

CHAPTER 47

Consent: Verification of Informed Consent or Refusal

I. POLICY

The patient's informed consent for any "complex" treatment or procedure shall be documented in the patient's unit health record (UHR). Clinicians shall document in the patient's UHR that the patient has freely given informed consent prior to the initiation of treatment, care, services, and any invasive procedure(s). Documentation shall substantiate that the clinician has provided sufficient information to the patient in language and in terms that the patient understands.

Documentation of the informed consent process is evidence that the patient has been provided the opportunity to decide whether or not to submit to the proposed treatment, care, services and procedures. Informed consent shall be an educational process. Clinicians have the fiduciary responsibility to the patient to provide material information about the proposed treatment, care, and services. Material information is that which a reasonable person in the patient's position regards as significant to a decision to proceed or not to proceed with treatment.

The explanation shall include the nature of the anticipated treatment, expected outcomes of treatment, risks, possible complications, benefits or effects of treatment, alternatives, including their risks and benefits, information about potential outcomes if treatment is refused, and the professional(s) involved in the care. The documentation shall include acknowledgment that the patient can withdraw consent at any time.

The documentation of the informed consent discussion provides evidence that the patient received information and was given the opportunity to request information. It also records the patient's decision to consent to the procedure, treatment, or service. Documentation of the process protects the clinician from charges of battery, negligence and/or unprofessional conduct.

II. PROCEDURE

A. The clinician shall:

1. Use the progress notes to record the essence of the informed consent process, e.g., the discussion with the patient and the patient's subsequent decision. [CDC Form 7230]
2. Enter the time(s) and full date(s) of all discussions with the patient pertinent to the proposed treatment, care, or service.
3. Record sufficient information to provide the essence of the discussion with the patient.
4. Sign with full name and title.

B. Health Care Staff shall:

1. Record the patient's decision to proceed with treatment. Refer to policy: "Consent: Surgical, Special Diagnostic, or Therapeutic Procedures".
2. If the patient refuses treatment:
 - a. Notify the physician requesting or recommending the treatment.
 - b. Complete the refusal of treatment form, and file it in the patient's UHR.