



Government of **Western Australia**
Department of **Health**

WA Health Consent to Treatment Policy

2016



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Suggested Citation:

WA Health Consent to Treatment Policy 2016

Perth: Department of Health WA

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Consent to treatment

1. Introduction

In the context of health care, consent to treatment is a person's agreement for a health professional to proceed with a specific proposed treatment. That agreement is obtained (or withheld) following communications between one or more health professionals and the patient about the proposed treatment(s) and their inherent risks and benefits. Consent communications are likely to comprise of one or more verbal exchanges between the patient and the health professional(s), and also in the case of more invasive or risky procedures, documentation of that exchange including written consent provided by the patient.

In the vast majority of cases, patients are entitled to decide whether or not they will receive medical treatment. The patient's decision must be made in the context of relevant and understandable information about the risks and benefits of the treatment, as applicable to their circumstances. Health professionals are responsible for providing this information to patients and recording consent communications, as explained in this WA Health Consent to Treatment Policy 2016 (the policy).

For the purposes of this policy, the term:

- * treatment – includes any treatment, procedure or other health care
- * patient – unless context indicates otherwise, encompasses substitute decision maker/s (for example, “persons responsible” in the Guardianship and Administration Act 1990¹ .

If you have a query about consent which is not addressed in this policy (or by site specific policies/senior staff expertise as relevant), it may be appropriate to seek legal assistance (see Glossary for additional information about legal assistance).

1.1 Purpose

The aim of this policy is to outline the minimum mandatory requirements for health professionals in obtaining a patient's consent to treatment. The policy aims to:

- * provide guidance for health professionals about the consent process and explain relevant concepts
- * assist health professionals to be aware of their obligations in terms of seeking and obtaining consent from patients
- * support a consistent approach with regard to the documentation of valid consent.

1.2 Scope and compliance

This policy applies to all health professionals:

- * who provide treatments on behalf of WA Health
- * who admit patients to a public hospital from his or her private rooms, irrespective of whether the patient is to be admitted as a public or private patient.

Compliance with the policy is mandatory. WA Health hospitals/health services must adopt and follow this policy in toto OR develop local operational policies which are wholly aligned with the principles of consent set out in this policy. This applies to all treatment, whether mentioned specifically in this policy or not.

1.3 Principles

The policy is guided by key two legal principles which underpin consent:

- * Patients have the right of autonomy or self-determination, recognised at law.
- * This has been described as the “right of every human being of adult years and sound mind to determine what shall be done with his own body”.²
- * The provision of medical treatment without patient consent exposes health professionals to risks of legal claims including trespass to the person (assault and battery) and/or negligence (failure to inform), except in cases where the law permits or requires treatment without consent.

1.4 Relevant guidelines and policies

This policy should be read in conjunction with relevant guidelines and policies including but not limited to:

- * WA Health Language Services Policy 2011³
- * A Guide for Health Professionals to the *Acts Amendment (Consent to Medical Treatment) Act 2008*⁴
- * *Acts Amendment (Consent to Medical Treatment) Act 2008*⁵
- * *Mental Health Act 2014*⁶
- * National Safety and Quality Health Service Standard 1: Governance for Safety and Quality in Health Service Organisations (criterion 1.18)⁷
- * Clinicians’ Practice Guide to the *Mental Health Act 2014*.⁸

1.5 Review

This policy will be reviewed by the Department of Health WA every three years.

2. Consent to treatment

In the context of health care treatments, consent is agreement given by a patient to undergo a proposed treatment. Consent is sought after communicating with the patient about the proposed treatment, as detailed below. Health professionals must seek a patient’s consent prior to providing treatment, unless there is an ‘exception’ where consent is not required, e.g. in an emergency (in which the patient is incapable of giving consent).

Situations where consent may vary include where legislation specifically sets out circumstances in which consent must occur e.g. in relation to consent for human tissue removal under the *Human Tissue and Transplant Act 1982*⁹ (See Appendix 8).

Consent will be valid if it is:

- * **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 health professionals, friends or family
- * **informed** – the patient must receive sufficient information about the proposed treatment to enable them to make an informed decision
- * given by a patient who has **capacity** (see Glossary) to understand the information presented to them and to make a decision. Capacity may be diminished by illness, age, medication, drugs and alcohol (amongst other things)
- * **current** – consent must be reviewed if, after consent was obtained, the patient’s circumstances (including treatment options and risks) have changed

- * **covers the treatment to be performed** - treatment provided must fall within the scope of consent that has been given by the patient.

2.1 Implied consent

Consent may be implied where a patient indicates through their actions that they are willing to proceed with an aspect of their treatment. Implied consent may apply where significant risks to the patient are not anticipated, e.g. a patient holds out their arm to allow blood to be taken. If there is doubt about whether the actions of a patient imply agreement to proceed or not, their explicit consent must be sought.

2.2 Explicit consent

Where a health professional proposes a higher risk/more complex treatment to a patient, the health professional must seek the patient's **explicit consent** (also known as express consent) to that treatment before providing it. The health professional must provide relevant information to the patient, including details of the benefits and risks specific to that patient (see further at Step 3).

Communications relevant to explicit consent may be verbal and/or written. In either case it is imperative that relevant details of the consent communication be recorded in the patient's medical record, including the patient's decision to refuse or consent to treatment (see further at Step 6). The medical record will be important evidence of the content of the communications which underpin the patient's consent decision (see Step 6).

Note that the term '**medical record**' encompasses consent forms where relevant and also includes integrated progress notes (see Glossary).

2.2.1 Treatments requiring explicit consent to be sought and specifically recorded

Under this policy, explicit consent must be obtained and recorded in writing before proceeding with any of the following treatments (other than in an emergency) requiring general, spinal, epidural or regional anaesthesia and intravenous sedation:

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

Explicit surgical consent does not imply anaesthetic consent. Anaesthetic consent must also be obtained and recorded in writing. See sample consent form in Appendix 4 - Form D. See Appendix 7 for additional information about the anaesthetic consent.

Examples of treatment where prior explicit consent must be obtained and recorded include but are not limited to:

- * 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
- * blood transfusions or the administration of blood or blood products (see Appendix 7)
- * commencement of medications with known high risk complications including:
- * 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 (see Glossary)
- * investigational drugs (see Glossary).

All high risk and invasive imaging procedures (see Glossary) require written consent as per the Diagnostic Imaging Accreditation Scheme 2015.¹⁰

See Section 4 for exceptions and variations to consent.

3. Seeking consent

The consent process should be conducted face-to-face where possible and should be considered as a series of steps:

- Step 1. Determine which health professional is responsible for seeking consent.*
- Step 2. Assess the patient's capacity.*
- Step 3. Provide sufficient information so the patient can make an informed decision.*
- Step 4. Verify that the patient understands the information given and all their queries have been addressed.*
- Step 5. Seek a decision from the patient about the proposed treatment.*
- Step 6. Document consent.*

Step 1. Determine which health professional is responsible for obtaining consent

Seeking informed consent involves an interactive process that commences with the health professional who discusses treatment options with the patient. Where a team of health professionals is involved in the process, the most senior health professional responsible for providing the treatment must be satisfied that valid consent has been obtained prior to conducting the treatment. While this health professional has overall responsibility for the consent process he/she may request assistance by another clinical member of the treating team who has sufficient clinical knowledge of the proposed treatment and understands and can communicate the risks and benefits involved.

Involving more than one health professional in the consent process is not without risks. The most senior health professional who conducts the treatment is ultimately responsible for ensuring that informed consent has been obtained to the proper standard and adequately recorded in the patient's medical record.

3.1.1 Seeking consent for treatments that are performed by medical practitioners

For treatments performed by medical practitioners (and that require explicit consent) the task of informing a patient about the material risks of treatment and of seeking consent cannot be delegated to administrative or nursing/midwifery staff, other than nurse practitioners or eligible midwives, as appropriate.

Step 2. Assess the patient's capacity

A mentally competent patient (i.e. who has capacity) can either consent or refuse treatment. If the patient has been provided with the information relevant to the treatment and understands its consequences, including the consequences of not having the treatment, then the patient's decision to proceed or not must be respected regardless of whether their decision appears illogical or irrational to others. Competent adults can make decisions which appear unreasonable to others.

