Consent to Health Care

1. Introduction

This document is a resource for health care providers across Providence Health Care (PHC) with respect to obtaining, validating and documenting consent for health care, including blood transfusion and mental health care, for Patients, whether adults or minors.

The policy has been written with consideration to the relevant legislation and current "best practices" from a risk management perspective where legislation is silent.

1.1. Scope

This policy applies to all individuals providing health care to PHC Patients with no exceptions.

2. Policy

Every capable Patient has the right to:

- Give, refuse, or revoke consent to health care on any grounds, including moral or religious grounds, even if refusal will result in death;
- Expect that a decision to give, refuse or revoke consent will be respected;
- Be involved to the greatest degree possible in all care planning and decision-making.

Except in exceptional circumstances as described in this policy, a valid consent must be obtained before any health care is provided.

Consent is considered valid if it is given by a capable adult Patient and it is:

- Specific to the health care proposed;
- Given voluntarily;
- Not obtained through misrepresentation or fraud; and
- Informed.

2.1. Capacity

All Patients are presumed to be capable of making decisions about their health care until the contrary is demonstrated.

If the Patient's capability is in question, the health care provider must assess the Patient to determine whether or not they demonstrate an understanding of the information provided about the nature, consequences and alternatives of the proposed health care; and that the information applies to the Patient's own situation. The health care provider must document the observations that form the basis for the assessment in the health record.

If an adult Patient is deemed incapable of making a consent decision, consent is obtained through an authorized Substitute Decision Maker ("SDM").

There is no minimum legal age of consent in British Columbia. If consent is required from a minor (< 19 years of age) the case must be assessed individually on the basis of the extent to which the minor's physical, mental and emotional development will allow for a full appreciation of the nature and consequences of the proposed treatment, including the refusal of such treatments. If the minor Patient is deemed incapable of providing consent, consent is obtained from a parent or legal guardian.

2.2. Scope of Consent

Consent to health care applies only to the specific health care, including a course of treatment, to which a Patient has consented. If the health care changes significantly, or if new health care issues arise, a new consent is obtained.

A health care provider may provide additional or alternative health care without a new consent if:

- the health care that was consented to is in progress;
- the person is unconscious or semi-conscious; AND
- it is medically necessary to provide additional or alternative health care to deal with conditions not foreseen when consent was given.

If a plan of treatment is proposed, one health care provider who is able to answer the Patient's questions about all aspects of the treatment may, on behalf of all the health care practitioners involved in the plan of treatment, propose the treatment, assess capacity and complete the consent process.

2.3. Duration of Consent

Consent for health care is valid:

- until it is revoked;
- until there is a change in the patient's health status;
- until there is a change in the health care provider's knowledge which may affect the original consent, or
- for a period of one year. If a year has passed since consent was obtained, the health care provider should re-affirm the patient's condition and document the fact of continued consent by initialling and dating the health care consent form, or obtaining a new consent.

Consent from a Temporary Substitute Decision Maker (TSDM) must be received with 21 days of initiation of the proposed health care. Consent is valid until the proposed treatment is complete. New treatment requires new consent.

2.4. Documentation of Consent Decision in Acute Care

2.4.1 Documentation Required

Documentation of a consent decision is required in the following situations:

- Blood products – Any administration of fractionated or non-fractionated blood products;
- Any procedure or course of treatment meeting one of the following criteria:
  - Involving procedural sedation or general anaesthetic
  - As determined as a standard within a particular program setting.
- Any procedure or course of treatment for which the health care provider has reason to believe that documentation is warranted, both as a communication tool and also as a means for managing risk in the event of an adverse event;
- Research or experimental care.

All health care providers are encouraged to document in the Patient's health record the discussions that took place as part of the informed consent process.

2.4.2 Witnessing consent

Whenever possible, the Most Responsible Provider ("MRP") who obtains consent should witness the patient's signature when a consent form is utilized. If the MRP is unable to witness the signature, another health care provider may sign as a witness. In those circumstances, the witness is confirming ONLY that it was the patient who signed the form and that the person's mental state at the time appeared to allow for an understanding of what was signed. If the Patient implies or states that they have been inadequately informed about the nature of the proposed treatment, the witnessing should not continue and the MRP must be notified.

