the WA health system, and those who admit patients to a public hospital from their private rooms, irrespective of whether the patient is to be admitted as a public or private patient.

3. Policy requirements

a. Explicit consent processes

Consent processes must be consistent with consent obligations contained in mandated documents external to this Policy, including the Australian Charter of Healthcare Rights, the National Safety and Quality Health Service Standards, the National Framework on Advance Care Directives, and issued national codes of conduct of health practitioners.

Explicit consent must be sought prior to proceeding with any of the following treatments (other than in an emergency) that require general, spinal, epidural or regional anaesthesia and intravenous sedation:

- surgical
- medical
- endoscopy
- obstetric
- radiology
- mental health
- oncology

In addition:

- blood transfusions or the administration of blood or blood products
- any invasive treatment where there are known significant risks or complications
- participation in clinical trials and medical research for which the approval of an ethics committee is required

- commencement of medications with known high-risk complications (e.g. clozapine, mifepristone, thalidomide, lenalidomide and pomalidomide)
- off-label use of medications or therapeutic devices with known high-risk complications
- commencement of medications:
  - under the Special Access Scheme
  - for investigational purposes.

The explicit consent process must be conducted face-to-face. If this is not possible, using Telehealth is permissible. The explicit consent process must adhere to the following steps:

Step	Instruction
1 **Determine which health practitioner is responsible for seeking consent**	Where a team of practitioners are responsible for a patient the most senior must be satisfied that the consent process has been properly undertaken.
2 **Assess the patient's capacity relevant to the decision to be made**	❖ Patient has capacity Adults are presumed to have capacity until there are reasonable grounds to conclude otherwise. Children can have capacity to consent if assessed as a 'Mature Minor' for the particular treatment being assessed. Refer to Assessing Capacity to Consent in Minors: A Clinical Handbook. ❖ Patient does not have capacity If the patient does not have capacity, follow the WA Hierarchy of Treatment Decision-Makers (Attach.3) to determine the most appropriate pathway.
3 **Provide sufficient information so the patient can make an informed decision**	Information must be appropriate in terms of the patient's health literacy, language and culture. The clinician must explain in broad terms the proposed treatment, the benefits and must warn the patient of the possible complications (material risks), as well as alternative treatment options and the possibility that the treatment may be unsuccessful.
4 **Verify that the patient understands the information given and all**	Ensure the patient can communicate key information about the treatment back to the consenting health practitioner. Whenever there is uncertainty about language an interpreter must be used, as per the WA Health System Languages Services Policy.

their queries have been addressed	Family members and friends must not be used as interpreters during decision making discussions.
5 **Seek a decision from the patient about the proposed treatment**	Any patient with capacity has the absolute right to decline or refuse treatment. Consent for treatment may be withdrawn at any time.
6 **Document consent**	Details of information provided, discussions and the patient's consent, or decline, must be clearly documented. This includes the material risks discussed, the use of any visual aids, interpreters or prepared patient information sheets provided (e.g. Procedure Specific Information Sheets). If consent is obtained, the appropriate consent form must be completed.

A patient's consent remains valid until either the patient withdraws it, or the proposed treatment is no longer appropriate due to a change in the patients' circumstances. Examples of changed circumstances include:

- An improvement or deterioration (e.g., a change from cure to palliative goals) in the patient's condition.
- Development of new treatment options since consent was given.

b. Assessing Capacity

The following principles must be considered when assessing a person's capacity:

- Capacity can be lost and regained. Though incapacity may be permanent in some cases, in other cases it will be temporary, for example if a patient regains consciousness or if they are no longer affected by medication or other substances.
- A person may have capacity to make decisions about simple treatments, but not have capacity to make decisions about more complex treatment with longer term ramifications for their health.
- It must not be assumed that a patient lacks capacity solely because of their age, disability, behaviours, medical condition (including mental illness), beliefs or the fact that they disagree with a health practitioner.

Also refer to WA clinician consent to treatment flowchart "Can your patient consent to treatment FLOWCHART" (Attach.4)

Situations where a patient does not have capacity:

- Multiple appropriate decision makers

  Where there is more than one person in the same level of the Hierarchy of Treatment Decision-Makers who wish to be involved and those persons cannot agree on the treatment decision, the health practitioner must encourage them to reach consensus. If this cannot be achieved, it may be appropriate to seek advice from the State Administrative Tribunal.

- Failure to identify appropriate decision maker

  If a 'person responsible' cannot be identified, an application can be made to the State Administrative Tribunal for appointment of a Guardian.

c. Provision of information

The exchange of meaningful information between the health practitioner and patient is vital to good decision making. Health practitioners must attempt to find out what matters to the patient, their needs, values, beliefs, and priorities, so they can share relevant information about the benefits and harms of proposed treatment options and reasonable alternatives, including the option to take no action.

Consent discussions can occur across several consultations, as more information comes to light about a patient's condition, change in personal situation and treatment options.

All patients have the right to be listened to, and to be given not only the information they require to enable them to decide, but also time and support to understand that information. This can include the provision of written information, use of decision aid tools, interpreters, and translated information.

Patients must be given written information about their treatment, where available and appropriate. This must not be used as a substitute for a face-face discussion. Where available, Procedure Specific Information Sheet (s) should be provided to the patient. Health practitioners must be aware that pre-prepared information sheets usually refer to the risks facing an "average" patient having the treatment and this detail may be insufficient to cover a particular patient's circumstance. In these cases, additional information must be provided to each patient, based on their individual needs and risk factors.

When there is a 'person responsible' for providing consent on behalf of a patient, they must be given the same information as would have been given to the patient if they had the capacity to make the treatment decision.

d) Documenting Consent

Explicit consent discussions must be documented in the patient's medical record, regardless of whether the patient consents to or declines the proposed treatment.

Health Service Providers must provide consent forms to be utilised by health practitioners when gaining consent from patients. However, completing a consent form isn't a substitute for a meaningful discussion tailored to the individual patient's needs.

Consent discussions can occur via Telehealth, where a signature may not be obtainable at the time of consent. The consent process and documentation must still occur in full. The health practitioner that undertook the consent discussion must annotate the consent form on behalf of the patient, noting that the discussion occurred via Telehealth. This consent should be confirmed with the patient's own signature prior to treatment commencing.

Abbreviations or acronyms must not be used in the consent documents due to the potential for misinterpretation or misunderstanding.

Electronic signatures of the health practitioner or patient are acceptable on electronic consent documents as long as they clearly identify who the signatory is (e.g. accessed system with a HE number).

Examples of consent forms and best practice are available on the **Collaborative Shared Decision-Making Hub.**

e) The law either permits or forbids treatment

Some laws specify that treatment either may be provided, or must not be provided, regardless of whether the patient has provided consent. These include:

- *Road Traffic Act 1974* - samples of blood and urine can be taken on motor vehicle accident patients without their consent.
- *Human Tissue and Transplant Act* 1982 - provides specifically for blood transfusions on children without parental consent (in stated circumstances).
- *Prisons Act 1981* - medical officers may provide medical treatment to prisoners who refuse it in certain circumstances (where the medical officer is of the opinion that the life of health of the prisoner or any other person is likely to be endangered by that refusal).
- *Guardianship and Administration Act 1990* – where a patient's interests are represented by a guardian, that guardian cannot on their own consent to the patient undergoing sterilisation.