There are some principles to be applied when assessing a person's capacity:

- * **Adults are presumed to have capacity** until there are reasonable grounds to conclude otherwise. As children get older their capacity to understand treatment and its consequences increases, and they may be assessed as 'mature minors' in relation to the proposed treatment.
- * **Capacity can be 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.
- * **Capacity is decision-specific.** Capacity must be relevant to the treatment decision. 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.

A patient has capacity to give consent if they are capable of understanding the nature, consequences and risks of the proposed treatment. ¹¹

See 4.3.1 for information about patients who lack capacity.

See 4.3.2 for information about treatment of a minor - parental consent and mature minors.

See 4.4 for information about capacity and mental health patients.

Step 3. Provide sufficient information so that the patient can make an informed decision

Health professionals must assess how to effectively communicate information to the patient and provide the patient with opportunities to clarify the information. The patient must be provided with and be able to understand information relevant to their circumstances so that they can reach an informed decision to consent or not to the proposed treatment.

The information provided to the patient must be given in terms and language (see Section 3.3.3) appropriate to the patient. Health professionals need to be attuned to individual patient differences and concerns and they must respond appropriately to them.

There are two legal principles relevant to **informed consent**:

1. Firstly, consent must be obtained in order to avoid a legal claim for trespass to the person (in assault, battery or false imprisonment). This requires the health professional to explain in **broad terms** the proposed treatment or procedure to the patient.
2. Secondly, health professionals must warn patients of the **material risks** of the proposed treatment/s, so that they can make informed decisions about associated risks and whether they wish to proceed. Providing sufficient information to the patient will negate a claim in negligence for failure to warn.

When there is a person responsible for providing consent on behalf of a patient, he or she must be given the same information as would have been given to the patient if they had the capacity to make the treatment decision (see 4.3.1.2 for information about treatment decisions by a substitute decision maker).

3.3.1 Information to be provided to the patient

The following information related to the treatment, must be provided to patients. In cases where the health professional who recommends the treatment is not the person who provides the treatment, information should be provided within their scope of practice and should include, as relevant to the circumstances:

- * an explanation of the patient's condition and diagnosis (including any uncertainty in the diagnosis and prognosis)
- * the nature of the proposed treatment, including the time required for the treatment, the likely recovery period and the likely time that the patient will be unable to continue their usual activities
- * the likely outcomes of the proposed treatment
- * outcomes which are inevitable if the proposed treatment is performed
- * the likely consequences of delaying or not choosing to have the proposed treatment
- * alternative options for investigation, diagnosis and treatment and why these other treatments are not recommended (as known to the health professional)
- * any follow-up treatment or care which may be required
- * the patient's right to refuse or withdraw their consent at any time prior to the treatment
- * risks and benefits of delaying or not receiving the proposed treatment
- * any short or long term side effects of the proposed treatment (including emotional, physical, psychological, social and sexual effects)
- * the risk that no benefit will be achieved or that the condition will deteriorate after the treatment
- * material risks not otherwise covered above.

3.3.2 Material risks

Health professionals have a legal duty to warn a patient of a material risk inherent in the proposed treatment and failure to do this may result in legal action for negligence. A risk is material if "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 medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it".¹²

Effective communication is the key to sufficient disclosure of material risks by the health professional to the patient. As different treatments carry different risks for different patients, the more complex and risky the treatment the greater the level of disclosure required. Some patients may demonstrate that they attach significance to risks of the treatment by seeking greater detail and the health professional should accommodate such questions with truthful and relevant information. However, health professionals are not required to force "unsolicited detail" onto patients.¹²

A health professional's duty to warn clients of the material risks of treatment is subject to **therapeutic privilege**. The principle of therapeutic privilege recognises there are situations where a health professional is entitled to withhold information from a client where it is in the client's best interests not to receive that information. There are limited circumstances in which information can be withheld from the patient and therefore therapeutic privilege should only be applied "in exceptional" circumstances.

3.3.3 Prepared resources

Patients should be given written information about their treatment, where available and appropriate. The Department of Health recommends the use of Procedure Specific Information Sheets which are available for use by public sector staff in WA Health. These can be a useful source of information and can be given to patients. Translated versions of selected sheets have been made available in 17 different languages. Copies can be downloaded at http://intranet.health.wa.gov.au/osqh/info_sheets/index.cfm

Prepared resources must not be used as a substitute for a face-to-face discussion. Health professionals 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 circumstances. Additional information should be provided to each patient, as relevant.

It cannot be assumed that a patient has read or understood a printed information sheet. Clarification of understanding must be obtained during the discussion. If an information sheet is provided to a patient, this should be documented in the medical record.

3.3.4 Patients with low English proficiency or special needs

People who are not able to communicate effectively in written and/or spoken English may require language services such as interpreting and translations. This includes people who are deaf, hard of hearing, Aboriginal Australians and people from culturally and linguistically diverse backgrounds.

Where a patient is identified as having special language requirements, the health professional should not rely on family members or friends but should engage the services of a professional interpreter in accordance with the *Western Australian Language Services Policy 2014*¹³ and the *WA Health Language Services Policy 2011*³. Although family and friends may be helpful in interpreting health information to allow provision of some simple care, generally it is not appropriate to rely on them to interpret more complex health information, for example where treatment has been recommended "for which explicit consent" must be sought.

If an interpreter is used, the interpreter's declaration within the consent form must be completed or be documented elsewhere within the medical record. For all patients, any methods used to facilitate communication must also be documented in the medical record.

Aboriginal and Torres Strait Islander patients should be offered to the option to speak to an Aboriginal Liaison Officer.

Step 4. Verify that the patient understands the information given and all their queries have been addressed

Health professionals must be satisfied that the patient understands the information presented and that all their queries have been addressed. They can do this by verifying that the patient:

- * understands the effect of the treatment decision
- * understands that a choice can be made
- * has had sufficient time to consider and clarify the information presented
- * can communicate their decision back
- * had all their questions answered.

Step 5. Seek a decision from the patient about the proposed treatment

Health professionals must seek the patient's consent prior to providing treatment.

3.5.1 Declining treatment

If a patient with capacity to make a voluntary and informed decision declines a particular treatment, their decision must be respected and the health professional must not proceed with treatment.

If the patient declines the proposed treatment, it is essential that the decision and the circumstances in which consent was declined are documented in the patient's medical record.

If a patient declines treatment, they should be encouraged to:

- * seek a second opinion
- * inform his or her family and any potential substitute decision makers who may be responsible for making treatment decisions in the future.

For information about treatment of minors see 4.3.2

For refusal of consent for blood products see Appendix 7.

Step 6. Document consent

It is imperative that the details relevant to consent be documented, regardless of whether the patient consents to or declines the proposed treatment. Well-documented consent communications will assist in verifying that a health professional has met his/her obligations in providing relevant information to the patient about their treatment options. The more complex or risky the procedure, the more important it is that specific details are captured in the patient's medical record.

3.6.1 Minimum documentation requirements

Explicit consent to treatment must be documented in the patient's medical record. This record will be evidence that consent was sought and obtained. Details relevant to consent must be recorded on the consent form where one is used, and/or elsewhere in the patient's medical record, as appropriate.

For treatments that require the patient's consent to be captured in writing, evidence that valid consent for the proposed treatment has been obtained must be kept within the medical record. As a minimum the following must be documented:

- * the patient's name
- * the proposed treatment (including whether anaesthesia is required)

- * review of the patient's condition and confirmation of consent prior to treatment (if applicable)
- * details about the information provided to the patient including who has provided that information
- * all key points of the discussion, including questions raised by the patient and responses
- * material risks discussed with the patient, if not otherwise recorded
- * whether or not an interpreter is required
- * signature of the patient
- * name and signature of the person who has determined that the consent process has occurred
- * date of consent.

