

OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-I-05

SUBJECT: INFORMED CONSENT AND RIGHT TO REFUSE

POLICY: Inmates shall have the opportunity to evaluate knowledgeably the options available and the attendant risks of interventions recommended for the diagnosis and treatment of conditions effecting medical and mental health status. The health care provider is obligated to provide information sufficient for an inmate to make an informed decision to consent or refuse the recommended health care intervention.

REFERENCE: ORS 677.097
OAR 291-124-080(2)
NCCHC Standard P-I-05

PROCEDURE:

Informed Consent

- A. Written informed consents shall be obtained from an inmate prior to any invasive health care procedure that are invasive or with significant risk. Exceptions to the provisions of informed consent are life-threatening conditions that require immediate medical intervention to prevent certain death or serious permanent impairment, emergency care of inmates who do not have the mental capacity to understand the information to make an informed decision, and certain public health matters.
- B. An inmate with a health condition that requires diagnostic evaluation or prescribed treatment shall be provided with an explanation by the prescribing practitioner which includes
 - Procedure or treatment to be undertaken.
 - Any alternative procedures or methods of treatment.
 - Any risks to the prescribed procedure or treatment.
 - The prognosis if the proposed treatment is not undertaken.
- C. The inmate will be asked if further explanation of the recommended prescribed treatment or diagnostic evaluation is required. If not, the recommended treatment or evaluation is prescribed.
- D. If the inmate requests, a more detailed explanation shall be provided to include details of the recommended procedure or treatment, the viable alternatives, and any material risks to the recommended procedure or treatment.
- E. The process for receiving consent from an inmate is documented in the health care record.

- F. After information, risks, and alternatives have been discussed with the patient, the informed consent form will be completed and signed by the inmate for procedures that are invasive or with significant risk, including but not limited to the following procedures:
1. Incision and drainage
 2. Skin removal, including biopsy
 3. Cauterization
 4. Contraception methods/prescription
 5. All major and minor surgical procedures
 6. Immunizations
 7. Psychotropic/neuroleptic medication
 8. Articular and Bursa injections
 9. Other procedures in which there is a probability of major adverse risks.
 10. All invasive dental procedures
- G. The prescribing provider shall also sign the treatment consent form indicating that information sufficient to provide informed consent was given to the inmate.
- H. The completed treatment consent form is placed in the Consents section of the health care record.
- I. The inmate's informed consent is not required in the following circumstances:
1. A life-threatening emergency requiring immediate medical intervention to prevent certain death or serious permanent impairment.
 2. Emergency care of an inmate who does not have the mental capacity to provide informed consent and for whom there is not sufficient time to obtain a court order.
 3. When there is a court order to provide the medical treatment or procedure.
 4. Informed consent given by a legal guardian.
- In the situations described above where informed consent is not obtained, all aspects of the inmate's medical condition and reasons for medical intervention are to be documented in the progress notes of the inmate's health care record.
- J. Staff will follow the Administrative Rules specific to Informed Consent to Treatment with Psychotropic Medication (OAR 291-064-0010 to 2910064-0040).

Medical Right to Refuse

- A. An inmate who elects to refuse a specific aspect of recommended health care or treatment shall be provided with an explanation of the health risks or consequences of the refusal by the health professional. Refusing treatment at a particular time does not waive the patient's right to subsequent health care.
- B. At the time of the inmate's stated refusal, complete the treatment refusal form (attached).

