**Canberra Health Services**

**Policy**

**Informed Consent (Clinical)**

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| Policy Statement |

Canberra Health Services (CHS) staff must obtain valid and informed consent from a person or their legal guardian or other substitute decision maker before commencing any clinical activity, treatment or procedure.

Obtaining consent from a person before treating them is an important part of communication in shared decision-making . It is not simply about getting a form signed. The context and conversation are both important.

Australian law and health care ethics recognises that people have the right to decide whether or not they wish to receive health care treatment and to change their mind. If a doctor or other clinician touches someone or carries out a procedure without a person’s permission then the clinican may have committed a trespass to the person (such as assault or battery in civil law) or even a criminal offence. There is a limited exception to this, where a person cannot consent and emergency treatment is necessary to treat a serious and imminent threat to their life or health. This might occur if someone is unconscious.

Consent is often not a single act. It is an integral and often repeated requirement in an on-going care relationship between a clinician and a patient. For example, when part of the treatment which a person has agreed to is to be changed, because their situation changes, then new consent for the changed treatment should be sought. A single signed form does not discharge this ongoing responsibility. All conversations about treatments to be provided to a patient need to be documented on their health care record.

‘Valid’ consent means that:

* The person providing consent has the capacity to make treatment/procedure decisions (and in the case of a substitute decision maker, has the legal authority to do so)
* Consent provided by the person must be free and voluntary
* Consent must relate to the specific clinical activity, treatment or procedure and must be revisited if circumstances (e.g. the person’s diagnosis) changes
* Consent is able to be withdrawn at any time. A decision must not be made under coercion or when someone has been administered medication that can affect their decision-making ability.

‘Informed’ consent means that:

* The person is provided with information in a way that they can understand in accordance with requirements outlined in section 2
* The person has the opportunity to ask questions and have those questions answered

As a public authority under the *Human Rights Act 2004* (HRA), CHS must act in ways that are compatible with human rights. Sub-section 10(2) of the HRA provides that no-one may be subjected to medical or scientific experimentation or treatment without his or her free consent. Other rights which may be engaged in seeking consent or providing clinical activities, treatments or procedures include:

* Right to non-discrimination
* Right to life
* Protection from torture, cruel, inhuman or degrading treatment
* Rights of the child
* Right to privacy
* Freedom of thought, conscience, religion and belief
* Freedom of expression
* Right to liberty and security of person
* Cultural and other rights of Aboriginal and Torres Strait Islander peoples and other minorities

These rights may be subject only to reasonable limits, which must be assessed according to the nature of the right affected; the importance of the purpose of the limitation; the nature and extent of the limitation; the relationship between that limitation and its purpose; and any less restrictive means reasonably available to achieve the purpose the limitation seeks to achieve.

The Australian Charter of Healthcare Rights clearly articulates the rights of all people when accessing health care. Three of these rights clearly articulate the rights related to consent:

*Respect*

* Be treated as an individual, and with dignity and respect
* Have my culture, identity, beliefs and choices recognised and respected

*Partnership*

* Ask questions and be involved in open and honest communication
* Make decisions with my healthcare provider, to the extent that I choose and am able to
* Include the people that I want in planning and decision-making

*Information*

* Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
* Receive information about services, waiting times and costs
* Be given assistance, when I need it, to help me to understand and use health information
* Access my health information
* Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

The information upon which valid consent can be given includes communication of the diagnosis, benefits, risks and alternatives of treatment. The clinician also needs to take into account a person’s personal circumstances, beliefs, and priorities including:

* emotional state, age and level of understanding
* cultural and linguistic diversity
* influences that are non‐medical but may have an impact. Examples are:
* people may have preconceived ideas regarding particular medical conditions or treatments based on previous experiences which may influence decisions
* previous experiences in the health system that effect expectations and may influence decisions
* lifestyle factors such as family commitments, exercise regimens (e.g. sports/hobbies), occupational/work commitments which a particular treatment might impact and which may influence a decision, and
* communication and/or cognitive difficulties.

**Capacity**

An adult or young person of sufficient maturity and understanding (see Section 6) is presumed to have the capacity to make decisions about their health care, unless it is established that they do not. Legally, capacity is present if the person is able to understand the nature, effect and consequences of the decision to be made, rationally weigh up the options, understand the implications of his or her decision and communicate the decision. The clinician needs to take into consideration individual circumstances, cultural identity, illness and treatment. For example, a mental disorder/illness, drugs or alcohol may affect a person’s capacity to consent in the short or long term. The fact that someone does not agree with the view of a clinician about what might be the best treatment is not evidence of lack of capacity.

A person has capacity to make a decision if they can, with assistance if needed, demonstrate all of the following elements:

* understand when a decision about treatment, care or support needs to be made
* understand the facts related to that decision
* understand the main choices available in relation to the decision
* weigh up the consequences of the main choices
* understand how the consequences of the main choices affect them
* on the basis of the above elements, make the decision, and
* communicate the decision they make in whatever way they can.

Note that:

* capacity refers to a particular decision at a particular time and should not be generalised (i.e. a person’s capacity can change over time)
* capacity is proportionate to the nature and consequences, or importance, of the particular decision
* capacity is assessed having regard to any and all reasonable assistance or support that may be required
* if clinically safe, a decision can be delayed until a person regains capacity.

If a clinician is unclear if there is capacity to consent, there is no prescribed clinical test. The circumstances of each individual person must determine how to proceed. Where a clinician is unsure as to whether the person has the capacity to consent, a second opinion should be sought from another clinician with appropriate expertise and qualifications and other methods of increasing capacity, such as support decision making should be used.

If it is considered that the person does not have capacity to consent, and the decision cannot safely be delayed or the person cannot be assisted with supported decision making, then as a last resort, decisions may be made without consent in an emergency or through a substitute decision-maker.

**Emergencies**

In the case of a medical emergency, treatment that is immediately necessary to save a person’s life or prevent serious deterioration in their condition can be provided when the person is not able to provide consent at the time, due to a lack of capacity (e.g. because they are unconscious). Refer to Section 3 of this document for further information.