The sample consent forms attached at Appendices 1-6 have been developed for use in the most commonly occurring situations to support the documentation of consent:

- * **Form A** *Patient Consent to Treatment or Investigation* - adult or mature minor
- * **Form B** *Consent for a Minor Requiring Parental/Guardian Approval for Treatment or Investigation*
- * **Form C** *Adults Unable to Consent to Treatment or Investigation* - Authorised person responsible consenting on behalf of the patient who is unable to consent
- * **Form D** *Patient Consent to Anaesthesia (general or regional)*
- * **Form E** *Authorisation to Proceed with Surgery on a Patient without a Valid Consent Form.*
- * **Form F** *Blood products consent form.*

For a copy of the ECT consent form is available from the Office of the Chief Psychiatrist (see Useful Contacts).

3.6.2 For how long is consent valid?

A patient's consent remains valid until:

- * the patient withdraws it
or
- * the proposed treatment is no longer appropriate due to a change in a patient's circumstances.

A change in the patient's circumstances may include but is not limited to:

- * an improvement or deterioration in the patient's condition
- * development of new treatment options since consent was given
- * progression of the disease which may have changed the recommended treatment regime, or changed the therapeutic goal from e.g. "cure" to "palliative care"
- * other personal circumstances.

It is a requirement of this policy that:

- * a patient's clinical condition and consent must be reviewed **prior to** the treatment being performed
- * evidence of such a review is documented on the consent form or elsewhere in the patient's medical record
- * patients are advised that they can withdraw their consent at any time.

If the patient's circumstances have not altered (as referred to above) and the patient can confirm the key points of the consent communications, the review can be recorded on the consent form or elsewhere on the medical record, as relevant.

If the patient's circumstances (as referred to above) have changed a new consent process must be conducted and a new consent form must be completed.

Some treatments, such as chemotherapy or electroconvulsive therapy (ECT) can involve more than one treatment as part of a course and the consent form can cover all treatments in the course. The patient must be informed that their consent is for the entire course of treatment and that they may withdraw their consent at any time. Consent must be reviewed in response to changed circumstances, as relevant. The course of treatment may include a corresponding series of anaesthesia, if consented to.

See Appendix 7 for consent related to blood and blood products.

3.6.3 Withdrawal of consent

If a patient consents to treatment and then subsequently withdraws their consent the health professional should discuss that decision with the patient. The treatment must not commence or if it has already commenced it must cease immediately. The date of withdrawal and any relevant circumstances must be documented in the patient's medical record.

3.6.4 Scanned, photocopied and faxed consent forms

The patient's original consent form should be used whenever possible. Occasionally it may be necessary to use duplicate forms (scanned, photocopied, faxed) but this may create a potential risk that the form relied on is not the most current version.

Before proceeding with a treatment, the responsible health professional must ensure they have the patient's consent and this includes reviewing the most current consent form and confirming its content is accurate.

Hospitals and health services must have a documented process to reduce the risk of confusion around duplicate and outdated consent forms.

3.6.5 Development of hospital specific and specialty consent forms

Where hospital specific and speciality consent forms are required, hospitals should seek approval through appropriate hospital/health service governance structures. Hospitals/health services must ensure all consent forms contain the minimum documentation requirements (as per 3.6.1) and follow the principles of consent outlined in this policy. Hospitals/health services should develop local operational guidelines with regards to the use of consent forms.

4. When different consent arrangements apply

Consent is either not required or irrelevant in certain circumstances. These include where there is an emergency in which the patient is incapable of providing consent, and where the law either permits or forbids treatment regardless of consent. In other circumstances, the consent process may vary.

4.1 Exceptions

4.1.1 Treatment in an emergency

In an emergency, treatment may be necessary to save a person's life or avert serious injury to a person's health. Consent should still be sought if the person is able to provide it. Consent processes may need to be somewhat abridged due to time pressures but the key principles of consent set out in this policy should still be applied. The circumstances of the emergency and details of communications should be recorded in the patient's medical record at the earliest opportunity.

In an emergency where a person is incapable of giving consent, treatment may be provided without consent, i.e. where treatment is necessary to save a person's life or prevent serious injury to the person's health. The treatment in these cases is that which is:

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

In these situations, the completion of a consent form is not required but the circumstances that constitute the medical emergency and the patient's inability to consent must be clearly documented in the patient's medical record.

The emergency exception (to the requirement to obtain consent prior to treatment) only applies where a person:

- * is unable to give consent
- * does not have an Advance Health Directive (AHD) or common law directive that is known, immediately available and applicable in the circumstances
- * does not have a substitute decision maker who can be readily identified and immediately available to consider consent (see Fig.1).

Note: Emergency treatment does not include emergency psychiatric treatment (see 4.4 for treatment of patients with mental illness).

4.1.1.1 Emergency surgery

When a patient arrives in an operating theatre for emergency surgery, the health professional providing the treatment should:

- * confirm that emergency treatment is necessary and in the patient's best interest
- * if necessary, seek a second opinion.

Prior to surgery the *Authority to Proceed with Surgery on a Patient without Valid Consent Form* (see Appendix 5) should be completed. As indicated on the consent form, the rationale for proceeding with the treatment must be documented in the patient's medical record.

4.2 The law either permits or forbids treatment and consent is immaterial

Some laws specify that treatment either may be provided, or must not be provided, regardless of whether the patient, or person authorised to make treatment decisions on their behalf, has provided consent. See Appendix 8 for more details.

4.3 Variations to the usual consent process

The process of obtaining consent may vary in certain circumstances. This includes where:

- * adult patients lack capacity to provide consent themselves, e.g. where they:
 - * are experiencing mental health issues which impede relevant decision making ability
 - * otherwise lack capacity
- * the patient is a child.

4.3.1 Patients who lack capacity

Where adult patients do not have capacity to make treatment decisions themselves and consent is required prior to providing that treatment, health professionals are required to ascertain whether the patient has made:

- * a formal Advance Health Directive (AHD) which covers the decision to be made

or

- * a common law directive that covers the decision to be made.

In the absence of a formal AHD or common law directive, the health professional should determine a substitute decision maker (person responsible) who is authorised to make the decision (see 4.3.1.2 for further detail).

4.3.1.1 Advance Health Directives (AHDs)

The *Guardianship and Administration Act 1990*¹ (*GA Act*) applies to treatment decisions when a patient 18 years or over is not able to make reasonable judgments about proposed treatment.

A person who has capacity and is 18 years or older can make a 'living will' i.e. a document which sets out the person's health care directives to be followed if the person no longer has capacity to make treatment decisions. Living wills can take different forms. Those which clearly comply with formalities may be more readily relied upon, depending on the circumstances.

In WA, the *GA Act* sets out formalities relevant to AHDs. An AHD made under the *GA Act* contains a person's decisions to either consent to or refuse specified treatments which may be proposed in the future. AHDs come into effect when the person no longer has capacity to make their own treatment decisions.

Health professionals are obliged to follow treatment decisions expressed in an AHD except in limited circumstances (see further below). Unless an exception applies, AHDs override decisions made by substitute decision makers (known as persons responsible under the *GA Act*) as set out in the hierarchy of decision makers for treatment, explained further below in 4.3.1.2.

The *GA Act* specifically preserves the common law in relation to treatment decisions. This means a person's entitlement to make decisions in respect of future treatments must be respected. If the person has communicated their intentions regarding future treatment, this communication may be a valid common law directive if their decision (i) was made when they had capacity, (ii) was made voluntarily (without duress or undue influence), and (iii) clearly applies to the treatment that is proposed. It may be necessary to seek legal assistance to help assess whether a common law directive may be valid.

If a person has made a formal AHD in another Australian state or territory and it corresponds sufficiently in form and effect to an AHD made under the *GA Act*, the State Administrative Tribunal (SAT) can make a declaration that the AHD is valid (or invalid, as the case may be).

Where there has been no application to SAT for a declaration of validity the AHD may still be persuasive as a common law directive, depending on the circumstances.

Treatment should be provided in accordance with decisions expressed in AHDs and generally 'persons responsible' cannot override these decisions.

There are some circumstances which may affect the operation of AHDs please refer to the *GA Act 1990*. If there is any doubt about the validity of an AHD or whether it applies in any given situation, it may be necessary to obtain direction from the SAT.