2.4.3 Use of PHC Forms

If a consent decision requires documentation on a form, the PHC consent form must be used. The use of a consent form from Vancouver Coastal Health Authority, or any other Health Authority, for care provided at PHC is not permitted.

In exceptional circumstances (e.g. when forms are not readily accessible), documentation by the MRP of the consent decision in the health care record is acceptable. The documentation should include the scope of discussion, questions asked, and the decision of the Patient.

All relevant blanks on the form are to be completed. Alterations to the form are permitted, but must be initialed by the Patient to be considered valid. Abbreviations are to be avoided.

If the treatment is to be performed under the auspices of PHC but the consent decision is obtained in the MRP's office, the form is completed in the MRP's office and sent to the appropriate department for inclusion in the health record.

The identity of a SDM must be documented in the SDM/TSDM powerform within the Cerner health record.

2.5. Documentation of Consent Decision in Long-Term Care

On admission, the nature of the care to be provided in the facility is explained, and then the resident signs the Long-Term Care: Consent for Treatment form.

When the care plan is developed, the resident is required to provide consent to the treatment contained in the plan. Consent to the care plan, or the refusal to provide consent, is documented in the resident's Health Record. Refer to Code Status (Options for Care) policy for further information on obtaining informed consent for long-term care admissions.

2.6. Consent Exceptions

2.6.1 Emergent/Urgent Treatment

In the case of an emergency a health care provider may provide health care without consent. An emergency is defined as care necessary to preserve a patient's life, prevent serious physical or mental harm or alleviate severe pain. If the health care could be delayed without repercussion to the patient, then it is not an emergency and consent must be obtained.

Emergent or urgent health care may also be provided when:

- The patient is unconscious or impaired by drugs or alcohol and is unable to give consent; AND
- There is no substitute decision maker available.

Where practical, a second health care provider should confirm the incapacity of the patient and the need for health care.

In the case of an emergency, the health care provider must respect any Advance Directive available. If an MRP has reasonable grounds to believe that an adult, while capable, expressed a relevant instruction to refuse consent to certain health care, an MRP must not provide that health care, even in an emergency.

Continuing efforts must be made to get consent from the patient directly, or from an SDM once the emergent health care has been initiated.

Emergent/urgent treatment without consent requires documentation of the rationale for proceeding without delay.

2.6.2 Preliminary examination, treatment of diagnosis

A health care provider may undertake triage or another kind of preliminary examination, treatment or diagnosis of an adult without obtaining an informed consent decision if:

- The adult indicates that he or she wants to be provided with health care, or
- In the absence of an indication by the adult, the adult's spouse, relative or friend indicates that he or she wants the adult to be provided with health care.

2.6.3 Involuntary Psychiatric Care

Certified patients may or may not be competent to consent to psychiatric care and treatment. The Director of the Mental Health Program is authorized by Section 22 of the *Mental Health Act* to override the refusal of a certified patient and consent to involuntary psychiatric treatment on the patient's behalf.

Certified psychiatric patients may or may not be competent to consent to non-psychiatric care. The Director of the Mental Health Program is not authorized to consent to nonpsychiatric health care treatment unless the health care is necessarily collateral to the psychiatric care. If the patient is not competent to make non-psychiatric health care decisions, the health care provider must obtain consent from an authorized SDM.

2.6.4 Communicable Disease

Under the authority of the *Public Health Act*, treatment of patients with certain communicable diseases is compulsory and requires no consent. Please consult with the Medical Microbiologist or Risk Manager if you have any questions about treatment of communicable disease.

2.7. Telephone Consent

In the event that informed consent is being obtained when the patient or SDM is not attending in person with the MRP, telephone (or video) consent may be obtained as follows:

a. Video conferencing tools (e.g. Zoom, Skype) or a telephone with a conference call feature are ideal, so that the health care provider, the patient or the SDM and a third party who will verify that consent was obtained can participate simultaneously.

b. The person providing consent must be aware of all parties on the call.

c. The MRP explains the nature of the proposed treatment, expected benefits, material risks and side effects and health consequences of not having the treatment. Questions from the patient/SDM are answered.

d. Patient/SDM indicates their consent or refusal.

If a written consent is required, the wording in the consent form is dictated to the patient/SDM and consent is obtained. When a paper consent form is used, the **Telephone Consent Declaration** on the back of the form must be completed.