**Substitute decision-makers**

Where someone is determined to not have capacity to make a specific decision, they may have appointed someone as a substitute decision-maker for health care decisions. If they have not appointed someone, there are alternate ways decisions can be made depending upon the cause of the incapacity, including a treating doctor or dentist choosing of a health attorney. Substitute decision-makers can be chosen by the patient or someone else.

All these options are detailed further in Section 4 of this document. A substitute decision-maker often has specific obligations in relation to the decisions they make, depending upon how they are appointed. Often they are required to look at the person’s “best interests”, based on information provided by clinicians.

**Documentation of Consent**

Consent and the information provided to the person at the time consent is obtained **must** be documented in the clinical record. It is the responsibility of the clinician performing the treatment, or procedure, to ensure consent is obtained and documented for all aspects of the clinical activity, treatment or procedure. Where a person is assessed as not having capacity, this must be documented in the clinical record, and any decisions made about the persons care, including benefits and risks should be clearly documented. Any consent discussions or attempts to obtain consent should also be documented in the clinical record at the time when consent is sought and at any time in the future when decisions need to be made by the patient or their substitute decision-maker(s). Note consent does not always need to be captured on a specific consent form, refer to Section 1 and Section 2 for documentation requirements.

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| Purpose |

To assist clinicians (medical officers, allied clinicians, nurses and midwives) working within CHS to meet their professional and legal obligations in seeking and obtaining informed consent from people seeking treatment or undergoing a clinical assessment or procedure.

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| Scope |

This policy document applies to all staff and students working within their scope of practice, across all Divisions, Branches and Units within CHS.

**Compliance with this policy is mandatory.**

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| Roles & Responsibilities |

Executive Directors and Executive Group Managers of Divisions, Branches and Units are responsible for ensuring there are strategies in place relating to consent within their areas for:

* communication
* training and/or orientation
* evaluation and continuous improvement
* compliance.

Executive Sponsor, Partnering with Consumers National Standards Committee is responsible for:

* monitoring compliance with this policy

Managers and Supervisors are responsible for:

* ensuring that staff are able to access, interpret and apply this document and are provided with education related to this policy.

All CHS staff who obtain consent should be aware of the:

* principles of consent
* human rights of people seeking treatment
* nature of the clinical activity, treatment or procedure the person is being asked to consent to, including the likelihood and degree of possible harm, and
* required consent procedures including rules applying to:
* emergencies and particular procedures
* principles of support decision making
* decision-making by substitute decision makers
* documentation requirements
* legal and ethical considerations and risks
* relevant legislation, policies and standards.

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| Section 1 – Types of Consent |

The following outlines the different types of consent which are required for different clinical activities, treatments or procedures.

* 1. **Implied Consent**

Implied consent may be adequate for minor or routine clinical activities, treatments or procedures and is not required to be documented in the clinical record. It is still important for clinical staff to explain what they are doing and to stop if the person’s actions indicate they do NOT give consent. Implied consent refers to a person indicating their agreement through their actions or by cooperating with the clinician’s instructions. For example when a person:

* presents to pathology out-patient collection centre with a referral from a treating clinician
* extends their arm to provide a routine blood sample for testing
* allows a wound dressing to be performed in an acute or community setting
* accepts and swallows medication that is provided
* attends an appointment for the purpose of receiving information or advice regarding management of their condition
* is receiving a procedure where the evidence based risk profile is so low, that it does not warrant obtaining valid informed consent e.g. intravenous line insertion, fine needle aspirate.

Note:

For implied consent, the clinician must still provide the same information to the person before proceeding with the clinical activity, treatment or procedure. For example, implied consent for swallowing a medication that is provided would only occur after a clinician had explained the purpose, type, benefits, side effects etc. of the particular medication, and the patient had agreed to its prescription.

* 1. **Verbal Consent:**

Verbal consent may be required for non-routine clinical activities, treatments or procedures that do not require a significant increase in level of care as a result, and do not carry a significant risk (specific to a person as determined by clinical judgement) to the person. The same duty of care about providing information on risks would be required to be met in situations of verbal consent Verbal consent may also be required for clinical activities, treatments or procedures that are considered intimate, for example, insertion of a urinary catheter. The person’s verbal consent should be documented in the clinical record. Verbal consent entails a conversation between the clinician and the person following the principles of consent in section 2.

* 1. **Written Consent:**

Written consent is the most formal type of consent, and involves a thorough documentation of the consent process as outlined in Section 2, usually on a CHS approved consent form. Procedures that require written consent include, but are not limited to:

* Procedures that carry a significant risk to the person or require a significant increase in level of care as a result
* All surgical procedures, or any procedure requiring sedation or the administration of general anaesthesia
* A procedure that intentionally puts a high level of stress on the body (even transiently) e.g. a cardiac stress test
* A procedure that involves, or forseeably may involve the removal of tissue from the person e.g. removal of moles, podiatric nail surgery
* Any other procedure identified by clinical areas or Divisions as requiring formal written consent.

**Note:**

Consent, whether implied, verbal or written, does not extend to all aspects of a person’s treatment. For example, if a person provides consent to a particular surgery, and during that surgery additional procedures were performed which had not been discussed as part of the original consent, it could not be said that there was implied consent to the additional procedures. It is therefore important that all expected elements of a clinical treatment or procedure are discussed as part of the informed consent process (e.g. collecting routine pathology samples and associated cost implications).

