**PURPOSE**

To obtain written consent for care during the admission process and to communicate the organization’s process for informing patients and family/caregivers regarding services.

**POLICY**

Upon admission and throughout the course of care/service, the patient and family/caregiver will be:

1. Given information, in an understandable language, to make informed decisions regarding the care/service being provided.
2. Allowed to refuse all or part of his/her care/service to the extent permitted by law; the expected consequences of such actions will be explained.
   1. Specific consent for recording, photographing, or filming care, treatment, or services will be obtained as needed.
3. During the admission visit, the patient or authorized representative will sign the organization’s written consent for care/service as part of the admission agreement.

**PROCEDURE**

1. During the admission visit and follow-up visits, the patient and family/caregiver will be given information (verbally and/or in writing) that describes:
   1. The services and/or disciplines anticipated to be involved in the care/service of the patient
   2. The nature and purpose of any procedure, including written information   
      when available
   3. The potential benefits and effects of the procedure, including who will perform the procedure
2. When appropriate, the family/caregiver will be utilized in the care, treatment, and service of the patient. This may include:
3. Assisting with ordered treatments—with physician (or other authorized licensed practitioner) approval
4. Carrying out activities specified in the plan of care/service
5. Encouraging the patient with designated activities
6. Every attempt will be made to include, to the extent possible, available family/caregiver(s) in rendering care and meeting patient-specific goals of care.
7. The patient may refuse all or part of his/her care/service except a face-to-face encounter visit at appropriate timeframes.
8. The patient will be informed of the expected consequences whenever any treatment/care/service is refused. Documentation of such refusal and physician notification will be made part of the clinical record and includes:
9. If the patient is determined to be a danger to himself/herself or others or if the patient refused treatment and does not verbalize clearly that he/she understands the consequences of such refusal, the clinician should:
10. Notify his/her Clinical Team Leader immediately
11. Notify the attending physician immediately
12. The Clinical Team Leader will notify the Executive Director/Administrator and/or the Hospice Medical Director.