- C. Provide the completed form to the inmate to sign and date in the presence of a health services witness.
- D. In the presence of the inmate, the witness is to sign and date the treatment refusal form.
- E. If the inmate refuses to sign the form, the witnessing health services staff is to sign and date the form indicating the inmate's refusal to sign.
- F. The health professional will document the information provided, circumstances, and the inmate's stated reason for refusal in the progress notes of the health care record.
- G. The completed treatment refusal form is then filed in the health care record in the Consents section. Forward the health care record to the Chief Medical Officer, or designee, for clinical review.
- I. The Chief Medical Officer, or designee, will review the circumstances and clinical consequences of the inmate's treatment refusal. If the refusal presents significant adverse health risks, schedule the patient for a subsequent appointment with the provider to discuss the refusal. A corresponding progress note will be written in the health care record. If adverse health risks are expected, the refusal is to be noted on the health care record problem list.
- J. An inmate may rescind a treatment refusal at any time by notifying Health Services and consenting to recommended health care and/or treatment. Enter the inmate's stated decision to rescind treatment refusal and circumstances into the progress notes. If the treatment is identified on the problem list, note the date of rescinding refusal in the resolved column.
- K. If the inmate is rescinding refusal for health care and/or treatment that is significant, initiate the procedure to obtain written informed consent.
- L. If an inmate refuses health care and/or treatment that place others in the institution at risk of infectious disease, the inmate is to be appropriately isolated as per P&P #P-B-01.1, Isolation Control Precautions.
- M. Health care professionals shall periodically discuss the recommended treatment or care with an inmate whose refusal has significant adverse health risks or consequences

Mental Health Informed Consent and Right to Refuse

- A. All examinations, treatments and procedures are governed by informed consent practices. Information is confidential and not shared outside Health Services without written consent.
- B. Exceptions are governed by informed consent practices outlined by mental

health and delineated within the Behavior Health Services Informed Consent Treatment form (Attachment A).

- C. A separate Inmate Medication Informed Consent/Refusal (Attachment B) is required to provide patient instructions for medications offered. Medication benefits, risks and side effects are addressed, and alternative treatment options are provided as well.
- D. All inmate mental health consent or refusal for treatment is recorded and signed by both the inmate and the mental health provider. In instances where an inmate signature is refused by the inmate, the mental health provider will document the inmate's response.
- E. Completed treatment consent forms are placed in the consent section of the mental health care record.

Effective Date: _____

Review date: August 2014

Supersedes P&P dated: May 2014

Oregon Department of Corrections

IMPORTANT

Sign only in one place after carefully reading entire form.

PATIENT INFORMED CONSENT / REFUSAL

On _____, _____ has explained to me in a way
(Date) (Name of provider)
that I understand:

- 1. The general treatment or procedure to be undertaken: _____
- 2. There may be other procedures or methods of treatment; and
- 3. There are risks to the procedure or treatment proposed.

My provider has also asked if I want a more detailed explanation; but I am satisfied with the explanation and do not want any more information. I give my permission and consent to the treatment or procedure.

_____ X _____
(DATE) (PATIENT'S SIGNATURE)

SIGN IN THIS BOX ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

After explanation of the procedure or treatment, other alternative procedures or methods of treatment and information about the material risks of the procedure or treatment, **I give my permission and consent** to the procedure or treatment.

_____ X _____
(DATE) (PATIENT'S SIGNATURE)

SIGN IN THIS BOX ONLY IF YOU REFUSE THIS TREATMENT OR PROCEDURE

After explanation of the procedure or treatment, other alternative procedures or methods of treatment and information about the material risks of the procedure or treatment, **I do NOT give permission and consent** to the procedure or treatment.

_____ X _____
(DATE) (PATIENT'S SIGNATURE)

Explained by me and signed in my presence:

_____ (PROVIDER) _____ (DATE)
 _____ (WITNESS) _____ (DATE)

Name: _____
 SID#: _____
 DOB: _____

**BEHAVIORAL HEALTH SERVICES
INFORMED CONSENT TO TREATMENT**

Information given to Behavioral Health Services treatment providers is confidential and not shared with anyone outside of Health Services without written consent of the inmate except as follows:

Correctional professionals may be given the inmate's name, services recommended or provided, provider's name, dates of treatment, and a brief comment about extent of participation. Treatment providers may also make recommendations to correctional professionals about ways to be helpful to inmates with mental health problems without giving details of diagnosis or medication prescribed.

Some mental health information may be disclosed to non-Health Services staff who are currently acting within the official scope of their duties to develop or evaluate treatment programs, plans and strategies; to diagnose or treat; as members (e.g. designated correctional counselors, mental health housing officers, etc.) of a multidisciplinary team, treatment team or committee; risk management or suicide prevention; or for purposes of release planning. This type of disclosure must be necessary or beneficial to the treatment of the inmate.