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| Section 2 – Requirements and documentation |

Consent involves a number of interconnected processes, and requires clinicians to:

* provide people with information that will assist them to reach an informed decision about whether or not to consent to the proposed treatment. This must include:
* a description of the possible or likely nature of the person’s condition or diagnosis, including the degree of certainty of any diagnosis
* a description of the proposed clinical activity, procedure or treatment and any potential benefits or any material risks inherent in that procedure, including the possibility that the treatment may be unsuccessful, and of any risks of not undergoing the proposed treatment or procedure
* a description of anticipated recovery time, any significant long term physical, emotional or other outcome
* an explanation of the expected costs involved, including out of pocket expenses (gaps)
* consideration and provision of information in relation to what a reasonable person would want to know and what the particular person being treated would want to know (both subjective and objective).
* ensure the person:
* understands and retains the information
* believes the information (i.e. is not confused, delirious or delusional, or unable to comprehend what is being said)
* understands that a choice can be made, and
* is able to reason, make a choice, and convey their decision.
* seek a decision from the person about the proposed treatment. Subject to some specific exemptions (see Section 4 – Substitute Decision Makers for more information), it is always the person’s right to determine, with support if necessary, whether or not to consent to receiving the treatment recommended by the clinician.
* record in the person’s health care record if the person does not consent to the proposed treatment, and the circumstances in which consent was refused (refer to Section 7 of this policy)
* thoroughly and accurately record and document the consent process and the person’s decision on the consent form within their clinical record, including:
* the person’s core identifiers (full name, date of birth and CHS medical record number or if no record number, the person’s address – please see Patient Identification and Procedure Matching Procedure). This information will be automatically populated within the consent form in the clinical record if the consent form needs to be printed. Do not use a blank form template unless in a business continuity plan.
* how any communication barriers were addressed (e.g. use of an accredited interpreter)
* any substitute decision maker used if the person doesn’t have the capacity to consent
* the presence or revocation of any relevant legal document/s, e.g. enduring power of attorney, health direction, guardianship order, advance consent direction, etc
* relevant risks, benefits and alternatives of the treatment or procedure
* any tools used to support decision-making e.g. presence of support person or family member, provision of information sheets
* any specific wishes or concerns the person may have regarding the proposed clinical activity, treatment or procedure
* whether the person consents for a student/s to be involved in the procedure
* date and time when the consent was given
* the full name, title and signature of the clinician obtaining the consent.
* obtain the person’s signature on the consent form as this formalises the process and should be done in all cases, where practicable. The person may sign electronically where the hardware is available or the consent form may be filled in electronically, printed for the person to sign by hand, then scanned into the clinical record.
* communicate information about the consent provided to relevant members of the treating team.

Abbreviations are not to be used on consent documents due to the potential for misinterpretation or misunderstanding. If abbreviations are noted on the consent then a new consent needs to be completed and the old consent cancelled.

Some treatments, such as chemotherapy, or admission to a specialist program, can involve more than one course of treatment or instance of the required clinical activity. In this situation, if consent has been provided, a single consent to treatment form is adequate for the entire course of treatment. However, the consent form must clearly state that consent has been provided for the entire course. In such situations, the consent form and person’s health care record should provide information covering:

* elements of the course of treatment and any associated material risk
* alternatives, and
* consequences of withdrawal from treatment at a future date.

People should be informed that they can withdraw their consent at any time during a course of treatment.

Consent is considered valid until different circumstances arise, such as a person’s clinical condition has changed, they withdraw their consent or a different procedure is recommended. A change in clinical condition may include:

* improvement or deterioration in the person’s condition (this may not change the recommended procedure, however should still be discussed with the person)
* development of new treatment options since consent was given
* progression of the disease which may have changed the recommended treatment regime, or changed the therapeutic goal e.g. from “cure” to “palliative care”
* development of a new condition that may affect the risks associated with the procedure or the type of procedure/treatment offered
* other personal circumstances

All CHS staff are responsible for ensuring people are aware that information relating to their care will be kept by CHS and may be shared with members of the person’s treating team as necessary, including their nominated General Practitioner (GP). People have the right to decline to have their information shared at any time. For more information, refer to the *Release or Sharing of Clinical Records or Personal Health Information procedure*.

## 2.1 Responsibility for Obtaining Consent

The clinician that recommends treatment or advises a person to undergo treatment is responsible for providing sufficient and appropriate information and advice to that person (note: for surgical procedures this should be a Consultant or Registrar only).

Where a team of clinicians is involved in the care and treatment of a person, the responsibility for obtaining consent lies with the most senior clinician responsible for providing the treatment or performing the procedure to which the person is being asked to consent. When students are to be involved in any clinical activity, treatment or procedure, it is the supervisor’s responsibility to ensure appropriate consent is obtained. Refer to *Clinical Placement procedure* for more information.

The name and designation of the clinician responsible for obtaining consent must be clearly documented in the person’s health care record.

If a clinician delegates the task of gaining consent, they remain responsible for ensuring both that:

* the clinician delegated the task:
* is able to do so within their scope of practice and is competent to undertake the task, and
* understands and is capable of informing the person of all relevant information including the risks and benefits.
* the consent documentation is properly completed.

Any clinician that has been delegated to perform the consent task must be aware that they have legal and professional responsibilities to:

* provide all necessary and proper information to the person on the same basis required of the clinician from whom the delegation came
* ensure the person can ask any questions they may have in considering their decision
* record the patient’s decision to either consent or not consent to a specific treatment.

Delegated clinicians should therefore refuse to undertake the consent process if they do not consider they have sufficient skill or experience to meet these legal and professional responsibilities.

Refusal by a clinician to undertake the consent process on behalf of another person must be respected by the hospital/health service and senior clinician.

## 2.2 Blood Products

Consent for receipt of identified blood and/or blood products (including intra-operative cell salvage), as part of their treatment or procedure, must be sought from the person prior to administration of the blood product. Documented consent for Blood and Blood Products is required under the Blood Management National Safety and Quality Health Service Standard.

Significant risks, benefits and other alternative blood management strategies, including the person’s right to decline the transfusion must be discussed with the person and documented on the *Blood and Blood Product Prescription and Checklist* and/or the *Consent to treatment form* available on the CHS Clinical Forms register, or electronic equivalent.

Consent should be sought from patients with an acute need who are receiving a single transfusion associated with surgery or some other medical condition prior to this episode of transfusion, and documented in the clinical record. Even if it is not expected that the use of blood or blood products may be required for a particular procedure, consent should still be sought if it is foreseeable that blood or blood products may be required in the event of a complication associated with the procedure.

Consent should be sought from patients with a chronic need undergoing regular/frequent transfusions at the commencement of their treatment or as their condition evolves and the indication for transfusion changes. This consent will remain valid for 12 months unless there is a significant change in the indication or risk profile of transfusion.

