

	DEPARTMENT OF PUBLIC SAFETY CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: MAR 09 2010	POLICY NO.: COR.10.11.05
		SUPERSEDES (Policy No. & Date): COR.10.11.05 (12/29/2008) COR.10.11.06 (12/29/2008)	
	SUBJECT: INFORMED CONSENT & RIGHT TO REFUSE		Page 1 of 4

1.0 PURPOSE

The purpose of this policy is to provide guidelines for medical and mental health examinations, treatments, and other medical procedures that require informed consent by the patient and provide guidelines on how to manage a patient's refusal of medical interventions and treatments

2.0 REFERENCES AND DEFINITIONS

.1 References

- a. Hawaii Revised Statutes; Section 26-14.6, Department of Public Safety; Section 353C-2, Director of Public Safety, Powers and Duties; Section 352-8, Guardianship and Custody of Persons Committed; and Section 671-3, Informed Consent.
- b. National Commission on Correctional Health Care, Standards for Health Services in Prisons and Jails, (2008).

.2 Definitions

Informed Consent: Voluntary consent or agreement by a patient to a treatment, examination, or procedure after they have received the significant facts regarding the condition being treated and the nature, consequences, risks (e.g. side effects), benefits, and alternatives concerning the proposed examination, procedure, or treatment, including the right of refusal.

3.0 POLICY

- .1 Information exchanged between a health care provider and a patient while rendering health care is privileged and confidential except where mandated or allowed by law.
- .2 Informed consent shall be required for patients undergoing those examinations, treatments, and procedures that are intrusive or governed by informed consent standards in the community, or that are associated with any significant risks to the patient.

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- .3 The health care provider attending to the patient shall be responsible for informing the patient of the condition and recommended procedure or treatment and any risks that may be involved in the treatment, including available alternatives.
- .4 In the case of treatment or procedures performed in the community by a specialist or by a provider of a community hospital, or by any other non-state employee providing services to an inmate/patient, the specialist or community provider is responsible for securing the informed consent from the patient.
- .5 A competent patient has the right to refuse medical care of any sort including diagnostic or laboratory procedures and blood products, unless their refusal represents a danger to themselves or others; or is otherwise the subject of an exception according to policy, procedure, or state or federal law.
- .6 In every case in which the health care provider waives consent, reasons for the decision to undertake the procedure without consent of the patient shall be documented in the medical record. The informed consent requirement may be waived for the following reasons:
 - a. An emergency that requires immediate medical intervention for the preservation of life or the safety of the patient unless there is an established initiative by the inmate, such as a living will, waiving such intervention.
 - b. If in the professional opinion of the provider, the facility security and operations or the safety of individuals is endangered by the patient.
 - c. When a psychiatrist, or court of law, judges an inmate to be incapable of understanding the necessary medical information according to the standard, legally defined criteria of competence.
- .7 Inmates shall not participate in experimental projects involving medical, pharmaceutical or cosmetic research, including aversive conditioning, psycho-surgery or the application of cosmetic substances to the body that are being tested for possible ill effects prior to sale to the general public.
 - a. This policy statement does not preclude the use of experimental medical procedures or treatments as part of a research protocol passed by an institutional human research review committee and subject to informed consent.

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- b. This policy statement does not preclude the collection of statistical or epidemiological data on inmates.

4.0 PROCEDURE

- .1 When a patient consents to a treatment or procedure provided by a Health Care section, the health care provider shall ensure that Form DOC 0427 , Consent to Operation, Post Operative Care, Medical/Mental Health Treatment, Anesthesia, or Other Procedure or DOC 0448 Informed Consent for Hepatitis C Combination Therapy Introm A and Ribavirin (as appropriate) is reviewed with and signed by the patient, if applicable. The attending physician/psychiatrist shall enter a narrative progress note indicating the information provided and the results of the discussion with the patient. The clinic or mental health nurse shall ensure the form is completed and health information staff shall file the form under the Consent index in the medical record.
- .2 When a patient refuses a scheduled medical appointment, medical or mental health treatment, surgical procedure, or medications, the patient shall be informed by health care staff of the consequences of such a refusal and shall be asked to sign form DOC 0417, Refusal To Consent To Medical, Mental Health Or Surgical Treatment. The provider shall record a narrative statement on the progress notes. The health care provider shall review the refusal and sign form DOC 0417 indicating the refusal was reviewed. If appropriate, the patient shall be counseled regarding consequences associated with the refusal of the treatment and record the refusal in the patient's medical record regarding the encounter and the patient's refusal.
- .3 If the refusal will have adverse effects on a serious medical condition, the nurse shall refer the refusal to a health care provider for review. The provider shall counsel the patient regarding the refusal and the consequences of refusing the procedure, treatment or medications. The physician shall sign the appropriate line on Form DOC 0417 to indicate a review was conducted and, if appropriate, shall further document the encounter on the progress notes in the patient's medical record.
- .4 When an inmate refuses medical care, and declines to sign Form DOC 0417, the refusal shall be signed by health care staff and witnessed by a corrections facility employee who both shall sign their names and write, "inmate refused to sign" on Form DOC 0417 and the date of refusal.