3. Responsibilities

Responsibility for obtaining informed consent rests with the MRP proposing or performing the care. This is both a professional obligation and a legislated duty imposed on the health care provider and cannot be delegated. However, every health care provider has a responsibility to ensure that a consent decision is in place before providing care, and to advise the MRP if consent has not been obtained or if concerns arise as to the validity of a consent decision.

For clarity of communication among members of the heath care team, the MRP must ensure accurate and timely documentation of the consent decision in accordance with this policy.

4. Compliance

Failure to comply with this policy is a serious infringement on the rights of patients and may result in disciplinary action and/or legal consequences.

5. Supporting Documents

5.1. Related Policies

Advance Care Planning and Serious Illness Conversations
Death
Disclosure of Serious Patient Safety Incidents
Code Status (Options for Care)

5.2. Guidelines/Procedures/Forms

Consent Form
Consent for Transfusion of Blood and/or Blood Products
Consent for Jurisdiction of Treatment form
Consent for Photography and Audiovisual Recording
Consent for Autopsy form

6. Definitions

"Advance Care Planning" is the process of a capable adult talking over their beliefs, values, and wishes about the health care they wish to consent to or refuse, with their health care provider and/or family, in advance of a situation when they are incapable of making health decisions.

"Advance Directive" provides written consent to (or refusal of) health care to a health care provider in advance of a decision being required about that care. Advance Directives must be written, signed by a capable adult, and witnessed by two witnesses (or one witness who is a lawyer or notary public). A witness cannot be a person who provides personal care, health care, or financial services to the adult for compensation, nor the spouse, child, parent, employee, or agent of such a person. An Advance Directive that adheres to these requirements is referred to in this document as "properly executed".

A properly executed Advance Directive is considered to be legally binding in British Columbia.

"Emergency/Urgent Care" is care that is immediately necessary in order to save life, prevent serious physical or mental harm or to alleviate severe pain.

"Health Care" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes:

a. A series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem; or
b. A plan for health care that is developed by one or more health care providers and deals with one or more of the health problems that an adult has or is likely to have in the future.

"Informed Consent" includes receiving information that a reasonable person in the same circumstances would require, including:

a. The nature of the treatment;
b. The expected benefits of the treatment;
c. The material risks of the treatment;
d. The material side effects of the treatment;
e. Alternative courses of action;
f. The likely consequence of not having the treatment; and
g. Any information the patient/resident specifically requests.

"Most Responsible Provider" (MRP) is the person who has the overall responsibility for the management and coordination of the care of the patient at any given time.

"Patient" For the sake of readability, reference is made to the "patient" throughout this policy. Unless otherwise directed, any reference to "patient" should be interpreted to mean patient, client and/or resident.

"Substitute Decision Maker" (SDM) If an adult is determined to be incapable of making a consent decision, consent must be obtained from a properly executed Advance Directive or from someone on the patient's behalf. The person making decisions on behalf of a patient is called a "substitute decision maker". Please see Appendix B for further clarity.

7. References

1. *Public Health Act*, SBC 2008, c. 28
2. *Health Care (Consent) and Care Facility (Admissions) Act*, RSBC 1996, c. 181
3. *Human Tissue Gift Act*, RSBC 1996, c. 211
4. *Infants Act*, RSBC 1996, c. 223
5. *Mental Health Act*, RSBC 1996, c. 288
6. *Patients Property Act*, RSBC 1996, c. 349
7. *Representation Agreement Act*, RSBC 1996, c. 405

8. Appendices

Appendix A: Requirements for Consent
Appendix B: Substitute Decision Makers
Appendix C: Autopsy
Appendix D: Special Consent Situations

Appendix A: Requirements for Consent

Elements

Whether the consent is verbal or written, consent must incorporate the following five elements:

- The patient is capable of giving or refusing consent;
- The consent is specific to the health care proposed;
- The consent is given voluntarily;
- The consent is not obtained through misrepresentation or fraud; and
- The consent is informed.

An informed consent includes receiving information that a reasonable person in the same circumstances would require, including:

- The nature of the treatment;
- The expected benefits of the treatment;
- The material risks of the treatment;
- The material side effects of the treatment;
- Alternative courses of action;
- The likely consequence of not having the treatment; and
- Any information the patient/resident specifically requests.

Assessing Capability

Every patient is presumed competent to consent to or refuse health care unless/until there is evidence to the contrary. A health care provider must communicate with the patient in a manner appropriate to the patient's skills and abilities to help him/her demonstrate understanding of the information.