A person’s decision to decline or withdraw consent to blood and/or blood products, and any known reasons, is to be documented in the clinical record by the treating clinician and confirmed in writing by a second clinician.

People who decline treatment with blood transfusion or other blood products should be encouraged to document this decision in an advance care plan (refer to Section 4 of this policy).

In the event of a life saving emergency transfusion when no authorised substitute decision maker is available or health direction is in force, the transfusion may be administered if the treating medical officer believes that immediate action is necessary to preserve the life of the person. This decision must be documented in the clinical record retrospectively and is made with the best information available at that time.

## 2.3 People on the Elective Surgery Waiting List

Informed consent can be obtained by a Medical Officer, by either:

1. Completing the request for admission within the clinical record, and consent is either scanned or electronically signed in the clinical record; or
2. at the time the Planned Hospital Admission Booklet For Surgical and Medical Care (which includes the CHS Request for Admission [RFA] and CHS Procedureal Consent form) is completed. This consent form must be scanned into the clinical record.

This can occur in the consultant’s rooms or various ambulatory areas across the health service.

Consent is considered valid until different circumstances arise, such as a person’s clinical condition has changed, they withdraw their consent or a different procedure is recommended.

Note: it is possible for a clinician to obtain consent via telehealth (phone or video conference) for some people on the elective surgery waiting list, as long as the conditions of this policy are met and the person is provided sufficient information to inform their decision, and is given an opportunity to ask questions. To complete consent via telehealth, the clinician would complete the consent form while on the phone with the person, and then would either upload the form into the person’s clinical record, seek the person to upload their consent into their myDHR record or post the form to the person for them to sign, along with any information sheets or consumer handouts that are available. This method of gaining consent must be documented in the clinical record, and consent must be confirmed at the time of admission according to the usual procedure.

### Clinical Review of patients on the Elective Surgery Waiting List

People may be clinically reviewed while on the Elective Surgery Waiting List.

Depending on the expected time and category of surgery, validity of consent and clinical review may occur in the Pre-Admission Clinic, Outpatients Department, Specialist rooms or on admission.

A person may be clinically reviewed by a General Practitioner (GP) while on the elective surgery waiting list. However in these cases, if the GP feels it is necessary to obtain a new consent, the person will need to be referred to Specialist rooms, Pre-Admission Clinic or Outpatients Department where a medical officer will review the person. If during this review it is determined that different circumstances have arisen such as the person’s clinical condition has changed and the patient requires a different surgical procedure, they withdraw their consent, a new consent must be obtained by a medical officer.

If there has been no change in circumstances, the person’s consent remains valid.

Evidence of clinical review and any requirement for a new consent is recorded in the person’s clinical record.

### Hospital admission for surgery – confirmation of consent

If consent was provided by the person prior to their current admission, and recorded within the clinical record, a nurse or medical officer on the ward or in the Surgical Admissions Area must confirm that the consent in the clinical record is the patients consent . For more information see the surgical consent process map at Attachment 1.

If in the process of confirming consent, a person has questions or concerns regarding the procedure/treatment to be undertaken, the admitting medical officer or their delegate must be contacted to provide additional information.

If further clinical review is required and results in a new consent discussion and decision regarding the procedure, this is to be recorded in the person’s clinical record. This is done by replacing the existing consent, with a new consent form. If a person’s clinical urgency category needs to be changed, it should be requested in the clinical record by submitting an elective surgery re-categorisation request. The reason for the re-categorisation is documented in the patient’s clinical record. The patient is informed of any change to their clinical urgency categorisation. This is outlined further in the *Waiting Time and Elective Surgery Access Policy.*

A summary of the above information is available at *Attachment 1 – Elective Surgical Consent Process Map.* For further information on management of people on the Elective Surgery Waiting List, please refer to the *Waiting Time and Elective Surgery Access Policy.*

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| Section 3 – Treatment in an Emergency or Non-elective cases |

In the case of a medical emergency where someone is unable to give consent (e.g. because they are unconscious), the requirements to obtain consent can differ from the process set out in Section 2 of this Policy.

In an emergency or a non-elective case, where a person has capacity to consent,there is a requirement to obtain informed consent within the necessary time constraints and the person’s best interests. This consent form must be completed or scanned into the clinical record. Consent should be confirmed by a nurse er prior to commencement of surgery. If, in the process of confirming consent, a person has questions or concerns regarding the procedure/treatment to be undertaken, the admitting medical officer or their delegate must be contacted to provide additional information.

In a medical emergency where a person lacks capacity to consent to the required treatment, either generally or because of their clinicalcondition, treatment that is immediately necessary to save theperson’s life or prevent a serious deterioration in their condition can be provided withoutconsent. This ‘principle of necessity’ operates as a defence to any civil claim for trespass. The medical emergency and communication with the person, next of kin or substitute decision maker must be clearly documented in their clinical record.

To fall within the principle of necessity, the following conditions must be met:

* the action taken must be necessary, and not merely convenient or prudent, in order to sustain life or prevent a serious deterioration when it is not practicable to obtain consent
* the action taken must be such as a reasonable person would take in all the circumstances having regard to the best interests of the person.

Depending on the nature of the emergency, it may still be necessary to consider any wishes expressed by the person in the following documents:

* an Advance Care Plan that is known and immediately available
* an Inpatient Resuscitation Plan completed with medical staff.

It may also be necessary to consider any views expressed by a substitute decision maker or health attorney with the authority to provide consent for treatment decisions and who is immediately available/contactable.

The circumstances that comprise the emergency and the person’s lack of capacity to consent must be documented in the person’s clinical record.

If and when a person becomes competent they should be informed of the treatment/ procedure that has been performed and the reasons for providing it.

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| Section 4 – Substitute Decision Makers |

For a Quick Guide to Substitute Decision Makers and Supported Decision Making, refer to Attachment 2. If a person has appointed a substitute decision maker, this must be documented in their clinical record following the appropriate process.

