Consent to Treatment Policy

1. Purpose

The purpose of the Consent to Treatment Policy is to provide a consistent approach across the WA health system by outlining the minimum requirements for Health Service Providers. This Policy also outlines the responsibilities of health practitioners when seeking a patient's informed consent to treatment.

Legislation pertinent to this Policy includes:

- *Guardianship and Administration Act 1990*
- *Acts Amendment (Consent to Medical Treatment) Act 2008*
- *Mental Health Act 2014*
- *Children and Community Services Act 2004*
- *Commonwealth Family Law Act 1975*.

This Policy is a mandatory requirement under the *Clinical Governance, Safety and Quality Policy Framework* pursuant to section 26(2)(d) of the *Health Services Act 2016*. It should be read in conjunction with the *Consent to Treatment Procedure*.

This Policy supersedes *Operational Directive 0657/16: WA Health Consent to Treatment Policy.*

2. Applicability

This Policy is applicable to all Health Service Providers that provide clinical treatment. To the extent that the requirements contained within this Policy are applicable to the services purchased from Contracted Health Entities, Health Service Providers are responsible for ensuring these requirements are accurately reflected in the relevant contract and managed accordingly.

3. Policy requirements

Health Service Providers are responsible for ensuring they have policies in place which direct health practitioners and Contracted Health Entities (where applicable) on informed consent to treatment processes in alignment with this Policy.

3.1 Informed consent process

Health Service Providers must determine, and capture in local policy, those treatments which require explicit consent, and those which may be dealt with by implied consent:

Implied Consent
Implied consent applies where a patient indicates through their actions that they are willing to proceed with an aspect of their treatment. This applies where significant risks to the patient are not anticipated.

Explicit Consent
Explicit consent applies where the proposed treatment is complex or there are higher risks to the patient. The health practitioner must provide meaningful information to the patient, including details of the benefits and risks specific to that patient. Explicit consent must be obtained and documented.

In the case of surgical procedures, explicit consent does not imply anaesthetic consent. Explicit anaesthetic consent must be obtained separately.

3.1.1 Validity of Consent

To be valid**,** consent must be:

- **Voluntary** - the decision to either consent or not to consent to the proposed treatment must be made by the patient themselves and must not be unduly influenced by the health practitioner, friends or family.
- **Informed** - the patient must receive meaningful information about the proposed treatment to enable them to make an informed decision.
- Given by a patient **who has capacity** to understand the information presented to them about the treatment decision to be made.
- **Covers the treatment to be performed** - treatment provided must fall within the scope of consent that has been given by the patient. Some treatments can involve more than one treatment as part of a course and the consent process can cover all of those treatments.
- **Current** - consent must be reviewed if, after consent was obtained, the patient's circumstances (including treatment options and risks) have changed.

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.

3.2 Assessing capacity

Capacity of the patient to make a treatment decision must be assessed prior to commencing treatment. Capacity is decision-specific and must be relevant to the treatment decision. Principles for assessing capacity are outlined in the *Consent to Treatment Procedure (Section 3b).*

3.2.1 Adults

Adults are presumed to have capacity until there are reasonable grounds to conclude otherwise.

3.2.2 Children and Mature Minors

Children are assumed not to have capacity for consent (see section 3.6). As a child gets older, if they are assessed as having sufficient intellectual and emotional maturity and competence to understand information relevant to a proposed treatment, including its

risks, benefits and alternatives, they can consent to or decline that treatment as a 'Mature Minor'.

An assessment of a child as a 'Mature Minor' must be made in the context of the treatment, that is maturity in relation to one treatment decision does not necessarily equate to maturity for all treatment decisions. There is no specific age at which a child becomes a 'Mature Minor'.

3.3 Provision of information

Relevant information regarding treatment must be provided to the patient, at minimum, in a verbal discussion. Information must be appropriate in terms of the patient's health literacy, language and culture. Whenever there is uncertainty about language an interpreter must be used, as per the WA Health System Languages Services Policy.

All reasonable efforts to provide information to the patient in an additional suitable manner (e.g. written information, Procedure Specific Information Sheets, decision aid tools, videos) also must be made prior to treatment. See *Consent to Treatment Procedure (Section 3c)*.

3.4 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 explicit consent from patients. As a minimum the following must be documented on the consent form:

- The patient's full name.
- The proposed treatment (including whether anaesthesia is required, insertion of a medical device).
- Date/s of consent discussion(s).
- Details about what information was provided to the patient by whom.
- All key points of the discussion, including patient questions and health practitioner responses.
- Whether or not an interpreter was used.
- Whether or not a medical student has permission to participate (if applicable).
- Review of the patient's condition and confirmation of consent prior to treatment (if applicable).
- Full name and signature(s) of the health practitioner(s) who determined that the consent process has occurred.
- Signature of the patient

  See *Consent to Treatment Procedure (Section 3d)* for consent requirements via Telehealth.

3.5 Children and young people

Under *the Commonwealth Family Law Act 1975*, parents are responsible for children under 18 years of age (subject to section 3.2.1 Mature Minors) and may authorise treatment on behalf of their child where that treatment is in the child's best interests.

This is not affected by changes to the parent's relationship, unless varied by a court order. Where one parent consents and the other does not, legal assistance must be obtained.

If a health practitioner believes that a treatment decision made by a parent or substitute decision maker is not in the child's best interest, this must be referred for legal assistance as necessary.

Parents cannot give consent if the child is in are the care of the CEO of the Department of Child Protection and Family Support (including delegated officers as relevant), as set out in the *Children and Community Services Act 2004*.