Recommended guidelines for informally determining the patient's capability include evidence that the patient is able to demonstrate understanding of the information by:

- Repeating and explaining the health care in their own words;
- Providing clear, consistent and unambiguous answers to questions about the health care;
- Demonstrating an understanding of the consequences of authorizing or not authorizing the treatment;
- Asking pertinent questions to indicate an understanding; and
- Demonstrating that he/she understands that the information being provided pertains to their own situation.

A patient may be capable with respect to some treatments and incapable with respect to others (e.g. a mildly cognitively impaired patient may not be able to make a consent decision about abdominal surgery but may be able to consent to suturing of a laceration).

A patient incapable with respect to treatment at one time may be capable at another (e.g. patient admitted to Emergency for severe alcohol intoxication may not be able to make decisions about the

immediate treatment, but after a period of time they may regain ability to assess information and make decisions about ongoing care).

Where there is a difficult judgment or dispute over a patient's capability, a psychiatrist or other qualified health care provider may be asked to examine the patient to make a determination.

Whatever the decision, it is important that the MRP who is proposing the health care document the observations that form the basis of their determination of capability.

If an adult is incapable, consent must be obtained from the SDM.

Voluntariness

Consent must be voluntary. Coercion or undue influence will invalidate consent. If a health care provider is concerned that consent was given because the patient felt fearful of the reaction from others (either family and friends or the health care providers), the health care provider must take steps to ensure that the decision accurately reflects the patient's wishes.

A consent obtained under false pretenses is also invalid. This issue most often arises in cases of placebo therapy. A deliberate misrepresentation (as to procedure or outcome) from the health care provider for the purposes of obtaining consent will invalidate consent.

It is preferable to obtain consent prior to the administration of any sedation. If sedation has been given and it is discovered that there is no informed consent, the health care provider cannot proceed unless confident that the effect of the sedation has not adversely affected the patient's ability to understand the basic nature of the contemplated procedure.

Appendix B: Substitute Decision Makers

Until the contrary is demonstrated, every adult is presumed to be capable of giving, refusing or revoking consent to health care. If a decision is made that an adult is incapable of making a consent decision, consent must be obtained from a properly executed Advance Directive or from someone on the patient's behalf. The person making decisions on behalf of a patient is called a "substitute decision maker" ("SDM").

In B.C. there is a ranked list of SDMs who can make health care decisions on a patient's behalf:

1. Committee (court appointed)
2. Representative under a Representation Agreement
3. Temporary Substitute Decision Maker

Please note that the authority of a Power of Attorney relates to financial matters only, and does not convey the right to make health care decisions.

In order to improve communication between members of the health care team, the identity of the SDM is documented in the Substitute Decision Maker and Temporary Substitute Decision Maker (SDM/TSDM) powerform in Cerner.

1. Committee

Under the *Patient's Property Act* the Supreme Court of British Columbia may have appointed a "Committee" for an adult who is incapable of making health care decisions. This would commonly be seen in the case of adults with severe mental disabilities, who would never have had an opportunity to plan in advance for their own care.

If the patient has a Committee, complete the SDM/TSDM powerform and obtain a copy of the Committee's appointment which will be placed in the patient's Paper chart ("chartlet") as verification of the appointment. The copy will be scanned as an "Advance Care Planning Scanned" document by Health Information Management (HIM) on acute care discharge, and for out-patient and long-term care units it will be scanned either by the HIM office or unit coordinator.

2. Representative

An adult may have planned for their future by making a Representation Agreement under the *Representation Agreement Act*.

A Representation Agreement is used if a capable adult wants to name a specific adult to make decisions on their behalf (when they are not capable of making those decisions themselves). The Representative is authorized to act within the authority given in the Representation Agreement.

There are two levels of Representation Agreements. Section 7 agreements are used to authorize a representative to make health care, personal and financial decisions but MAY NOT be used to help make, or to make on the adult's behalf, a decision to refuse health care necessary to preserve life or to physically restrain, move or manage the adult, or authorize another person to

do these things. Adults who are not capable of making a section 9 agreement may be able to make a section 7 agreement.

Section 9 agreements have wider scope than section 7 agreements and the Representative may be authorized to make health care and personal decisions (not financial) that include giving or refusing consent to health care necessary to preserve life.