Where there are concerns that an adult does not have the decision-making capacity to provide consent to treatment or procedures themselves, the following substitute decision makers can provide consent in specific situations:

* an Attorney under an Enduring Power of Attorney
* a Guardian, when appointed
* a Health Attorney
* the Public Advocate of the ACT when appointed guardian
* the Chief Psychiatrist or Community Care Coordinator (where there are issues relating to mental disorder or mental illness and the person is under a Mental Health Order).

When a substitute decision maker is used, clinicians should also seek to engage the person with impaired decision making capacity as much as possible.

To determine who can provide consent as a substitute decision maker refer to the flowchart at Attachment 3.

**People with a mental disorder or illness may be assessed as needing treatment under the *Mental Health Act 2015*. Specific information regarding supported consent, nominated persons and substitute decision makers for people with a mental disorder or illness can be found in section 5 of this document.** For supporting documentation to help consumers express their views and preferences about their mental health treatment, see [My Rights, My Decisions Toolkit](https://www.actmhcn.org.au/mrmd/).

A substitute decision maker will give or withhold consent based on the expressed wishes of the person (if available), or failing that, on the substitute decision makers’ perception of the “best interests” of the person.

“Best interests” is assessed having regard to the welfare, wellbeing and interests of the person and, assuming that ongoing treatment is not futile, will involve continuation of life and maintenance of the health of the person. The following should be taken into account by the substitute decision maker when considering what the best interests of a person might be:

* the wishes of the person, so far as they can be ascertained
* what would happen if the procedure/treatment was not carried out
* what alternative treatments are available
* whether the treatment can be postponed because better treatments may become available, and
* for a transplantation of tissue—the relationship between the two people.

The substitute decision-maker must provide or facilitate, as far as practicable, the support necessary for the protected person to understand the decision to be made, participate in decision-making and communicate their wishes.

The authority of a substitute decision maker will usually depend on the legal documents under which they are authorised or appointed and the statutory and regulatory requirements of ACT legislation.

If a person resides in another state or territory, any legal documents that have been made in that state or territory will reflect the local statutory and regulatory requirements. Statutory and regulatory requirements for the above legal documents can differ between jurisdictions. If a person presents a legal document created outside the ACT, care should be taken to ensure the powers, roles and responsibilities within the document are understood and that that person has been properly delegated the power to make the relevant decision and provide consent on behalf of the person.

Enduring power of attorney documents validly created in other jurisdictions are taken to be made under and in compliance with ACT legislation due to the mutual recognition provisions under the *Powers of Attorney Act 2006* (ACT). If there is any doubt as to whether or not a legal document is valid or whether the person has been properly authorised to make the relevant decision and provide consent, advice can be sought from the ACT Government Solicitor.

A person should not be considered to have impaired decision making capacity because they are thought to be:

* eccentric
* making unwise decisions or choices the clinician may not agree with
* expressing a particular political or religious opinion or sexual preference/orientation, and/or
* engaging or have engaged in illegal acts.

CHS staff must treat all people with respect, which means treating others with the sensitivity, courtesy and understanding we would wish for ourselves, and recognising that everyone has something to offer. It means thinking “would I be happy if this was happening to me”. Despite this, in assessing whether a person has impaired decision-making capacity, any effect of drug-taking of the person must be taken into account. If there is a particular concern about a person’s decision making capacity, it should be referred to the treating team for review/assessment. Refer to the information in the Policy Statement section of this document for further information regarding capacity.

For any substitute decision maker, evidence of their authority to consent needs to be sighted and confirmation of having done this needs to be documented and a copy of the documentation placed in the person’s clinical record.

## 4.1 Telephone Consent

Wherever possible, consent to treatment should be obtained through face-to-face conversation with the substitute decision maker. However, when a person requires treatment, that is not a medical emergency, and consent cannot be obtained from the parent, guardian or other substitute decision maker in person, telephone consent may be provided.

In these situations, another clinician must listen to the telephone conversation to corroborate the information given to the substitute decision maker. When the decision maker cannot see the physical condition or affected part or side of the body of the person for themselves, both clinicians must also confirm the information given to the decision maker about the proposed treatment or procedure, including confirmation of the correct site or side.

This information must be documented in the person’s clinical record and signed by both clinicians, confirming that consent has been obtained or that it has not.

## 4.2 Enduring Power of Attorney

In the ACT, the *Powers of Attorney Act 2006*, allows a person (adult) who has decision making capacity to appoint one or more people as an attorney under an Enduring Power of Attorney (EPoA). In the event that the person no longer has decision making capacity, this provides authority for the attorney/s to make specified decisions in relation to financial matters, personal care, health care matters or medical research matters and provide consent on the person’s behalf. To provide consent for medical treatments the health section of the Enduring Power of Attorney document must be completed. Where the person has expressed their wishes clearly in the EPoA, this should be a guiding factor. However, if the attorney believes that the person would now have a different view, this is also relevant to determining the substitute decision.

A person cannot authorise the attorney to exercise power in relation to special health care matters, including:

* Removal of non-regenerative tissue from the principal while alive for donation to someone else
* Sterilisation of the principal if they are or are reasonably likely to be fertile
* Termination of the person’s pregnancy
* Electroconvulsive therapy or psychiatric surgery
* Health care prescribed by regulation.

If one of these procedures is deemed necessary by clinicians , staff should seek legal advice. Refer to *Request for Legal Advice Procedure.*

Enduring attorneys making decisions about medical research matters must follow the process in Part 4.3A of the *Powers of Attorney Act 2006*.  This includes considering only medical research projects which are approved by a human research ethics committee acting in accordance with, and compliance with the National Statement of Ethical Conduct in Human Research in force at the time, accessible at [www.nhmrc.gov.au](http://www.nhmrc.gov.au)

An attorney under the Enduring Power of Attorney has a right to all the information that the person being treated would have been entitled to if they had decision making capacity.

A person is entitled to have decisions made by an enduring attorney about health care matters and medical research matters, in a way that is in their best interests, respects their rights and freedom of action, and in a way that maintains or promotes their health and wellbeing to the greatest extent possible.

