Policy 18 - Version 6

dental health services victoria
oral health for better health

Consent to Treatment Policy

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1 GENERAL

1.1 Purpose and scope

To provide Dental Health Services Victoria (DHSV) staff a clear policy on obtaining consent for dental and medical treatment, including emergency procedures.

Sections 1 to 4 cover consent issues applicable to service delivery in the Royal Dental Hospital Melbourne (RDHM). **Section 5** covers specific requirements for procedures conducted under General Anaesthetic (GA) in the Day Surgery Unit (DSU).

1.2 Desired patient outcome

- Patients are entitled to make their own decisions about dental and medical treatments or procedures and should be given adequate information on which to base those decisions.
- Information should be provided in a form and manner which helps patients understand the problem and treatment options available and which are appropriate to the patient's circumstances, personality, expectations, fears, beliefs, values and cultural background.
- Health practitioners should give advice. There should be no coercion and the patient is free to accept or reject the advice.
- Legally competent patients have a common law right to make their own decisions about healthcare and their right to grant, withhold or withdraw consent before or during examination or treatment.

1.3 What is required for valid consent?

Consent is valid (legally effective) if:

(a) it is freely given (if a patient can establish that there was undue pressure, coercion or fraud associated with the obtaining of consent, it will not be valid)

(b) it is in respect of the proposed treatment and/or procedure *(*consent does not normally extend to a further or different procedure. If two or more procedures are contemplated, each should be explained so that the patient is informed of the range of likely treatment)

(c) it is given by a person who is legally able to consent (this issue is discussed below in section ***3.10***)

(d) the patient has been informed at least in broad terms, of the nature of the proposed treatment and/or procedure.

Failure to discuss and/or warn of matters raised in section ***1.4*** below, may not render the treatment unlawful but may expose the relevant health practitioner to liability for damages in negligence and professional conduct charges under relevant regulatory legislation.

The signing of a completed consent form does not, in itself, establish that legally effective consent has been obtained. A correctly completed and signed consent form is evidence, likely to assist to establish that consent was given if there is a dispute between the patient and the health practitioner/DHSV.

However, the principal evidence will always relate to discussion between the health practitioner and the patient, as well as the notes of such discussion in the patient's record (hardcopy or Titanium electronic patient record). Note: A hospital or organisation cannot gain informed consent – only a clinician can do this.

As described below (in section ***1.6***: *In what form should consent be provided?*) consent does not always have to be in writing.

1.4 What should be discussed with patients?

Health practitioners must give patients information about the material risks of any intervention, especially those risks likely to influence a patient's decision.

A risk is material if the health practitioner knows or should know that a person in this patient's situation or this particular patient would be likely to attach significance to it.

Known risks should, therefore, be disclosed whether an adverse outcome be a common event, although the detriment is slight, or where an outcome is severely adverse even though its occurrence is rare.

Care must be taken when addressing specific risks, particularly where specific concerns regarding adverse outcomes, however unlikely, are raised by the patient.

In 1993, the National Health and Medical Research Council (NHMRC) produced general guidelines for the provision of information by doctors to patients. These are endorsed by DHSV for application by DHSV health practitoners.

Health practitioners should discuss with each patient:

(a) the possible or likely nature of the illness/disease/problem

(b) the proposed approach to investigation, diagnosis and treatment including:
- what it entails
- the expected benefits
- common side effects and material risks
- whether the procedure/treatment is conventional or experimental
- who will undertake the procedure/treatment

(c) other options for investigation, diagnosis and treatment

(d) the degree of uncertainty of any diagnosis and of any therapeutic outcome

(e) the likely consequences of not choosing the proposed procedure/treatment, or of not having any procedure/treatment

(f) any significant long term health related outcome, which may be associated with the proposed procedure/treatment

(g) the time and cost (if applicable) likely to be involved, including any out of pocket expenses.

The guidelines recognise that a health practitioners judgement about how to convey risk information will be influenced by:

(a) The seriousness of the patient's condition - the manner of giving information may need to be modified if the patient is too ill or too badly injured to digest a more detailed explanation.

(b) The nature of the intervention (for example, whether it is complex or straightforward, necessary or purely discretionary) - complex interventions require more information, as do interventions where the patient has no illness.

(c) The likelihood of harm and degree of possible harm - the greater the risk of harm and the more serious it is likely to be, the more information that must be given.