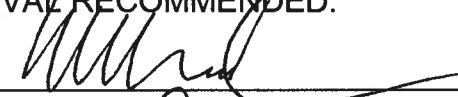

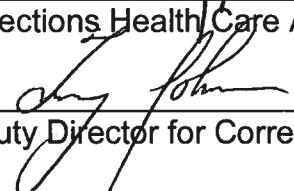
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Inmates diagnosed with contagious diseases who refuse treatment may be medically quarantined or isolated by the health care authority, if necessary, to control the spread of the disease.

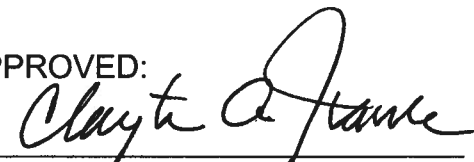
5.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

	3/2/10
Medical Director	Date
	3/2/10
Corrections Health Care Administrator	Date
	3/8/10
Deputy Director for Corrections	Date

APPROVED:


Director
3/9/10
Date

CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE Patient: _____ SSN: _____ DOB: _____ Facility: _____ Date: _____

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision.

(1) Explain the nature of the condition(s) in professional and ordinary language. PROFESSIONAL: _____

ORDINARY LANGUAGE: _____ AT _____

(2) Describe procedures(s) to be performed in professional and ordinary language, if appropriate. PROFESSIONAL: _____

ORDINARY LANGUAGE: _____ AT _____

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are disposed necessary to preserve my life and bodily functions. accustomed

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(5) No promise or guarantee has been made to me as to result or care.

Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(8) Any tissue or part surgically removed may be of by the hospital or physician in accordance with practice.

(9) Any additional comments may be inserted here: _____

(10) I have had the opportunity to ask questions about this form.

FULL DISCLOSURE

[] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

- a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
e) ANTICIPATED RESULTS OF THE TREATMENT.

Patient/Other Legally Responsible Person Sign, If Applicable

Date

Physician

Date

DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION

NAME: _____ SID: _____ DOB: _____

FACILITY: _____ DATE: _____ TIME: _____

I, the undersigned patient, refuse the following treatment and/or medication: _____

(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility administration and personnel, the Health Care Division administration and medical personnel from any responsibility or liability for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

(Signature of Patient)

(Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health and I witness the patient's refusal of the recommended treatment or medication

(Print Name)

(Signature & Title)

(Date)

A referral has been made to a provider: YES NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

(Print Name of Provider)

(Signature & Title)

(Date)

** If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

(Print Name & Title)

(Signature & Title)

(Date)

INFORMED CONSENT FOR HEPATITIS C
COMBINATION THERAPY INTRON A AND RIBAVIRIN

I AGREE THAT:

1. Combination therapy (Intron A and Ribavirin) has been explained to me in terms and language I understand;
2. I have been given the opportunity to ask questions related to the combination therapy (Intron A and Ribavirin);
3. No promise or guarantee has been made to me as to positive results or cures related to the combination therapy (Intron A and Ribavirin).

MY PHYSICIAN HAS INFORMED ME OF:

4. The diagnosis or probable diagnosis related to my condition;
5. The nature of the recommended treatment plan;
6. The risk, side effects, complications, or other consequences involved in such treatment;
7. Alternative forms of treatment available including no treatment if I so choose;
8. At any time during the course of treatment that I have a positive drug test, treatment will be terminated;
9. I understand I will be subject to random drug testing throughout the course of treatment;
10. Anticipated results of the treatment.

I ACCEPT COMBINATION THERAPY FOR HEPATITIS C

I REFUSE COMBINATION THERAPY FOR HEPATITIS C

PRINT NAME OF PATIENT

SIGNATURE OF PATIENT

DATE

PRINT NAME OF WITNESS

SIGNATURE/TITLE OF WITNESS

DATE

PRINT NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

DATE

Original: Medical Record
Canary: Patient

DOC 0448 (2/00)

CONFIDENTIAL