If an AHD doesn't cover the treatment decision to be made, then a 'persons responsible' should be identified, as set out below.

For more information about AHDs see Section 8 - Useful Contacts.

4.3.1.2 Treatment decisions by a substitute decision maker

In the event that a patient who is 18 years or older is not able to give consent and an applicable AHD does not exist, the **hierarchy of decision makers for treatment** (see Fig.1) must be used to identify a substitute decision maker known in the *GA Act* as a 'person responsible' who can provide consent on the patient's behalf. In these situations where the patient is not able to make reasonable judgments about any proposed treatment a 'person responsible' can be appointed to make decisions in the best interests of the patient.

Health professionals should consult with the '**person responsible**' if they have questions or concerns about the AHD or a treatment decision contained within an AHD.

The hierarchy of decision makers for treatment identifies the criteria and the order of priority for the 'person responsible' empowered to make treatment decisions for a patient (with the exception of sterilisation).

A treatment decision made by a 'person responsible' on behalf of a patient has the same effect as if the decision had been made by the patient himself or herself.

The treatment decision should be made by the first person in the hierarchy of decision makers for treatment who is:

- * 18 years of age or older
- * of full legal capacity
- * reasonably available
- * willing to make the treatment decision.

Where there is more than one person within a category who wishes to be involved and those persons cannot agree on the treatment decision, the health professional should encourage them to reach consensus. If this cannot be achieved, it may be necessary to seek legal assistance (see Glossary). In some cases direct referral to SAT may be appropriate e.g. where:

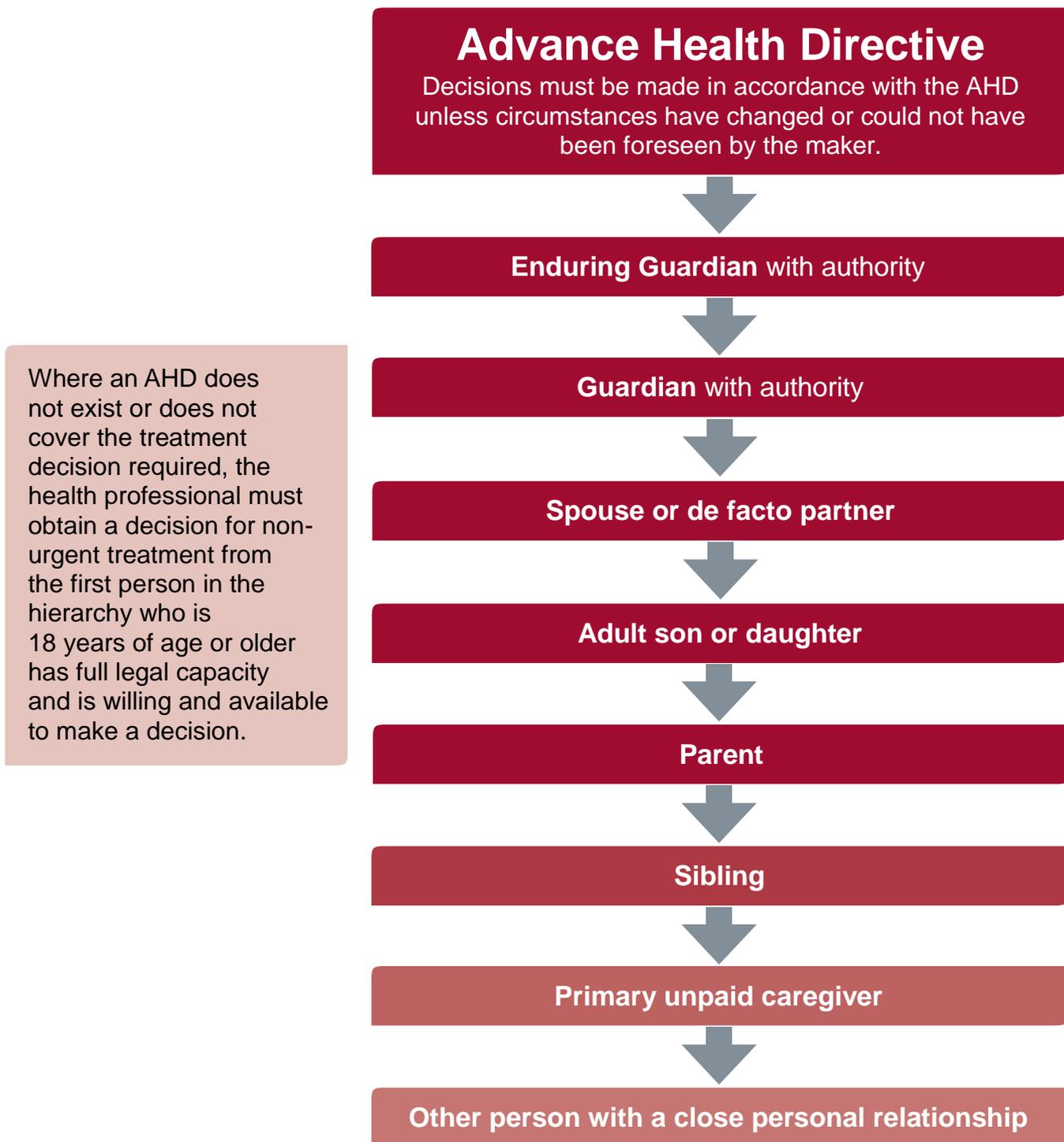
- * there is no one in the hierarchy of treatment decision makers for treatment who is available and willing to make the treatment decision

or

- * there is doubt about the person's relationship to the patient.

See Section 8 - Useful Contacts for additional information about AHDs and the SAT.

Figure 1: Hierarchy of decision-makers for treatment⁴



4.3.2 Children and young people

4.3.2.1 Emergencies

The policy regarding consent to treatment in an emergency is set out in sections 4.1.1 and 4.1.1.1 It applies equally to minors except that consent should be sought from parents or substitute decision makers where circumstances permit.

4.3.2.2 Consent by parent or substitute decision maker

Generally, parents may authorise treatments on behalf of their children, where the treatment is in the child's best interests. However, 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, then they can consent to or decline that treatment on their own behalf.

Responsibility for treatment decisions may not remain with parents if children are in the care of the CEO of the Department of Child Protection and Family Services (including delegated officers as relevant), as set out in the *Children and Community Services Act 2004*¹⁴.

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

Under the Commonwealth *Family Law Act 1975*¹⁵ responsibility for any children who are under 18 years of age:

- * rests with parents
- * is not affected by changes to relationships (for example, if the parents separate, divorce or remarry). However, this may be varied by a court order where family relationships change and result in actions such as separation and divorce.

4.3.2.3 Mature minors

A minor who fully understands the nature and consequences of the proposed treatment is capable of effective consent or withholding consent.

An assessment of a child as a 'mature minor' must be made in the context of the treatment in question, 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'.

For further information about consent in relation to children and young people, refer to Child and Adolescent Mental Health Service's (CAMHS) guidelines¹⁶ Working With Youth resource¹⁷, *Mental Health Act 2014*⁶ and Appendix 8.

4.4 Treatment of patients with mental illness

The treatment of patients with mental illness is governed by the *Mental Health Act 2014*⁶ (MHA 2014). Some restrictions and prohibitions apply, including on the provision of electroconvulsive therapy (ECT), psychosurgery and deep sleep and insulin coma therapy (see Part 14 ss192-199, 205-209 and 210, *MHA 2014*).

According to the *MHA 2014* patients will have capacity to give consent if, after being provided with relevant information, they are able to:

- * understand the proposed treatment including alternative treatments and inherent risks
- * understand the information involved in making the treatment decision
- * understand the effect of the treatment decision
- * weigh up the above factors for the purpose of making the treatment decision
- * communicate the treatment decision in some way (see Part 5, MHA 2014).

As capacity is decision specific, a mental health patient may have capacity to provide consent to treatment for non-mental or mental illness. For example, they may have capacity to provide consent to take a Panadol or have a dental extraction and they may have capacity in relation to treatment for their mental health condition.