(d) The questions asked by the patient - when giving information a health practitioner should encourage the patient to ask questions and should answer them as fully as possible. Such questions will help the health practitioner find out what is important to the patient.

(e) The patient's temperament, attitude and level of understanding - every patient is entitled to information, but these characteristics may provide guidance to the form it takes.

(f) Current accepted clinical practice - the way the health practitioner gives information should help a patient understand the illness or condition, management options and the reasons for any intervention.

1.5 Can information be withheld from a patient?

Information may only be withheld from a patient in very limited circumstances. Those circumstances are:

(a) The patient expressly directs the health practitioner to make treatment decisions and does not want the offered information. Even in this case, the health practitioner should give the patient basic information about the illness and treatment. The health practitioner must try to ensure that the patient has sufficient information and understanding to be able to waive the right to be fully informed yet still give valid consent.

(b) The health practitioner concludes, on reasonable grounds, that the patient's physical or mental health might be seriously harmed by the information (not because the patient might be disconcerted or dismayed). Health practitioners should consider consulting colleagues before making such a decision.

1.6 In what form should consent be provided?

In general, consent can be given in writing or orally or can be implied by a patient's conduct (for example if a patient sits down in a dental chair and opens their mouth for a dental examination, the health practitioner may assume consent for a dental examination).

However, as detailed above in section ***1.3*** (*What is required for valid consent?*), a written consent form is likely to be of significant value if there is a dispute between the patient and the health practitioner/DHSV concerning consent to treatment. The absence of a record of the consent discussion either by entry in the clinical record (hard copy or electronic record) or via a completed and signed consent form, may give rise to the implication or suspicion that consent has not been obtained because an integral part of DHSV's protocols has not been followed.

It is extremely important that the record of consent specifies in detail exactly what procedure is being carried out. A written record of consent is of no value (and is in fact, harmful, if a dispute arises) if it does not correctly specify the proposed procedure.

Written consent

It is DHSV's policy that consent forms shall be used in the circumstances specified below.

- All treatment provided in the Day Surgery Unit and Oral Surgery Unit;
- All surgery in the lower jaw including removal of wisdom teeth.
- Where Department specific consent forms have been developed and incorporated within standard operating procedures of the Department.

The treating health practitioner must witness the signature of the patient or guardian who consents to the procedure and in addition, the health practitioner is required to sign the confirmation statement verifying that the procedure has been explained to the patient and that the patient has understood what was said to him/her in relation to the proposed procedure.

Consent form not required

DHSV does not require a written consent form to be signed for procedures not specified above. However, the consent for treatment discussion and the outcome of that discussion must be documented in the patient's clinical record. Where the clinical record is held in Titanium the consent discussion and outcome must be documented in Titanium. The extent of the entry depends on the procedure and treatment. Simple procedures with minimal risks need only a very brief note, while more complex procedures with greater risk require a more comprehensive record of the consenting process.

Consent forms faxed or emailed to DHSV

Where a consent form completed by a patient (or an authorised representative) has been faxed or emailed to DHSV, the original document must be obtained as soon as possible and placed in the patient's clinical record.

1.7 Who is responsible for obtaining consent?

Legally, responsibility for providing information to a patient to enable him or her to make an informed decision as to whether to undergo a procedure or treatment and responsibility for obtaining patient consent, both rest with the health practitioner who recommends and/or performs the operation, procedure or treatment.

For procedures undertaken in the DSU the operator (who may be different to the health practitioner who obtained informed consent) must check that written consent for the procedure has been given - see **section 5** for more detail.

How long does consent remain valid?

There is no specific time frame that consent is valid. Consent, once given, may be withdrawn at any time before the treatment is provided.

Health practitioners should be wary of any change in the patient's circumstances which may impact on the validity of the consent to treatment obtained from the patient.

In particular health practitioners should ask patients to affirm their previous consent at each subsequent visit and if a significant period of time has passed since the original consent was obtained.

2 MINORS

2.1 Who has the capacity to give consent for treatment to a minor?

In general, consent for treatment given to a minor (a person under the age of 18) must be given by a person who has parental responsibility for the child. However, there are certain circumstances in which the minor may give valid consent.

(a) In what circumstances can a minor give valid consent?

A child can consent to dental/medical treatment if he or she is sufficiently mature and intelligent to understand what is proposed, the major risks and benefits and any other information which is relevant to the decision.