The Representative must consult to the greatest extent possible with the adult to determine her/his wishes and comply with those. When current wishes are not known, the Representative must comply with instructions or wishes the adult gave while capable. If not known at all, then they must act on the basis of the patient's beliefs and values, and if those are not known, then in the adult's best interests.

If an adult has both a Representation Agreement and an Advance Directive, then the Representative must make decisions based on the adult's Advance Directive. If the Representation Agreement specifically states that a health care provider may act on an Advance Directive without consent of the adult's Representative, then the health care provider may do so.

If possible, a copy of the Representation Agreement should be placed on the patient's health care record with a completed SDM/TSDM powerform as verification of the appointment.

3. Temporary Substitute Decision Maker (TSDM)

If there is no Committee appointed, and no Representation Agreement that refers to the particular health care situation in place, the health care provider must choose the nearest individual who qualifies to make a health care decision.

The health care provider chooses the person who is highest on the following list to be the TSDM:

a. the adult's spouse (including same-sex partner living in a marriage like relationship);
b. the adult's child;
c. the adult's parent;
d. the adult's brother or sister;
e. the adult's grandparent,
f. the adult's grandchild,
g. anyone else related by birth or adoption to the adult,
h. a close friend of the adult, or
i. a person immediately related to the adult by marriage.

The *Health Care (Consent) Act* requires that the TSDM meet certain criteria in order to be entitled to make decisions. The TSDM must:

a. be at least 19 years of age
b. have been in contact with the adult in the preceding 12 months
c. have no dispute with the adult
d. be capable, and
e. be willing to comply with the duties of a TSDM

In the rare case that there is NO ONE available to act as a TSDM from the above list, the matter is referred to the Public Guardian and Trustee who will appoint someone from their office to act as the TSDM.

Confirmation of the person selected as the TSDM is documented within SDM/TSDM powerform.

Decisions on behalf of the adult to consent or refuse treatment will be made in accordance with the following guidelines:

a. known applicable instructions or wishes made by the adult when capable are to be followed. Applicable instructions in the form of an Advance Directive may be followed without referring to the TSDM;

b. if there are no known prior capable instructions or wishes, the decision is to be made in accordance with known applicable values and beliefs;

c. if there are no such known values and beliefs then a decision is to be made in the adult's best interests, considering:
   - the adult's current wishes
   - the likely effect of receiving or not receiving the proposed health care
   - the expected benefits, weighed against the risk of harm, and
   - whether there are less restrictive or less intrusive alternatives that would be as beneficial

Authority of the TSDM

A TSDM has the authority to:

a. Give or refuse substitute consent for a period of 21 days from date chosen,
b. If signed within a 21 day period, give or refuse consent for a course of treatment that will last longer than 21 days, and
c. Review the information necessary to make an informed decision about the proposed health care treatment (this includes being assisted to review areas of the health record relevant to the condition for which the treatment is proposed).

Restrictions on a TSDM

A TSDM can refuse consent for care necessary to preserve life only if there is substantial agreement of health care providers that this is medically appropriate, and if the decision would appear to reflect the patient's pre-expressed instructions, values, or best interests.

A TSDM cannot give consent to the following procedures:

a. Abortion unless recommended in writing by the treating physician and at least one other medical practitioner who has examined the adult from whom it is proposed;
b. Electroconvulsive therapy unless recommended in writing by the treating physician and at least one other medical practitioner who has examined the adult for who it is proposed;
c. Psychosurgery;

d. Removal of tissue from a living human body for implantation in another human body or for medical education or research;
e. Experimental health care involving a foreseeable risk that is not outweighed by the expected therapeutic benefit;
f. Participation in a health care or medical research program that has not been approved by the PHC Research Ethics Board;
g. Any treatment, procedure or therapy that involves using aversive stimuli to induce a change in behaviour.

A TSDM may be, but is not necessarily, the person entitled to give consent for autopsy.

The MRP may in emergency situations provide health care contrary to directions given by an SDM if the MRP is of the opinion that the SDM is not following the previous instructions or wishes of the patient.

In the event an MRP is concerned that a TSDM is making a decision in contravention of an adult's wishes, a new TSDM may be selected (compliance with the wishes of the adult expressed when capable is a requirement to be a TSDM).