A person’s wish in relation to health care matters and medical research matters (including a wish to not participate in the medical treatment or research), and any information provided by their health care provider must be taken into account when an attorney decides what is appropriate in the exercise of power for a health care matter or medical research matter.

A signed and witnessed copy of the Enduring Power of Attorney document must be kept with the person’s clinical record.

## 4.3 Health Attorney

A Health Attorney may be appointed by the senior treating doctor, dentist or health professional under the *Mental Health Act 2015,* for the purposes of medical consent, if a person has impaired decision making ability, and they do not have:

* an Enduring Power of Attorney for healthcare matters under the *Powers of Attorney Act 2006*, or a law of another state or territory that substantially corresponds to the *Powers of Attorney Act 2006*, and
* there are no Guardianship orders
* they do not have an Advance Consent Direction under the *Mental Health Act 2015*.

Listed in priority order, a health attorney can be:

1. the person’s domestic partner
2. a carer for the person (but does not receive remuneration or reward for the care, excluding Centrelink Carer’s allowance), or
3. a close relative or close friend of the person.

In accordance with the *Guardianship and Management of Property Act* *1991* health professionals may ask the health attorney who they believe on reasonable grounds is best able to represent the views of the person with impaired decision making capacity, to give a consent for medical treatment. A health attorney’s power to consent must be exercised in a way that is consistent with any health direction unless it is not reasonable to do so. Staff are not required to seek the views of more than one Health Attorney.

The use of a Health Attorney must be documented in the clinical record using the *Health Attorney for Consent to Medical Treatment* form. Consent provided by the Health Attorney is valid for six months only before it needs to be reviewed. It is the responsibility of all clinicians to ensure appropriate consent is obtained for each period of treatment(s), care or support(s).

## 4.4 Public Trustee and Guardian

If a substitute decision maker makes a decision in relation to the health care of a person that the clinician involved in providing treatment to the person, believes on reasonable grounds is not in their best interests, they must contact the Public Trustee and Guardian.

Clinicians must also contact the Public Trustee and Guardian of the ACT to provide or withhold consent in the following circumstances:

* if they become aware that another substitute decision maker exists and objects to the giving of consent, or
* in the absence of a Health Directive, an appointed Health Attorney, Guardian, or Enduring Power of Attorney.

Consent can be obtained by contacting the Office of the Public Trustee and Guardian during business hours (0900-1630) to apply for an emergency guardianship order. If consent is required outside of business hours, a procedure or treatment may only proceed if it is an emergency, otherwise the procedure or treatment must not proceed until the emergency guardianship order is in place.

The Office of the Public Trustee and Guardian contact is: **02 6207 9800.**

## 4.5 Advance Care Planning

Advance care planning is a process enabling a person (aged 18 years and over) to express and document their wishes about their future care, in consultation with their health care providers, family and other important people in their lives.

Advance care planning can include:

* appointing a person as an ‘attorney’ or substitute decision-maker under the Powers of Attorney Act 2006 – this is automatically revoked if someone loses capacity
* completing an Enduring Power of Attorney (EPoA) document, setting out their wishes in relation to health care matters – this does not become operative until the person has impaired capacity
* a non-legally binding Statement of Choices; and
* a legally binding Health Direction document, which must be invoked when the person has capacity.

Copies of all advance care planning documents provided to CHS are sent to Health Information Services for inclusion on the person’s clinical record.

For further information please see the *Advance Care Planning Procedure.*

### Enduring Power of Attorney

Enduring Power of Attorney is a legal document discussed earlier in this section.

### Statement of Choices

The Statement of Choices is designed to guide the enduring attorney/s and the treating team in the event that the person becomes temporarily or permanently incapable of participating in medical treatment decisions. It is not legally binding, but as an expression of wishes or will and preferences, it must be taken into consideration in consent situations, where treatment is authorised by a substitute decision maker, and in emergency situations, where treatment is authorised on the basis of necessity and considerations of best interests.

If the person becomes unable to make decisions about their care or treatment, the information contained in the Statement of Choices will assist the person’s chosen attorney(s) and the treating team in discussing healthcare decisions that are in accordance with the person’s expressed wishes and choices.

### Health Direction

Under the *Medical Treatment (Health Directions) Act 2006*, a person who has capacity can make or revoke a Health Direction. A Health Direction allows someone to refuse or require the withdrawal of some specific medical treatment or all medical treatment, and to be provided with adequate pain relief.

These directions can only be made by a person with capacity. They can be in writing or made verbally, and in both cases, requires the presence of two witnesses in the presence of each other and the person making the direction. In the case of a verbal direction, it requires both witnesses to be health professionals, one of whom must be a doctor. Health Directions can be revoked by a clear expression by the person who made the original direction to a health professional or someone else (either in writing or verbally).

If the person has capacity, the clinician must provide the person with advice on the nature of their illness, any alternative forms of treatment available, the consequences of these and the consequences remaining untreated before they comply with the Health Direction.

If the person loses capacity after they have made the Health Direction, and there is a pre-existing, earlier EPoA which therefore begins to operate, the Attorney must exercise their powers consistently with the Health Care Direction, unless it is unreasonable to do so. This also applies to other Substitute Decision makers including Health Attorneys or Guardians.

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| Section 5 – Treatment under the *Mental Health Act 2015* |

Persons with a mental disorder or illness are treated according to the *Mental Health Act 2015*. The following information does not apply unless a person is being treated for a mental disorder or illness. For more information about the *Mental Health Act 2015,* refer to the [Plain Language Guide to the Mental Health Act 2015 (ACT)](https://health.act.gov.au/sites/default/files/2018-09/Plain%20Language%20Guide_MH%20ACT.pdf). For supporting documentation to help consumers express their views and preferences about their mental health treatment, see [My Rights, My Decisions Toolkit](https://www.actmhcn.org.au/mrmd/).

A person with a mental disorder or mental illness can have the decision-making capacity to consent to medical or surgical treatment. The principles of valid informed consent apply; the person can participate in all aspects of their health care and exercise their rights to consent to, or decline health care. The person has the right to be assumed to have decision making capacity unless it is established they do not.