In Victoria, there is no fixed age for determining when children should be treated as being capable of consenting to their own treatment. An evaluation of each child's capacity is required.

As a general rule, older children will usually be capable of giving consent to a substantial range of procedures or treatment because they will generally be able to understand the implications of what is proposed.

(b) Who has parental responsibility?

"Parental responsibility" has replaced the term "guardianship and custody" in the *Family Law Act* 1975. Parental responsibility means all the duties, powers, responsibilities and authority, which, by law, parents have in relation to children.

Unless altered by a Court Order or agreement, each parent of a child has parental responsibility for the child, regardless of any change in the nature of the relationship between the parents. Parents retain parental responsibility even if they separate, remarry or live in a de facto relationship.

Where parents share parental responsibility, the consent of one parent to treatment for the child is sufficient.

If a dispute arises and the parents do not agree that consent should be given, it may be necessary to obtain a Family Court Order to resolve the issue.

Upon divorce (and in other limited circumstances), parental responsibility may be altered by order of the Family Court. Such an Order might place total parental responsibility with one parent, or may declare that the responsibility be shared between the parents. The Order might refer to parent responsibility in general, or

it might relate to specific aspects of parent responsibility, such as maintenance and/or residence.

When it is not clear who has parental responsibility for a child, enquiries should be made by DHSV staff of at least one, preferably both parents, to ensure that a purported consent is valid. It may be necessary to obtain and examine any Family Court Orders to confirm who has parental responsibility and whether any limitations apply. If a Court order is in place a copy should be requested from either parent and confirmed as current with both parents. Contact the Manager, Governance, Audit, Risk and Compliance if assistance is required.

(c) What happens when a child is under the care and control of someone other than a parent or legal guardian?

Legally, only a person with parental responsibility for a child has the authority to consent to the provision of treatment to that child if the child is not competent to provide consent themselves – see 2.1 a above.

However, when a child is under the care and control of someone other than a parent (such as a teacher, babysitter or relative) it is generally accepted although there is no judicial authority for this, that that person may consent to those procedures which are necessary for the immediate welfare of the child and which should not be delayed until a parent can be contacted.

(d) Who can consent on behalf of a ward of the State?

Where a minor is a ward of the State and is unable to give consent for a non-emergency procedure (in accordance with the principles stated in **2.1 (c) above**) the consent of the Authorised Officer from the Department of Human Services must be obtained.

3 INCOMPETENT ADULTS

3.1 Who can give consent on behalf of an incompetent adult for medical or dental treatment?

The *Guardianship and Administration Act* 1986, sets up a regime which permits "persons responsible" to provide consent for medical and dental treatment, to be provided by a "registered practitioner", on behalf of a person with a "disability" who is "incapable of giving consent", if the treatment is in the best interests of the patient.

This regime applies to the provision of "medical or dental treatment" to an adult patient with a "disability" who is "incapable of giving consent".

3.2 What is "medical or dental treatment"?

The regime only relates to the provision of "medical or dental treatment" which is defined in the *Guardianship and Administration Act* 1986 as meaning:

- Medical or surgical procedures, operations or examinations including prophylactic, palliative or rehabilitative care normally carried out by or under supervision of medical practitioner; and

- Dental treatment normally carried out by or under supervision of a medical or dental practitioner.

Medical and dental treatment does not include:

- a "special procedure" (the procedure for obtaining consent in these circumstances is discussed below)
- a non-intrusive examination made for diagnostic purposes (including a visual examination of the mouth, throat, nasal cavity, eyes or ears)
- first aid treatment
- the administration of a prescription or non-prescription drug.

3.3 Who is a "registered practitioner"?

A registered practitioner is:

- a person registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than as a student); or
- a person registered under the Health Practitioner Regulation National Law -
  - to practise in the dental profession as a dentist (other than as a student); and
  - in the dentist division of that profession; or
  - An Oral Health Therapist, Dental Therapist, Dental Hygienist or Dental Prosthetist.

3.4 What is a "disability"?

A "disability" is defined as an intellectual impairment, mental disorder, brain injury, physical disability or dementia. However, a disability does not have to be permanent or long term.

If a patient does not have a permanent or long term disability, and the patient is likely to be capable within a reasonable time of giving consent, the person responsible can only consent to the treatment if:

- the registered practitioner reasonably believes that a further delay in carrying out the treatment would result in a significant deterioration of the patient's condition; and
- neither the registered practitioner nor the person responsible has any reason to believe that the carrying out of the treatment would be against the patient's wishes; and
- the registered practitioner records this in writing in the patient's clinical records.