Resolution of Objections to Decisions Made by Authorised Substitute Decision Makers

A patient has the right to be informed when a decision is made to delegate consent decisions to a substitute decision maker. If the patient or a friend or family member disagrees with the substitute consent decision, the "objector" may contact the care team to determine how that decision will be reviewed.

Most conflicts can be resolved through the use of informal means. Resources available to assist in resolution include staff from Social Work, Client Relations, Ethics, the Patient Care Quality Office and Risk Management as required.

If informal resolution is not possible, the objector should be advised of their right to advise the Public Guardian and Trustee of their concerns about decisions made by the SDM.

If the objector is still dissatisfied with the consent decision made, they should be instructed to retain legal counsel in order to seek court intervention (Risk Management should be advised as soon as possible.)

Appendix C: Autopsy

An autopsy is anticipated in the following circumstances:

- As outlined in the *Coroner's Act*
- On request of the Attending Physician with consent from the family
- On family request

Coroner's Cases

Notification to the Coroner is required when a health care provider has reason to believe that the patient died:

a. as a result of violence, accident, negligence, misconduct or malpractice,
b. as a result of a self-inflicted illness or injury,
c. suddenly and unexpectedly, when the person was apparently in good health and not under the care of a medical practitioner,
d. from disease, sickness or unknown cause, for which the person was not treated by a medical practitioner,
e. during pregnancy, or following pregnancy in circumstances that might reasonably be attributable to pregnancy,
f. if the chief coroner reasonably believes it is in the public interest that a class of deaths be reported and issues a notice in accordance with the regulations, in the circumstances set out in the notice
g. while a patient of a designated facility or private mental hospital within the meaning of the *Mental Health Act*, whether or not on the premises or in actual detention,
h. while the person is committed to a correctional centre, youth custody centre or penitentiary or a police prison or lockup, whether or not on the premises or in custody, or
i. while a patient of a hospital within the meaning of the *Hospital Act*, if the patient was transferred to the hospital from a place referred to in paragraph (g) or (h).

The *Coroner's Act* authorizes the Coroner to order an autopsy without the family's consent.

Non-Coroner's Cases

The MRP is required to obtain consent for a non-coroner's case autopsy. The individual entitled to consent to autopsy is determined by the *Cremation, Interment and Funeral Services Act* **and is not necessarily the same individual entitled to make consent decisions while the patient was alive**. http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_04035_01 The physician obtains consent from the following in descending order of authority:

a. The personal representative (i.e. executor) named in the will of the deceased. If this person is not readily known and available at the time of the consent discussion, health care providers may proceed to the nearest relative as set out below;

b. The spouse of the deceased, including common law spouse or partner of the same gender, if living with the deceased for a period of at least two years immediately before the death of the deceased;
c. An adult child of the deceased;
d. An adult grandchild of the deceased;
e. If the deceased was a minor, the legal guardian at the date of death;
f. A parent of the deceased;
g. An adult brother or sister of the deceased;
h. An adult niece or nephew of the deceased;
i. An adult person having some family relationship with the deceased;
j. An adult person having some relationship with the deceased not based on blood ties or affinity;
k. If none of the foregoing is available, contact the Coroner for discussion of options.

The physician may rely on the word of the person stating their relationship unless there is some reason to doubt that attestation.

Written consent for or refusal of autopsy is required on the PHC Consent for Autopsy form.

Appendix D: Special Consent Situations

1. Adoption

In accordance with the *Adoption Act*, the authority to give consent remains with the biological mother until she has:

- In writing transferred 'care and custody' of the child to the Director (Ministry of Children and Family Development), or the administrator of an adoption agency; or
- Consented to adoption, at which time the Director or the administrator of an adoption agency becomes the guardian of the child, and authorized to make consent decisions. However, if the adopting parents wish to delay adoption procedures while health care is provided, the authority for consent remains with the biological mother unless 'care and custody' of the child has been transferred to someone else.

http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96005_01

2. Communication Challenges

It is the goal of Providence Health Care to ensure that the best possible interpretation services are provided for every patient utilizing our services. In many cases, the best possible translation service will require the use of a professional interpreter. However, with regard to logistics, care requirements and timeliness a professional translator may not always be possible.

If a patient's understanding of English is in doubt then the health care provider **must** ensure that an interpreter is used during the **consent** process. Every attempt should be made to ensure that the skill level of the interpreter is appropriate for the complexity of the situation.