The *MHA 2014* states informed consent to the provision of treatment means consent to the provision of the treatment given in accordance with Part 5 Division 2.

4.4.1 Voluntary mental health patients

A voluntary patient (including referred persons) cannot be provided with treatment without informed consent being given to the provision of treatment.

Patients must be supported to make their own informed decisions about treatment where possible. In some cases, where it does not place a patient's health or safety at risk, a decision about treatment could be delayed until the patient's mental health improves to the extent that they are competent to make an informed decision. Patients should be advised of their opportunities for advocacy assistance, via the Mental Health Advocacy Service, in providing consent if they require it (see Section 8 - Useful Contacts).

Informed consent must be recorded and must include:

- * the date it was provided
- * who provided it
- * if it was provided by someone other than the patient – the name and contact details of that person and their authority to make the treatment decision.

4.4.2 Involuntary mental health patients and mentally impaired accused

An involuntary mental health patient or mentally impaired accused who is detained in an authorised hospital, can be provided with treatment without informed consent being given prior to the provision of the treatment (except for the provision of electroconvulsive therapy, emergency psychiatric treatment, psychosurgery or deep sleep and insulin coma therapy, in which case different provisions apply (see s178 and s210 *MHA 2014*)).

In this situation, the medical practitioner must have regard for the patient's wishes (see s179 *MHA 2014*) and if practicable should still seek consent. Patients must be advised that the Mental Health Advocacy Service can assist them (see Section 8 - Useful Contacts).

A record of the treatment provided to the patient and the patient's wishes, to the extent that it is practicable to ascertain them, must be documented in the patient's medical record including:

- * any contemporaneous wishes expressed by the patient
- * any relevant treatment decision in an AHD
- * any relevant term of an enduring power of guardianship
- * any other things that the medical practitioner considers to be relevant to ascertaining the patient's wishes.

Where a health professional makes a decision that is inconsistent with a relevant treatment decision in an AHD or a relevant term of an enduring power of guardianship, the health professional must file a record of the decision and the justification. The decision and justification should be clearly explained to the patient and their personal support persons and their support obtained, if practicable.

In addition, the patient's psychiatrist must ensure that a copy of the reason why the AHD was not followed is provided to all of the following:

- * the patient

- * at least one of the patient's personal support persons (including enduring guardians or guardians, nominated persons, carers and close family members), unless the patient has reasonably refused this
- * the Chief Psychiatrist and the Chief Mental Health Advocate.

4.4.3 Emergency psychiatric treatment

Sections 202 – 204 of the *MHA 2014* allow for emergency psychiatric treatment to be provided to a patient without informed consent:

- * where treatment needs to be provided to save the person's life

or

- * where treatment needs to be provided to prevent the person from behaving in a way that is likely to result in serious physical injury to the person or another person.

Emergency psychiatric treatment does not include ECT, psychosurgery or treatment that is prohibited by s210(1) of the *MHA 2014* (deep sleep therapy, insulin coma therapy or insulin sub-coma therapy).

A medical practitioner who provides emergency psychiatric treatment to a person must make a record of that treatment in the form approved by the Office of the Chief Psychiatrist (Form 9A). A copy of the form must be provided to the person, the Chief Psychiatrist and, if the person is a mentally impaired accused, to the Mentally Impaired Accused Review Board.

4.4.4 Emergency ECT

Emergency ECT can only be provided under *MHA 2014* s199 where all of the following prerequisites are met:

- * the person is an adult involuntary patient, or an adult mentally impaired accused in an authorised hospital (see Glossary)
- * ECT is required to save the patient's life or to avoid an imminent risk of the patient behaving in a way that is likely to result in serious physical injury to the patient or another person
- * the Chief Psychiatrist has approved the provision of emergency ECT
- * the ECT is provided at a mental health service that has been approved under s544 *MHA 2014*, by the Chief Psychiatrist for the provision of ECT
- * ECT is performed with regard to the guidelines published by the Chief Psychiatrist under s547.

Mental health guidelines and further information about the *MHA 2014* can be obtained from the Office of the Chief Psychiatrist (refer to Section 8 - Useful Contacts).

4.4.5 Provision of urgent medical treatment to mental health patients

Urgent non-psychiatric medical treatment provided to an involuntary mental health patient who is under an inpatient treatment order or a mentally impaired accused detained at an authorised hospital (s242 *MHA 2014*) must be reported by the person in charge of the authorised hospital to the Chief Psychiatrist and, if the patient is a mentally impaired accused in an authorised hospital, to the Mentally Impaired Accused Review Board. The report must be in the form approved by the Chief Psychiatrist (Form 9B) and it must contain the information set out in *MHA 2014* s242. The person in charge is also responsible for

notifying at least one personal support person that the treatment has been provided.

4.4.6 Other requirements for provision of mental health treatment

Treatment of a person of Aboriginal or Torres Strait Islander descent

Where practicable and appropriate, treatment provided to a patient who is of Aboriginal or Torres Strait Islander descent must be made in collaboration with Aboriginal or Torres Strait Islander mental health workers and significant members of the person's community, including traditional elders and traditional healers (see s189, *MHA 2014*).

Compliance with standards and guidelines

The person in charge of a mental health service must ensure that clinicians:

- * comply with the Chief Psychiatrist's Standards for the provision of care and treatment
- * have regard to *Chief Psychiatrist's Guidelines*, which the Chief Psychiatrist must publish as a requirement of s547 of the *MHA 2014*.

5. Evaluation, monitoring and feedback

All WA Health hospitals must collect and review data locally to assess compliance with the consent process specified in this policy. The focus of monitoring is to verify the informed consent process through auditing the use of an appropriate consent form and the recording of discussions between a health professional and patient in the patient's medical record. Data can be used to inform quality improvement activities such as system, policy, guideline improvements and education and training activities.

In accordance with the National Safety and Quality Health Service Standards⁷ (NSQHSS) hospitals and health services must schedule periodic reviews of the effectiveness and outcomes of the policy (see NSQHSS 1.18, 7.11). Sites must ensure compliance with the policy is monitored including:

- * documentation of key points from consent communications
- * review of clinical condition and consent prior to the treatment.

6. Roles and responsibilities

Chief executives - hospital and health services

Hospital and Health Service Chief Executives must:

- * ensure this policy is distributed across their hospitals/health services
- * provide necessary training to staff to ensure understanding of this policy across the hospital/health service
- * ensure health professionals are well trained in seeking consent and understand the limited circumstances in which medical treatment can be provided without consent.

Hospitals and health services

Each site must ensure they have formal consent procedures to support the implementation of the policy which includes:

- * governance
- * roles and responsibilities
- * resources for consent
- * training requirements
- * evaluation, monitoring and feedback processes

All local guidelines and procedures must be informed by and consistent with the principles set out in this policy.

Health professionals

Health professionals who seek consent must:

- * be aware of the principles of informed consent
- * report any incidents or near misses relating to poor compliance with the policy through the Datix Clinical Incident Management System (CIMS)
- * monitor incidents of where consent may not have been obtained where required and use this information to inform future training of staff
- * adhere to the principles and aims of this policy and ensure they operate within the legal framework detailed in this policy.