3.5 When is a patient "incapable of giving consent"?

A person is considered "incapable of giving consent" if the person:

- is incapable of understanding the general nature and effect of the proposed procedure or treatment; or
- is incapable of indicating whether or not he or she consents or does not consent to the proposed procedure or treatment.
- A person may be temporarily "incapable of giving consent" for example if under the influence of drugs or alcohol.

3.6 Who is the "person responsible"?

A person responsible is the first person in the list of persons (set out in the *Guardianship & Administration Act*) who is responsible for the patient, reasonably available and willing and able to make a decision in relation to the carrying out of medical or dental treatment on the patient.

The list of persons responsible is:

- An agent appointed under the *Medical Treatment Act* 1988 (Vic)
- A person appointed by the Victorian Civil & Administrative Tribunal in relation to the proposed treatment
- A guardian with power to make decisions in relation to the proposed treatment
- A person appointed by the patient (when competent) as an enduring guardian with power to make decisions in relation to the proposed treatment
- A person appointed by the patient in writing (when competent) to make decisions in relation to medical or dental treatment which includes the proposed treatment
- The patient's spouse or domestic partner
- The patient's primary carer
- The patient's nearest relative who is the first person in the following list and is over 18 years of age:
  - (i) son or daughter
  - (ii) father or mother
  - (iii) brother or sister
  - (iv) grandfather or grandmother
  - (v) grandson or granddaughter
  - (vi) uncle or aunt
  - (vii) nephew or niece.

3.7 What are the obligations of the "person responsible"?

The person responsible is able to make a decision in relation to the patient's medical or dental treatment and must act in the "best interests" of the patient. In determining whether the proposed medical or dental treatment would be in the best interests of the patient, the following matters must be taken into account:

- the wishes of the patient, so far as they can be ascertained
- the wishes of the nearest relative or any other family members of the patient
- the consequences to the patient if the treatment is not carried out
- any alternative treatment available
- the nature and degree of any significant risks associated with the treatment or any alternative treatment
- whether the treatment to be carried out is only to promote and maintain the health and well-being of the patient.

3.8 What if there is no person responsible or the person responsible cannot be contacted?

If there is no person responsible, or the person responsible cannot be contacted, a registered practitioner may proceed to provide treatment if the registered practitioner considers, on reasonable grounds, the treatment is in the patient's best interests:

- the registered practitioner has made "reasonable efforts" to ascertain whether there is a person responsible and if there is one, to contact that person and obtain his or her consent
- the registered practitioner believes on reasonable grounds that the proposed treatment is in the best interests of the patient
- the registered practitioner, prior to carrying out the medical or dental treatment, gives notice to the Public Advocate.

A notice to the Public Advocate must include the following information:

- The nature of the patient's condition
- A description of the proposed medical or dental treatment
- Why the registered practitioner believes that the proposed treatment is in the best interests of the patient
- Despite reasonable efforts by the registered practitioner, the registered practitioner has been unable to ascertain whether there is a person responsible or if there is one, has been unable to contact them.

The Office of the Public Advocate provides a standard form (42k) on their website http://www.publicadvocate.vic.gov.au/ which complies with the above requirements.

Notices must be faxed to the Office of the Public Advocate on (03) 9603 9501. If the matter is urgent and outside office hours, the registered practitioner should phone 9603 9500 or 1800 136 829.

If a registered practitioner carries out medical or dental treatment in these circumstances, the registered practitioner must state in writing in the patient's clinical records:

- why the treatment is considered to be in the best interests of the patient; and
- how the treatment is considered to promote or maintain the health and well-being of the patient.

3.9 What if the person responsible refuses to give consent?

If a person responsible is able to be found and refuses to give consent to proposed treatment, the registered practitioner may nonetheless carry out the medical or dental treatment if:

- the registered practitioner believes on reasonable grounds that the proposed treatment is in the best interests of the patient; and
- the registered practitioner gives a statement to the person responsible and the Public Advocate within three days after the person responsible has refused to give consent.