3.6 Patients with mental illness

The treatment of patients with mental illness is governed by the *Mental Health Act 2014.* As capacity is decision specific, a mental health patient may have capacity to provide consent to treatment for non-mental or mental illness (i.e. physical health).

3.7 Circumstances where consent is not required

Patient consent is either not required or irrelevant in certain circumstances. These include where there is an emergency in which treatment is required urgently and the patient is incapable of providing consent, and where the law either permits or forbids treatment regardless of consent.

3.7.1 Treatment in an emergency

Non-psychiatric treatment can be provided without consent where necessary to save a person's life, prevent serious injury to the person's health or prevent the patient from suffering pain or distress, if a patient:

- is incapable of giving consent
- does not have an Advance Health Directive or Common Law Directive applicable and available
- does not have a substitute decision maker who can be readily identified and immediately available to consider making the treatment decision.

Treatment without consent must be:

- reasonably required to meet the urgency
- in the patient's best interests
- the least restrictive of the patient's future choices.

The rationale for treatment without consent must be clearly documented in the patient's medical record. The medical record must state details of attempts made to contact the Next of Kin.

Emergency treatment does not include emergency psychiatric treatment. See *Mental Health Act 2014 Section 4.*

3.7.2 The law either permits or forbids treatment

Some laws specify that treatment either may be provided, or withheld, regardless of whether the patient has provided consent. Pertinent legislation is outlined in the *Consent to Treatment Procedure (Section 3e).*

4. Compliance monitoring

Health Service Providers are responsible for ensuring compliance with the requirements of this Policy. This includes monitoring and evaluating the effectiveness of local policies, processes and systems to ensure health practitioners are meeting their legal and professional obligations in relation to informed consent.

The System Manager will periodically evaluate the effectiveness of this Policy using data sources available to the System Manager (i.e. accreditation reports, clinical incident data and consumer feedback).

To monitor compliance with this Policy the System Manager may request information, on a regular basis, on informed consent processes, including assurance that Health Service Providers are promoting and using Procedure Specific Information Sheets appropriately.

Non-compliance will be communicated to the Department of Health Chief Executive Officer, as the System Manager, and the Chief Executive of the Health Service Provider.

5. Related documents

The following documents are mandatory pursuant to this Policy:

- Consent to Treatment Procedure
- National Safety and Quality Health Service Standards Accreditation Policy
- WA Health System Language Services Policy

6. Supporting information

The following information is not mandatory but informs and/or supports the implementation of this Policy:

- Hierarchy of decision makers pyramid – based on the *Guardianship and Administration Act 1990 (PDF)*
- Procedure Specific Information Sheets (intranet)
- WA clinician consent to treatment flowchart 'Can your patient consent to treatment?' (PDF)
- A Guide for Health Professionals to the Acts Amendment *(Consent to Medical Treatment) Act 2008*
- Collaborative Shared Decision-Making Hub (intranet)

7. Definitions

The following definition(s) are relevant to this Policy.

Term	Definition
Adult	A person who has reached the age of 18 years

Advance Health Directives	An instrument recognised under the *Guardianship and Administration Act 1990* which records a competent adult's decisions about possible future treatment. Treatment decisions recorded in a valid Advance Health Directive must be followed in circumstances where the maker of the Advance Health Directive can no longer make or communicate the decision themselves.
Capacity	A patient has capacity if he/she is capable of understanding the nature, purpose and consequences of the proposed treatment. Capacity must always be assessed in the context of the decision that is to be made. Adults are presumed to have capacity unless shown otherwise; whereas children are presumed not to have capacity unless shown otherwise.
Consent (to medical treatment)	In the context of health care, consent is a patient's agreement that a health practitioner can proceed to perform a specific proposed treatment.
Health Practitioner	A person registered under the *Health Practitioner Regulation National Law (WA) 2010* in the health professions listed therein.
Interpreter	A person who conveys a message or statement verbally or by using sign language into another language with accuracy and impartiality to enable effective communication between two parties who use different languages.
Material Risks	A risk which, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the health practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it.
Medical Device	Drug delivery systems, non-diagnostic equipment, monitoring systems, therapeutic inserts (i.e. through existing body cavities), prostheses, tissue regeneration and bioengineered products used on the surface of the body; non-diagnostic imaging and biomaterials; and implantable devices.
Medical record	A written or electronic record which captures details of a patient's health information.
Patient	A person who has been, is being, or will or may be provided with health treatment. For the purposes of this Policy, "patient" also encompasses substitute decision makers, including "persons responsible" under the *Guardianship and Administration Act 1990*, and parents of a child under the age of 18 as relevant.
Person responsible	Under the *Guardianship and Administration Act 1990*, a person who is authorised to make a treatment decision on behalf of a patient who is unable to make reasonable judgments for him/herself.
Treatment	Any medical, surgical (including a life-sustaining measure or palliative care), dental treatment or other health care.
Urgent treatment	Under the *Guardianship and Administration Act 1990,* treatment urgently needed by an adult patient to save the patient's life or prevent serious damage to the patient's health

	or to prevent the patient from suffering pain or distress but does not include psychiatric treatment or sterilisation of the patient.

8. Policy contact

Enquiries relating to this Policy may be directed to:

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9. Document control

Version	Published date	Effective from	Review date	Effective to*	Amendment (s)
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10. Approval

Approval by	Nicole O'Keefe, Assistant Director General, Strategy and Governance Division, Department of Health
Approval date	Day Month Year

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