7. Glossary

Advance Health Directive	<p>Means an advance health directive made under Part 9B of the <i>Guardianship and Administration Act 1990</i>, including an instrument recognised as such under 110ZA of the GA Act. Part 90 applies to treatment decisions in relation to patients under legal incapacity, and specifies that ‘advanced health care directives’ include common law directives, in relation to a person under legal incapacity. Therefore AHDs include:</p> <ul style="list-style-type: none">* those which comply, or substantially comply with the form prescribed under the GA Act* those made under equivalent provisions in other Australian jurisdictions which have been recognised as AHD by an order made by the State Administrative Tribunal* common law directives, in relation to a person under legal incapacity.
Authorised hospital	<p>In the context of mental health, public or private hospital authorised to detain and treat involuntary patients.</p>
Capacity	<p>In the context of medical treatment, 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.</p> <p>The <i>Mental Health Act 2014</i> (s15) defines a person as having capacity when they:</p> <ul style="list-style-type: none">* understand any information or advice about the decision that is required* understand the matters involved in the decision* understand the effect of the decision* weigh up the above factors for the purpose of making the treatment decision* communicate the decision in some way.
Carer	<p>A person who (without being paid) provides ongoing care or assistance to another person who has a disability, a chronic illness, including a mental illness or a person because of frailty requires assistance with carrying out everyday tasks.¹⁸</p>
Competent patient	<p>A patient who has capacity.</p>
Consent (to medical treatment)	<p>In the context of health care, consent to treatment is a person’s agreement that a health professional can proceed to perform a specific proposed treatment.</p>

Emergency Psychiatric Treatment	<p>In an emergency, treatment that can be provided to a patient without any approval or consent in order to save the person's life or to prevent the person from behaving in a way that is likely to result in serious physical injury to the person or another person.</p> <p>Emergency psychiatric treatment does not include electroconvulsive therapy, psychosurgery or treatment that is prohibited by s210 (1) (see <i>Mental Health Act 2014, s202</i>).</p>
Emergency treatment	Treatment needed to save a patient's life or prevent serious damage to the patient's health. See <i>Guardianship and Administration Act 1990</i> for definition of urgent treatment.
Enduring guardian	A person appointed under an Enduring Power of Guardianship to make personal, lifestyle and treatment decisions on behalf of the adult person who makes the appointment (see the <i>Guardianship and Administration Act 1990</i> Part 9A).
Enduring Power of Guardianship (EPG)	A formal document in which a person nominates a competent adult to be an Enduring Guardian (see the <i>Guardianship and (EPG) Administration Act 1990</i> Part 9A).
Explicit (express) consent	Explicit or express consent, in the context of health care, refers to a patient's clear agreement that they wish to undergo a specific proposed treatment. Explicit consent must be obtained prior to various invasive/higher risk procedures as set out in Section 2.2.
Guardian	An adult appointed by the State Administrative Tribunal to make wide-ranging decisions, including treatment decisions, on behalf of an adult person who does not have the capacity to make such decisions for him/herself (see the <i>Guardianship and Administration Act 1990</i> Part 5).
Health professional	A person registered under the Health Practitioner Regulation National Law (Western Australia) 2010 in the health professions listed therein.
Hierarchy of decision makers followed for treatment	Relates to the consent process which must be for patients under legal incapacity who are unable to make reasonable judgments about treatment. The hierarchy identifies the criteria for each person responsible and the order in which they should be consulted about a treatment decision (see <i>Guardianship and Administration Act 1990</i>).

7. Glossary (continued)

High risk medications	Medications that have a heightened risk of causing significant or catastrophic harm when used in error and include: <ul style="list-style-type: none">* medications with a low therapeutic index* medications that present a high risk when administered via the wrong route or when other systems errors occur.
Invasive imaging procedures	Any surgical or exploratory imaging activity in which the body is pierced by a device, instrument or by manual digitation.
Investigational drugs	Any drug, reference product or placebo which is being tested or used as a reference in a clinical trial, including a registered drug used in a different formulation, or used for a TGA unapproved indication, or used in doses outside the approved range.
Involuntary patient	An involuntary patient is a person who is under an involuntary treatment order (made under the Mental Health Act). An involuntary treatment order is: <ul style="list-style-type: none">* an inpatient treatment order or <ul style="list-style-type: none">* a community treatment order.
Legal Assistance	If legal assistance is required, contact the State Solicitor's Office (teaching hospitals) or the Department of Health's Legal & Legislative Services (non-teaching hospitals) via the medico-legal contact for the hospital.
Material risk	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 medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it. ¹²
Medical practitioner	A person registered under the <i>Health Practitioner Regulation National Law (Western Australia) Act 2010</i> in the medical profession.
Medical record	A written or electronic record which captures details of a patient's health information, for example, their attendance, non-attendance, medical history, consultations, treatment, care, investigations and progress at a health facility.

<i>Mental Health Act 2014 (MHA 2014)</i>	Parts 5 and 13 of the <i>Mental Health Act 2014</i> contain specific provisions covering the treatment of patients and consent requirements. The <i>MHA 2014</i> defines ‘treatment’ as provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness. Treatment does not include seclusion, bodily restraint or sterilisation (Part 2, Division 1).
Mentally impaired accused	A person who is on a custody order under the <i>Criminal Law (Mentally Impaired Accused) Act 1996</i> . The person may be required to be detained in an authorised hospital, or they may be on a release order (either unconditionally or on conditions)
Mature minor	A person under the age of 18 who has sufficient emotional and intellectual capacity to fully comprehend the nature, consequences and risks of a proposed action (for example, a treatment decision or a decision to release health information), irrespective of whether a parent/ substitute decision maker consents to it. A child who is assessed to be a mature minor in relation to a particular treatment decision may either give or refuse consent to it.
Minor	A person under the age of 18 years i.e. not an adult.
Off label medications	Medications where a drug is used for an indication, a route of administration, or a patient group that is not included in the approved product information document for that drug.
Personal support person	A person who provides support, such as emotional support to a patient, e.g. a close family member, carers, nominated person, guardian or enduring guardian or an adult, or parent or guardian of a child. A nominated person means a person who is formally nominated by a person to be their personal support person.
Person responsible	Under the <i>GA Act</i> , a person who may legitimately make a treatment decision on behalf of a patient who is unable to make reasonable judgments for him/herself. Refer to the Hierarchy of Treatment Decision Makers to determine who is the ‘person responsible’.
Regional anaesthesia	Regional anaesthesia involves the injection of local anaesthetic around major nerve bundles supplying body areas, such as the thigh, ankle, forearm, hand, shoulder or abdomen. Regional anaesthesia includes Bier Block. Regional anaesthesia may be used on its own or combined with general anaesthesia.

7. Glossary (continued)

Special Access Scheme	The special access scheme refers to arrangements which provide for the import and/or supply of an unapproved therapeutic good for a patient on a case-by-case basis. This scheme is managed by the general Therapeutic Goods Administration.
State Administrative Tribunal (SAT)	Independent tribunal established under the <i>State Administrative Tribunal Act 2004</i> to hear disputes and make determinations about a range of administrative matters. Examples of proceedings relevant to health include health practitioners' disciplinary matters and guardianship matters.
Substitute decision maker	Can include a parent or other adult with authority to make a treatment decision on behalf of a child, and it can include a 'person responsible' who can make a treatment decision for an adult (who can't themselves make a decision).
Treatment	Any medical, surgical or dental treatment or other health care, including a life-sustaining measure or palliative care (see <i>Guardianship and Administration Act 1990</i>). Under the <i>Mental Health Act 2014</i> , treatment means the provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness, and does not include bodily restraint, seclusion or sterilisation.
Therapeutic privilege	The principle of therapeutic privilege recognises that there are situations where a health professional is entitled to withhold information from a client where it is in the client's best interests not to receive that information. Health professionals should not lightly decide to withhold information. The courts interpret therapeutic privilege narrowly.
Treatment decision	A decision to consent or refuse consent to the commencement or continuation of any treatment of the person (see <i>Guardianship and Administration Act 1990</i>).
Voluntary patient	A person to whom treatment is being, or is proposed to be, provided by a mental health service but who is not an involuntary patient or a mentally impaired accused who is required under the <i>Criminal Law (Mentally Impaired Accused) Act 1996</i> to be detained in an authorised hospital. The definition could include a referred person, or a mentally impaired accused who is on release order (whether unconditionally or on conditions).