Such a statement must state that:

- the person responsible was informed of the nature of the patient's condition to an extent that would be sufficient to enable the patient, if he or she were able to consent, to decide whether or not to consent to the proposed treatment
- the person responsible has not consented to the proposed treatment
- the registered practitioner believes on reasonable grounds that the proposed treatment is in the best interests of the patient
- unless the person responsible applies to the Victorian Civil & Administrative Tribunal and the Victorian Civil & Administrative Tribunal otherwise orders, the registered practitioner will, not earlier than seven days after giving the statement to the person responsible, carry out the proposed treatment.

If a registered practitioner carries out medical or dental treatment in these circumstances, the registered practitioner must state in writing in the patient's clinical records:

- why the treatment is considered to be in the best interests of the patient; and
- how the treatment is considered to promote or maintain the health and well-being of the patient.

The Office of the Public Advocate provides a standard form on their website www.publicadvocate.vic.gov.au which complies with the above requirements.

Statements must be faxed to the Office of the Public Advocate on (03) 9603 9501.

A person responsible then has seven days to ask the Victorian Civil & Administrative Tribunal to have the doctor's decision reviewed.

The registered practitioner cannot proceed with the treatment if the Victorian Civil & Administrative Tribunal determines that it is not in the best interest of the patient.

The registered practitioner can proceed if the Victorian Civil & Administrative Tribunal determines that the treatment is in the best interests of the patient or if no application to the Tribunal is made within the seven day period.

The Victorian Civil & Administrative Tribunal can be contacted on (03) 9628 9755. The Tribunal is available 24 hours a day for urgent applications.

3.10 Who can give consent on behalf of an incompetent adult for special procedures?

A person responsible cannot consent to a "special procedure". A "special procedure" is:

- any procedure intended or reasonably likely to make the patient permanently infertile; or
- any procedure carried out for the purposes of medical research; or
- termination of pregnancy; or
- any removal of tissue for the purposes of transplantation to another person.

Only the Victorian Civil & Administrative Tribunal can consent to a special procedure being carried out on an adult patient with a disability, who is incapable of giving consent. It is not expected that a special procedure will be conducted at RDHM. For further information about special procedures, contact the relevant RDHM Clinical Adviser or Manager Governance Audit Risk and Compliance.

4 EXCEPTIONS TO THE REQUIREMENT FOR VALID CONSENT

(This section relates to persons who cannot give consent)

4.1 Emergency situations

Under the *Guardianship and Administration Act* 1986, a registered practitioner may carry out a special procedure or medical or dental treatment without consent, if the medical practitioner believes on reasonable grounds that the treatment is necessary, as a matter of urgency:

- to save a patient's life; or
- to prevent serious damage to the patient's health; or
- in the case of medical or dental treatment, to prevent the patient from suffering or continuing to suffer significant pain or distress.

4.2 Mental Health Act 2014

In circumstances where a compulsory patient is transferred to RDHM for dental treatment and has capacity to consent to dental/medical, then treatment may be administered to the patient with their informed consent.

If a compulsory adult patient (of or over the age of 18 years) is incapable of giving informed consent to the performance of medical treatment, the treatment may be performed with the consent of the first available person on the list contained in the *Mental Health Act* 2014 (section 75).

In relation to compulsory patients who are under 18 years of age, and are incapable of giving informed consent to medical treatment, the treatment may be performed with the consent of a person who, in relation to the patient, has the legal authority to consent to medical treatment, if that person is not reasonably available or willing to make a decision concerning the proposed treatment, then the authorised psychiatrist, subject to section 76 of the *Mental Health Act* 2014 (Vic), may make the treatment decision.

5 DAY SURGERY UNIT

This section concerns specific requirements for gaining informed consent for procedures undertaken in the DSU. The following three patient/procedure areas are covered:

1. Surgical Procedures
2. Paediatric patients
3. Patients with special needs

5.1 Surgical Procedures

- All patients requiring a surgical procedure will be assessed initially in the Oral Surgery Outpatient clinic. During this assessment the nature of the proposed procedure(s), the risks and other relevant aspects of informed consent will be discussed with the patient and recorded in the clinical record.
- On the day of the procedure, the treating clinician will check that the initial consent process occurred within the last three months. If greater than three months, a new consent discussion will occur and records/forms should be updated. If under three months, the treating clinician will confirm with the patient their understanding of the previous discussion and record this on the "consent form".