To establish the person’s decision making capacity, staff must consider if the person can:

* understand when a decision needs to be made about their treatment, care or support
* understand the facts of the decision
* understand the main choices available to the person in relation to the decision
* weigh up the consequences of the main choices
* understand how the consequences affect the person
* make the decision on the basis of the above information, and
* communicate the decision in whatever way they can.

Refer to the discussion regarding capacity in the policy statement section at the beginning of this document for more information regarding principles used to establish a person’s capacity to make decisions. For additional information in relation to the meaning of decision making capacity and the principles associated with this, please refer to Sections 7 and 8 of the *Mental Health Act 2015*.

For mental health pathways to consent, please see Attachment 4 of this policy.

Consent and consent discussions, including where consent was not provided, must be recorded in the person’s clinical record.

For a Quick Guide to Substitute Decision Makers and Supported Decision Making, refer to Attachment 2.

## 5.1 Supported Decision Making

A person with a mental disorder or mental illness must always be provided with the opportunity to make decisions about their treatment, care or support to the best of their ability.

A person should not be treated as lacking or having impaired decision making capacity until all practicable steps to support decision making have been exhausted. Staff must promote capacity and facilitate access to services for people by encouraging participation by the person and/or their advocate. Therefore, the person must be:

* verbally advised of their rights under the *Mental Health Act 2015*
* given the Statement of Rights, written information by a clinician, including a statement of the right to obtain a second opinion from an appropriate mental health clinician and a statement of the right to obtain legal advice, and
* communicated with in ways they can understand, for example through the use of aided forms of communication (teletypewriter services, communication boards and communication books), and unaided forms of communication (sign language and facial expressions). A person can also request the use of an interpreter, translation services or the use of an independent advocacy service.

For more information please see the *Assessment of Decision Making Capacity and Supported Decision Making procedure* on the CHS Policy Register.

### Supported decision making staff training

All clinical staff within the Division of Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) must complete training in supported decision making to develop the necessary skills and knowledge to ascertain a person’s decision making capacity and to aid them to make a decision if necessary. This training is available as part of the Introduction to the Mental Health Act Training on CHS’s training system. Search for CHS – Mental Health Act (el-2020).

## 5.2 Nominated persons

A person with a mental disorder or mental illness, who has decision-making capacity, may, in writing, nominate someone else to be their nominated person. This will assist clinicians and others to know who to contact for guidance about the person’s wishes. The main functions of a nominated person are to:

* help the person by ensuring that their interests, views and wishes are respected should they require treatment, care or support for a mental disorder or mental illness
* assist with supported decision making
* receive information under the *Mental Health Act 2015*, for example, be involved in discussions around ECT or other treatment discussions to provide support to the person
* be consulted about decisions in relation to treatment, care or support.

A nominated person cannot consent on the person’s behalf (unless they have that power in another role such as under a Power of Attorney). The nominated person’s name and contacts must be kept with the person’s clinical record.

For more information please see the *Advance Agreements, Advance Consent Directions and Nominated Persons procedure* on the CHS Policy Register.

## 5.3 Substitute Decision Makers

If a person is assessed as not having capacity to consent due to their mental disorder or mental illness and cannot attain capacity through supported decision making, the substitute consent provisions of the *Guardianship and Management of Property Act 1991* apply (see Section 4 of this policy) for all general medical or surgical conditions (except for under a Psychiatric Treatment Order or psychiatric surgery).

This means that the person may be treated under:

* a Power of Attorney (excluding Electro Convulsive Therapy (ECT) or psychiatric surgery)
* a Guardianship Order (excluding ECT or psychiatric surgery), or
* an Advance Consent Direction (this may have a section on agreement to ECT as a treatment of choice).

If the person does not have an Advance Consent Direction, Power of Attorney or a Guardianship Order, they will be treated under the *Guardianship and Management of Property Act 1991.*

### Treatment under the Guardianship and Management of Property Act 1991– without a guardianship order

The person may need immediate treatment, in which case the following provisions apply under the *Mental Health Act 2015*:

* A Health Attorney can give consent for up to 21 days.
* Prior to the 21 days expiring, if the person remains unable to give consent, an application is made to the Tribunal by the treating team and/or another interested party, to extend health attorney consent for eight weeks and consider a guardianship order.

If granted, the person would then be treated under the guardianship order.

If at any stage during the period of consent the person regains capacity to consent to treatment(s), care or support(s) under the *Mental Health Act 2015* and/or the guardianship order ceases, any substitute consent provided is no longer valid.

### Advance Agreements and Advance Consent Directions for a Mental Disorder or Illness

A person with a mental disorder or mental illness may enter into an Advance Agreement and/or an Advance Consent Direction unless they do not have decision-making capacity at that point in time. These documents are agreed, in writing, between the person and their treating team, and apply even in the event that a person lacks capacity. In the event that a person lacks capacity to consent, the treating team must check to see if an Advance Agreement or an Advance Consent Direction exists.

An Advance Agreement contains information the person considers relevant to their treatment, care or support for the mental disorder or mental illness and any preferences the person may have in relation to help they may need as a result of their mental disorder or mental illness (e.g. who will look after their house, pay their bills) or treatment options or preferences.

An Advance Consent Direction allows a person with a mental disorder or mental illness to make a direction about the treatment, care or support they consent to receive, particular medications or procedures they consent or do not consent to, and the people who may or may not be provided with information about their treatment or care. An Advance Consent Direction only comes into effect if the person does not have decision-making capacity at the time.

A representative of the treating team must ensure that a person with a mental disorder or mental illness is informed about and given the opportunity to enter into an Advance Agreement or Advance Consent Direction and advised that they may have someone with them to assist in entering into an agreement or making a direction.

Treatment will generally be provided in accordance with the preferences expressed in any Advance Agreement or Advance Consent Direction, provided the person continues to consent to any treatment they have consented to in either of these documents and it is safe and appropriate to provide that treatment.

A person may end an Advance Agreement or Advance Consent Direction by telling a member of the treating team verbally or in writing or by making another agreement or direction. Provided the person has decision making capacity, the agreement or direction ends on the day the person’s decision to cease the agreement or direction has been made known or any other day nominated by the person.