8. Useful Contacts

Advance Health Directive information

Tel: 9222 2300

Email: advancehealthdirective@health.wa.gov.au

Website: <http://www.health.wa.gov.au/advancecareplanning/home/>

Chief Mental Health Advocate

Tel: 6234 6300

Email: contactus@mhas.wa.gov.au

Website: www.mhas.wa.gov.au

Child Protection and Family Support

Tel: 9222 2555

After hours Crisis Care: 9223 1111; Country Areas Free Call: 1800 199 008

Website: <http://www.dcp.wa.gov.au/>

Legal and Legislative Services, Department of Health

Tel: 9222 4038

Website: <http://intranet.health.wa.gov.au/LLSD>

Office of the Chief Medical Officer

(for patient blood management information)

Tel: 9222 2072

Email: bloodmanagement@health.wa.gov.au

Website: http://ww2.health.wa.gov.au/Articles/N_R/Patient-blood-management

Office of the Chief Psychiatrist

Tel: 9222 4462

Email: reception@ocp.wa.gov.au

Website: www.chiefpsychiatrist.wa.gov.au/

Office of the Public Advocate

Telephone advice line: 1300 858 455

Email: opa@justice.wa.gov.au

Website: www.publicadvocate.wa.gov.au

State Administrative Tribunal

Tel: 9219 3111

Toll free: 1300 306 017

Email: info@sat.justice.wa.gov.au

Website: www.sat.justice.wa.gov.au/

State Solicitor's Office

For legal advice in the case of teaching hospitals only.

Tel: 9264 1888

Teaching Hospitals

Medico-Legal Department

Other useful information

New South Wales. Attorney General's Department. Capacity toolkit: Information for government and community workers, professionals, families and carers in New South Wales. [NSW]: Attorney General's Department. 2008. Available from:

http://www.diversityservices.justice.nsw.gov.au/agdbasev7wr/divserv/documents/pdf/capacitytoolkit0609.pdf?bcsiscan_c221d61a0ea4ff4c=O&bcsiscan_filename=capacitytoolkit0609.pdf

Patient confidentiality

http://www.health.wa.gov.au/CircularsNew/circular.cfm?Circ_ID=13003

Appendix 1 – Form A: Patient consent to treatment or investigation – adult or mature minor

Affix hospital stamp here Patient Consent to Treatment or Investigation	Surname Given Names	UMRN DOB
Treatment / Procedure / Investigation		
List the treatment/procedures/investigations to be performed, noting correct side/correct site		
This procedure requires: <input type="checkbox"/> General and/or Regional Anaesthesia <input type="checkbox"/> Local Anaesthesia <input type="checkbox"/> Sedation An Anaesthetist will explain the risk of general or regional anaesthesia to you.		
Signature of doctor / health professional who has determined the consent process has occurred		
Risks and benefits have been discussed with the patient and relevant consent discussions are to be documented in the medical record.		
Full name _____ Position/Title _____ Signature _____ Date _____		
Patient's declaration		
<ul style="list-style-type: none"> * I have been given written information about the procedure/treatment. * I understand that the doctor/health professional may not perform the procedure him/herself. * I have been informed of the risks that are specific to me, benefits, alternatives (including if I choose not to have the procedure/treatment) and the likely outcomes. * I have been given the opportunity to ask questions about this procedure and my specific queries and concerns have been answered. * I understand that if immediate life-threatening events happen during the procedure, I will be treated accordingly. * I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs. * I consent to a blood transfusion, if needed <input type="checkbox"/> Yes <input type="checkbox"/> No (please tick). The risks have been explained to me. Note: If a blood transfusion is anticipated, please complete the Consent to Blood Products Form. * I consent to undergo the procedure/s or treatment/s as documented on this form. 		
Patient's Full name _____ Patient's signature _____ Date/Time _____		
Interpreter's declaration		
Specific language requirements (if any) I declare that I have interpreted the dialogue between the patient and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.		
Interpreter's Full name _____ Date/Time _____ Agency name _____ Interpreter's signature _____		
Review of consent (if applicable)		
I confirm that the patient's consent, personal circumstances and clinical condition has been reviewed and the treatment/procedure is still to be undertaken.		
Full name (doctor/health professional) _____ Position/Title _____ Signature _____ Date _____		
I confirm that the request and consent for the operation/procedure/treatment above remains current.		
_____ (consenting person)		

Appendix 2 – Form B: Consent for a minor requiring parental/guardian approval for treatment or investigation

Affix hospital identification here Consent for a minor requiring parental/guardian approval for treatment or investigation	Surname Given Names	UMRN DOB
Treatment / Procedure / Investigation		
List the treatment/procedures/investigations to be performed, noting correct side/correct site		
This procedure requires: <input type="checkbox"/> General and/or Regional Anaesthesia <input type="checkbox"/> Local Anaesthesia <input type="checkbox"/> Sedation An Anaesthetist will explain the risk of general or regional anaesthesia to you.		
Signature of doctor / health professional who has determined the consent process has occurred		
Risks and benefits have been discussed with the patient and relevant consent discussions are to be documented in the medical record.		
Full name _____ Position/Title _____ Signature _____ Date _____		
Parent/guardian's declaration		
<ul style="list-style-type: none"> * I have been given written information about the procedure/treatment. * I understand that the doctor/health professional may not perform the procedure him/herself. * I have been informed of the risks that are specific to my/this child, benefits, alternatives (including if I choose for my/this child not to have the procedure/treatment) and the likely outcomes. * I have been given the opportunity to ask questions about this procedure and my specific queries and concerns have been answered. * I understand that if immediate life-threatening events happen during the procedure, my/this child will be treated accordingly. * I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform the doctor if this occurs. * I consent to a blood transfusion, if needed <input type="checkbox"/> Yes <input type="checkbox"/> No (please tick). The risks have been explained to me. Note: If a blood transfusion is anticipated, please complete the Consent to blood products form. * I consent for my/this child to undergo the procedure/s or treatment/s as documented on this form. 		
Parent/guardian's full name _____		
Parent/guardian's signature _____ Date/Time _____		
Interpreter's declaration		
Specific language requirements (if any) _____ I declare that I have interpreted the dialogue between the parent/guardian and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.		
Interpreter's Full name _____ Date/Time _____ Agency name _____ Interpreter's signature _____		
Review of consent prior to the procedure (if applicable)		
I confirm that the patient's consent, personal circumstances and clinical condition has been reviewed and the treatment/procedure is still to be undertaken.		
Full name (doctor/health professional) _____ Position/Title _____ Signature _____ Date _____		
I confirm that the request and consent for the operation/procedure/treatment above remains current.		
Signature _____ Date _____ (consenting parent/guardian)		

Appendix 3 – Form C: Adults without the capacity to consent to treatment or investigation

Affix hospital identification here	Surname	UMRN							
Adults without the capacity to consent to treatment or investigation	Given Names	DOB							
Proposed Treatment / Procedure / Investigation									
List the treatment/procedures/investigations to be performed, noting correct side/correct site.									
This procedure requires: <input type="checkbox"/> General and/or Regional Anaesthesia <input type="checkbox"/> Local Anaesthesia <input type="checkbox"/> Sedation An Anaesthetist will explain the risk of general or regional anaesthesia to you.									
Reason for the adult being incapable of consent									
The patient is incapable of consenting to the procedure/treatment because: (Tick one of the boxes below) <input type="checkbox"/> He/she lacks the legal capacity to be able to understand the nature and effect of the procedure/treatment. <input type="checkbox"/> He/she is unconscious/suffers from dementia and cannot indicate whether or not he/she does consent to the procedure/treatment.									
Declaration of person responsible/consenting person									
<ul style="list-style-type: none"> * I understand that the doctor/health professional him/herself may not perform the procedure on the patient. * I have been informed of the risks that are specific to the patient, benefits, alternatives (including if I choose not to have the procedure/treatment) and the likely outcomes. * I have been given the opportunity to ask questions about this procedure and my specific queries and concerns have been answered. * I understand that if immediate life-threatening events happen during the procedure, the patient will be treated accordingly. * I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs. * I consent to the patient having a blood transfusion, if needed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (please tick) The risks have been explained to me. Note: If a blood transfusion is anticipated, please complete the Consent to Blood Products Form. * I give consent for the patient to undergo the procedure/s or treatment/s as documented on this form 									
Signature of substitute decision maker/person(s) responsible/consenting person									
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Full name of consenting person (1)</td> <td style="width: 50%; border-bottom: 1px solid black;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Relationship to patient</td> <td style="border-bottom: 1px solid black;">Signature</td> </tr> </table> <small>Authority (Guardianship and Administration Act 1990, Mental Health Act 2014 - state the relevant category as per the hierarchy of decision)</small>	Full name of consenting person (1)	Date	Relationship to patient	Signature	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Full name of consenting person (2)</td> <td style="width: 50%; border-bottom: 1px solid black;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Relationship to patient</td> <td style="border-bottom: 1px solid black;">Signature</td> </tr> </table> <small>Authority (Guardianship and Administration Act 1990, Mental Health Act 2014 - state the relevant category as per the hierarchy of decision)</small>	Full name of consenting person (2)	Date	Relationship to patient	Signature
Full name of consenting person (1)	Date								
Relationship to patient	Signature								
Full name of consenting person (2)	Date								
Relationship to patient	Signature								
Interpreter's declaration									
Specific language requirements (if any) _____ I declare that I have interpreted the dialogue between the parent/guardian and health professional to the best of my ability, and have advised the health professional of any concerns about my performance. _____ Agency name _____ Interpreter's signature _____									
Signature of doctor/health professional who has determined the consent process									
Risks and benefits have been discussed with the patient and relevant consent discussions are to be documented in the medical record. Full name _____ Position/Title _____ Signature _____ Date _____									
Review of consent (if applicable)									
I confirm that the patient's consent, personal circumstances and clinical condition has been reviewed and the treatment/procedure is still to be undertaken. Full name (doctor/health professional) _____ Position/Title _____ Signature _____ Date _____									