- Staff are encouraged as much as possible to utilize the services of a **professional interpreter** when major health care decisions are being made (for example: surgical procedures, radiation therapy, chemotherapy, DNAR decisions or options for care).
- Friends or family members often do not have the understanding or vocabulary to interpret clinical issues, and may find it difficult to translate frank information to their loved one, so should only be used as interpreters for major health care decisions at the patient's and family's request.
- As the interpretive skill of bilingual staff is completely unknown the use of staff as untrained interpreters is discouraged.

When a professional interpreter is used for consent, the interpreter will witness the consent form, indicating that the consent process was interpreted to the patient. The patient signs the form in the interpreter's presence, acknowledging that they have been informed about the procedure and that all questions have been answered.

If interpreter services are provided via telephone, please follow the procedure for completing the Consent Form as described under Telephone Consent.

Assistance for coordinating Interpreting Service is available 24/7 at this link.

3. Involuntary Admission

Under the *Mental Health Act* an adult may be admitted and provided mental health treatment without their consent if all four of the following criteria apply:

- The patient is suffering from a mental disorder that seriously impairs their ability to react appropriately to their environment or to associate with others;
- The patient requires psychiatric treatment in a designated facility (St. Paul's Hospital is a designated facility);
- The patient requires care, supervision and control in a designated facility to prevent substantial mental or physical deterioration or for their own protection or the protection of others; and
- The patient is not suitable as a voluntary patient.

One Form 4 Medical Certificate is required to provide legal authority for an involuntary admission for a 48-hour period. A second Medical Certificate by a different physician must be completed within 48 hours of admission, otherwise the patient must be discharged or admitted as a voluntary patient. Once the second Medical Certificate is completed the person may be admitted as an involuntary patient for up to one month from the day of initial admission.

To obtain consent for health care **not related** to mental health treatment from patients who are involuntarily admitted, follow the same process and procedure as that for other patients. Patients under 16 years of age admitted under the *Mental Health Act* are admitted involuntarily with the consent of their parent or legal guardian. In this case, the parent or legal guardian is the person able to give consent.

4. Non-readers/writers

If a patient cannot read the consent form, the health care provider obtaining consent must read the form aloud to the patient. In place of a signature the patient may make a mark on the form that will be recognised as their identifier. The health care provider should write a note to this effect on the consent form.

A patient who is unable to make a mark on the consent form due to a physical impairment should indicate verbal agreement to the treatment in the presence of two witnesses. The witnesses will sign the consent form on behalf of the patient, and indicate on the form that the patient was unable to sign due to physical impairment.

5. Non-Residents of Canada

Patients identified as non-residents of Canada are asked by the admitting clerks to review and sign the Consent for Jurisdiction of Treatment form on admission. By signing the form the non-resident patient agrees that, if they are dissatisfied with their care, they will pursue litigation in the BC courts rather than the courts of their home jurisdiction.

The Consent for Jurisdiction of Treatment form (Form # PHC – AD066) is available from Printing in English, Chinese, French, Korean, Punjabi and Vietnamese.

Failure or refusal to sign the form should not result in denial to render care in an urgent/emergent situation. PHC may choose to deny care to a patient seeking *elective* treatment who refuses to sign this form.

6. Organ and Tissue Donation

Please see Organ, Eye and Tissue Donation

7. Photographs and other recordings

No photo, video, sound recording ("Recordings") or any other image of a patient may be made without the express consent of the patient unless:

- The patient will not be identified or identifiable in any way as part of the Recording; or
- The Recording is made expressly and solely for the care of that patient (and for which consent has been obtained as part of the procedure).

Consent for photographs and interview materials for the purposes of publicity are to be documented on the PHC Consent for Photography and Audiovisual Recording (PHC Form #MR032).

Consent for photographs, videos, sound recordings or any other images for the purposes of educational, scientific or research purposes are to be documented on PHC Form #MR033. Custody and control of the recorded image will be with Providence Health Care unless arrangements are made to the contrary.

Patients and their families are entitled to have recordings made at their own expense and under their own direction. However, it is important that no other patients or visitors be included in these recordings. Staff are permitted to participate in these recordings to the extent that they are comfortable.

8. Placebo Medications

No health care provider will provide a placebo medication to a patient without the patient's written consent.

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