5.2 Paediatric Patients

- Referrals to the DSU of paediatric patients from the Paediatric Dentistry or Primary Care Units are screened beforehand via the Unit Head or other senior clinician within the Paediatric Unit or Senior Dentist in Primary Care.
- After screening, a clinical assessment is completed by an Oral Health therapist (OHT) or dentist and a treatment plan is developed.
- A senior clinician then approves the treatment plan and assigns time required.
- On the day of the procedure in the DSU, the treating clinician will check that the initial consent process occurred within the last three months. If greater than three months, a new consent discussion will occur. If under three months, the treating clinician will confirm with the patient's parents (or Person Responsible) their understanding of the previous discussion and record this on the consent form.
- During the procedure the parent(s) or person responsible (see 3.6) must be present in RDHM or available by phone to discuss treatment and provide consent in case of the circumstance when a change to the treatment plan is considered necessary – see below.
- Where a patient is under general anaesthetic and a changed/varied treatment plan is considered to be in the best interest of the patient (e.g. extraction of more teeth than initial examination identified as necessary and avoidance of further episodes of care under general anaesthetic), the parent(s) or person responsible will be contacted again to obtain consent for treatment. In this circumstance, the parent(s) must be present or available by phone to discuss treatment and provide consent. This must be documented and co-signed by a witness in the patient's dental record. No treatment should be performed unless specific consent has been gained.
- There are occasions where emergency paediatric cases are booked urgently (these are generally cases where dental disease is accompanied by cellulitis). In these cases the full consent procedure will be undertaken by the treating clinician with the parent/carer on the day of the procedure.

5.3 Patients with special needs

Assessment in the Special Needs Dentistry Unit (SND) clinic

All Special Needs Patients requiring treatment under general anaesthetic will be assessed initially in the SND clinic. During this assessment, the nature of the proposed procedure(s), the risks and other relevant aspects of informed consent will be discussed with the patient. Alternatively, if the patient is not considered competent to provide informed consent then consent will be sought from the appropriate Person Responsible

in accordance with section 37 of the *Guardianship and Administration Act* 1986 (Vic). Details of the consent discussion will be recorded in the clinical record.

Confirming consent to treatment on the day of appointment

On the day of the procedure, the treating clinician will check that the initial consent process occurred within the last three months. If greater than three months, a new consent discussion will occur. If under three months, the treating clinician will confirm with the patient (or the Person Responsible if necessary), their understanding of the previous discussion and record this on the "consent form".

In situations where the Person Responsible is unable to attend, phone consent is acceptable as long as it is confirming the previous discussion that occurred at the initial consultation stage in the SND clinic. This is to be documented on the consent form and co-signed by a witness (RN, DA, another operator, etc.).

Consent for dental examination under GA

Where, due to a disability or lack of cooperation by the patient, it is impossible to examine the patient prior to the GA and the patient is not competent to provide consent, the consent is obtained in two parts.

Firstly, consent for a dental examination under GA is obtained from the Person Responsible. The examining/treating practitioner must explain to the Person Responsible why this procedure is required and what will be included (i.e. a full dental examination including the taking of radiographs as required).

Secondly, consent to any proposed treatment under GA must also be obtained from the Person Responsible. Once the dental examination is complete and the definitive treatment plan has been formulated, the Person Responsible will be contacted again to obtain consent for treatment. This must be documented and co-signed by a witness in the patient's dental record. On these occasions, consent will be sought for treatment while the patient remains under anaesthetic. In this circumstance, the Person Responsible must be present or available by phone to discuss treatment and provide consent. On some occasions consent will be sought for treatment under GA at a following appointment. It is important to stress that this situation is to be avoided as much as possible and every effort is made to determine the dental reason for which the patient is being admitted for GA.

If an examining/treating practitioner believes that a dental examination or dental examination and treatment under one GA episode is in the best interests of the patient and there is no Person Responsible or the Person Responsible cannot be contacted, the treating practitioner can undertake a dental examination under GA or conduct a dental examination and provide treatment under one GA episode without consent, if they inform the Public Advocate about the proposed examination and potential treatment before proceeding (i.e. it is not necessary to contact the Public Advocate twice). **Refer to 3.8** above.

Communication

This policy will:

- be disseminated via the RDHM Clinical Leadership Group and RDHM Management Group
- be notified to staff via a Word of Mouth
- be provided on appointment to new staff with independent responsibility for patient care.

Revision date	Policy owner
January 2020	RDHM Clinical Leadership Group

Approved by	Date approved
Executive Director RDHM	January 2017