Appendix 5 – Form E: Authorisation to proceed with surgery on a patient without a valid consent form

Affix hospital stamp here	Surname	UMRN
Authorisation to proceed with surgery on a patient without a valid consent form	Given Names	DOB
Reason for seeking authorisation to proceed with surgery on a patient without a valid consent form		
<p>A patient, who has been administered medication that may alter his/her mental state or who may otherwise be incompetent, has arrived at the Operating Theatre/Treatment Room: (Tick one of the boxes below)</p> <p><input type="checkbox"/> Without a valid consent form; or</p> <p><input type="checkbox"/> Information recorded on the patient's consent form is incorrect and requires amendment.</p> <p>Note: A Consent Form is valid if the information is correct in every detail (patient's details, description of operation or procedure and side and site of procedure of operation), is signed by the patient (or person authorised to give consent in the case of an incompetent patient) and has been witnessed by an appropriate person.</p>		
Proposed procedure		
List the proposed procedure to be performed		
Declaration of doctor/anaesthetist		
<p>The patient _____ (insert name) has arrived in the Operating Room without a valid consent form.</p> <p>In consultation with _____ (insert name of doctor/health professional if applicable) it is considered that the proposed surgery/procedure is urgent and must proceed without a valid Consent Form being completed.</p>		
Reason for urgency/procedure proceeding		
<p>I have documented the reason/s and rationale for proceeding with the procedure in the patient's medical record.</p> <p>Full name: _____ Position: _____</p> <p>Date/Time: _____</p> <p>Note: <i>Urgent treatment</i> means treatment urgently needed by a patient to</p> <ul style="list-style-type: none"> * save the patient's life; or to * to prevent serious damage to the patient's health; or * to prevent the patient from suffering or continuing to suffer significant pain or distress” as defined in the section 110ZH <i>Guardianship and Administration Act 1990</i>. 		

Appendix 6 - Form F: Blood and blood products

Affix hospital stamp here	Surname	UMRN
Consent to blood products	Given Names	DOB
This form is to be used for infusion of Red Blood Cells, Platelets, Fresh Frozen Plasma, Cryoprecipitate and/or Other: _____		
Clinical condition/indication for administration of blood components/products		
(To be recorded by the medical officer obtaining consent)		
Duration of consent:	<input type="checkbox"/> This hospital admission <input type="checkbox"/> 12 months (Recurrent transfusion/infusion to manage chronic illness. Consent is valid for 1 year from date of consent unless clinical condition changes OR consent is withdrawn).	
Patient's declaration		
1. I understand that blood transfusion/blood product infusion may be a necessary part of my medical treatment. 2. I acknowledge that I have had the opportunity to ask questions and request further information related to transfusion/infusion. 3. I understand that I am receiving a biological product, therefore comes with potential risks and complications. 4. I acknowledge that the doctor has discussed the potential benefits, and appropriate alternative treatments. 5. The doctor has discussed the possible consequences of refusing this treatment. Patient Comment (are there any blood products you do not consent to?) _____		
Patient's full name (printed) _____		
Patient's signature _____ Date _____		
Person responsible for giving consent if NOT the patient:		
Full name (printed) _____ Relationship _____ to patient _____		
Signature _____ Date _____		
Declaration of doctor obtaining consent		
I have explained the following information to the patient and or their person responsible: * risks and benefits associated with transfusion/infusion * appropriate alternative treatments * risks of non-transfusion/ infusion The patient has been given the opportunity to ask questions and request further information I have provided the patient with a patient transfusion information brochure YES /NO (circle) Full name (printed) _____ Position _____ Signature _____ Date _____		
Interpreter's declaration:		
Language requirements Inc. language spoken (if applicable): _____ Interpreter services used <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify: <input type="checkbox"/> Telephone <input type="checkbox"/> On site I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance. Interpreter's full name (printed) _____ Phone _____ Interpreter's signature and NAATI number _____ Date _____		

Appendix 7 - Examples of clinical scenarios which explicit consent to be obtained and specifically recorded.

Anaesthesia

If a general, regional anaesthetic or intravenous sedation is to be administered to a patient as part of the patient's elective treatment the usual consent process must be conducted.

Where a patient is referred to an anaesthetist for a separate anaesthetic consultation, it is that anaesthetist's responsibility to inform the patient of the risks associated with alternative types of anaesthesia (e.g. regional, general or epidural) and complete an Anaesthetic Consent Form (refer to Appendix 4 Form D). For separate anaesthetic consultations the following must be documented:

- * completed Anaesthetic Consent Form (see Appendix 4 Form D) including material or specific risks discussed with the patient
- * document the information provided to the patient as discussed
- * consent reviewed prior to the treatment.

Blood and blood products

If the need for a blood transfusion is anticipated, explicit consent must be sought after providing relevant information to the patient (as set out in this policy), unless an exception applies (see section 4.1). This should include advising the patient of the risks associated with receiving a blood transfusion and completing the Consent to Blood Products Form (Form F).

The transfusion of blood and blood products can involve more than one course. It must be clearly documented in the patient record or on a Consent to Blood Products Form the duration of consent. This may be up to 12 months, as long as the patient does not withdraw consent or there is not a change in the patient's condition.

Refusal of consent for blood products, whether for religious or personal reasons must be documented in the patient's medical record in either the integrated progress notes or on a specific form produced for this purpose. When a patient does not consent to transfusion for specific blood products, both those not to be administered and alternatives acceptable for administration should be clearly documented.

Appendix 8. The law either permits or forbids treatment and consent is immaterial.

Some laws specify circumstances in which treatment either may be provided, or must not be provided, regardless of whether or not consent has been provided by the patient or a person authorised to make treatment decisions on their behalf.

Examples include:

Some medical procedures on children can only be authorised by a court acting in its *parens patriae* jurisdiction. This requires the court to determine whether or not the proposed treatment is in the child's best interests, e.g. sterilisation in the case of severe intellectual handicap.

The *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. See Division 3 (ss.56-63)

The *Human Tissue and Transplant Act 1982* provides specifically for blood transfusions on children without parental consent (in stated circumstances).

The *Mental Health Act 2014* specifies circumstances in which treatment may be given in the absence of informed consent.

The *Prisons Act 1981* provides that 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 or health of the prisoner or any other person is likely to be endangered by that refusal). Force may be used to the extent that it is reasonably necessary for the purpose.

Under the *Children and Community Services Act 2004*¹⁴ it is an offence to perform intimate body piercing on a child regardless of whether the child is a mature minor or their parents have consented. Apart from piercing ears on a child of 16 or over, written consent must be obtained from the child's parents before carrying out non-intimate body piercing on a child.

Under the *Criminal Code 1913* genital mutilation is an offence and parental consent provides no defence to that offence.

Under the *Road Traffic Act 1974*, samples of blood and urine can be taken on motor vehicle accident patients without their consent.

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