Some information is not confidential and will be reported to security staff and/or a community agency as appropriate. This includes knowledge of:

- danger to self or others,
- child, disabled person, or elder abuse when a victim can be identified,
- staff abuse of inmates,
- escape plans or attempts,
- sexual assault.

Inmate rule violations may be reported when the violation poses an immediate threat to the health and safety of self, other inmates, staff, or to the community.

Reports will always be limited to what is necessary to maintain safety and within legal parameters.

My signature below indicates that I understand the confidentiality policy used by BHS treatment providers.

Inmate signature _____ Provider Signature _____ Date _____

BHS MENTAL HEALTH SERVICES CONSENT TO TREATMENT

Inmate initials below:

I consent to mental health services which may include on-going assessment, case management, and treatment for mental health concerns.

I do not consent to mental health treatment, but I understand a mental health specialist will follow my case to determine whether treatment should continue to be offered.

Inmate Comments:

Inmate Signature _____ Provider Signature _____ Date _____

Name: _____
SID#: _____
DOB: _____

MEDICATION INMATE INFORMED CONSENT/REFUSAL

I understand that these medication(s) _____ May be helpful in treating these problems:

Alternative treatment options have been reviewed with me. Patient instructions for this medication have been given to me. The medication actions, benefits, risks, and side effects have been explained to me.

I understand that some, all, or none of the side effects noted may occur. I am satisfied with the explanation provided and have had all my questions answered regarding the use of the medication.

I understand that my consent is voluntary. I understand that I have the right to refuse, withhold or withdraw consent at any time. I understand that I should talk with my prescribing practitioner before stopping or changing medication in order to avoid related problems.

I DO consent to taking this medication as part of my treatment. I presently believe the benefit of taking the medication outweighs the potential side effects. I understand how much medication to take and when to take it.

I DO NOT consent to taking this medication.

Client signature _____ Date _____

I have discussed this medication with the patient, including alternative treatments, medication actions, benefits, risks, and side effects. I have answered the patient's questions. It is my opinion that the medication may help with his/her illness.

The inmate has been informed both orally and in writing about the right to refuse, withhold or withdraw consent at any time.

Treating Practitioner _____ Date _____

Name: _____
SID#: _____
DOB: _____

HEALTH SERVICES INFORMATION DISCLOSURE

Information obtained within the patient/provider relationship, as well as information contained in a patient's health care record is confidential and may not be released except as provided by state and federal statute, or by order of Oregon or Federal Court. Information given to Health Services medical and mental health providers is confidential and not shared with anyone outside of Health Services without written consent with the following exceptions:

Non-Health services staff may be given the patient's name, services recommended or provided, provider's name, dates of treatment, and a brief comment about extent of participation. Treatment providers may also make recommendations to non-Health Services staff about ways to help patients with medical or mental health problems without giving details of diagnosis or medication prescribed.

Non-Health services staff may be given some health information (e.g. diagnosis, symptoms of decompensation, risk factors, etc.) if:

- they are currently acting within the official scope of their duties to develop or evaluate treatment strategies and plans;
- they are involved in developing correctional plans, medical treatment plans, risk or behavior management plans or suicide and crisis prevention plans as members (e.g. designated correctional counselors, mental health housing officers, etc.) of a multidisciplinary team, treatment team, committee, or other official;
- they are involved in release planning; or
- disclosure is necessary for the safety and security of the institution.

Some information obtained in a provider-patient relationship is not confidential and will be reported to non-Health Services staff and/or other agency personnel as needed even without written consent of the patient. According to State and Federal laws, this includes knowledge of:

- danger to self or others;
- abuse of a child under 18 years of age, abuse of an adult 65 years of age or older, or abuse of individuals who meet the legal requirement of developmentally disabled or mentally ill, and a specified victim can be identified;
- staff physical or sexual abuse of inmates;
- escape plans or attempts;
- sexual abuse of or by another inmate.

Confidentiality will not apply to information when it poses an immediate threat to the health and safety of self, other inmates, staff, or to the community. Reports will be limited to what is necessary to maintain safety and stay within legal parameters.

My signature below indicates I understand the confidentiality policy and practices used by HS treatment providers.

Inmate Comments:

Inmate Name: _____
SID #: _____
DOB: _____

Inmate Signature _____

Date _____

Staff Witness Signature _____

Date _____