Even if an attorney under a Power of Attorney or Guardian has been appointed, if there is an Advance Agreement or an Advance Consent Direction which deals with the relevant issue, consent of the Power of Attorney or Guardian is not required.

Where the person has made an Advance Consent Direction and then makes a Health Direction which is inconsistent, the Advance Consent Direction has no effect in relation to that matter or inconsistency.

For more information please see the Advance Agreements, Advance Consent Directions and Nominated Persons procedure on the CHS Policy Register.

## 5.4 Psychiatric treatment

If a person who is unable to provide informed consent appears to require psychiatric treatment and they are unwilling to receive the proposed treatment, an application by the Chief Psychiatrist or their delegate must be made to the ACT Civil and Administrative Tribunal (ACAT) for a Psychiatric Treatment Order. Legal guardians, Health Attorneys and Enduring Power of Attorneys may consent on behalf of a person who lacks decision making capacity under the *Mental Health Act 2015* and is willing to receive treatment, care or support.

## 5.5 Electroconvulsive Therapy (ECT)

Consent to ECT may be voluntary or under an ECT order.

* ECT may be administered to an adult only as provided for in the *Mental Health Act 2015.*
* ECT may be administered to a person who is at least 12 years old but under 18 years old only as provided for in the *Mental Health Act 2015*.
* ECT must not be administered to a person who is under 12 years old.

A person for whom ECT is recommended must have the nature and purpose of the therapy explained by a medical officer who will not perform the therapy.

Consent for ECT is mandatory and is to be documented on the Electro-Convulsive Therapy Consent and Prescription form in the clinical record. The person’s signature on the consent form must be witnessed by a person who has no financial interest in the person’s affairs. A new consent form is required if the course of ECT goes beyond nine treatments as specified within the *Mental Health Act 2015*.

Consent for ECT may be given or expressly refused in an Advance Consent Direction provided conditions regarding the witnessing of the Advance Consent Direction contained in the legislation are met. A guardian cannot not give consent for ECT.

**Where emergency ECT is required, the Chief Psychiatrist and a doctor must make an application to the ACT Civil and Administrative Tribunal for an Emergency ECT order.**

Involuntary ECT needs to be applied for through ACAT by a doctor.

For further information, refer to the *Electroconvulsive Therapy (ECT) adults and children over 12 years of age procedure* on the CHS Policy Register and/or the sections on Electroconvulsive therapy in the *Mental Health Act 2015*.

## 5.6 Psychiatric Surgery

This is rare and strictly done on a case by case basis. A guardian cannot give consent for psychiatric surgery. Please contact the Office of the Chief Psychiatrist for more information and/or refer to provisions on this in the Psychiatric surgery section of the *Mental Health Act 2015*.

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| Section 6 – Treatment of Children and Young People |

## 6.1 Consent from parent or guardian

Until the age of 18 years, consent is usually obtained from a parent or legal guardian, however clinicians should aim to involve children and young people in the discussions and decision making affecting their health and wellbeing.

Exceptions or variations to requirements for parental or legal guardian consent are:

* Parenting or Consent Orders: refer to 6.2
* Care and Protection Order or Voluntary Care Agreement: refer to 6.3
* Where an older child or young person has reached sufficient intelligence and understanding (is Gillick Competent): refer to 6.4

In an emergency, the parent with whom the child or young person has presented, can provide consent.

In non-emergency situations, it is expected that parents or legal guardians have joint decision making responsibility for medical decisions. However on a day to day basis for short term issues, usually only one parent or legal guardian is required to provide formal consent. The consenting parent is then required to attend (or be available) where that consent needs to be confirmed, or if follow up related to the original consent is required.

A child or young person’s informal carer (for example, a family friend or grandparent) may not legally consent to an examination, treatment or procedure.

Note:

It is important to note that when a child or young person is Gillick Competent (refer to section 6.4), this does not remove the right of their parent or legal guardian to consent to or refuse a clinical activity, treatment or procedure. This means:

* if a competent young person gives consent to treatment, it CANNOT be overridden by a parent
* if the young person withholds consent to treatment, consent CAN still be given by a parent
* if one parent withholds consent to treatment, consent CAN be given by the other parent
* neither the young person, nor a parent, can give consent to non-therapeutic treatment
* the giving or withholding of consent by either party can be overridden by the Family Court or Supreme Court
* a consent (or authority) for non-therapeutic treatment can only be given by the Family Court or Supreme Court.

## 6.2 Parenting and Consent Orders

Clinicians should be alert to where the parental responsibility for a child or young person lies.

The power of the Family Court or Supreme Court is superior to that of parents and may be exercised to ensure decisions about treatment are in the ‘best interests’ of a child or young person.

Where there are known Parenting or Consent Orders in place, the parental responsibility ruling for health related matters should be followed.

Where there is uncertainty about the authority to provide consent, the clinician should ask the parent or guardian if there is a Parenting or Consent Order in place. The clinician’s request and the information obtained should be documented within the child or young person’s clinical record.

If there is still uncertainty the clinician or their supervisor should contact:

* Child and Youth Protective Services (CYPS) Intake Team – 1300 556 728 (24 hours), or
* CYPS Health Liaison Officer, Office of Children Youth and Family Support – 6205 3693 (business hours)
* [healthliaisonchildprotection@act.gov.au](mailto:healthliaisonchildprotection@act.gov.au) (email not to be used in time limited circumstances e.g. during an emergency)

If there is still uncertainty the clinician or their supervisor should contact:

* The Family Court of Australia – 1300 352 000 (business hours)
* The Office of the Chief Justice of the Supreme Court ACT – 6205 0000 (business hours)

The clinician or supervisor will advise the Director of their Division, as well as the Senior Medical Officer where relevant, of the concerns raised and actions taken. The clinician will document within the child or young person’s clinical record.

## 6.3 Care and Protection Orders and Voluntary Care Agreements

Clinicians should be alert to where the parental responsibility for a child or young person lies.

For children and young people in care, a Court order or a Voluntary Care Agreement provides for the transfer of parental responsibility to certain people. In most cases, parental responsibility will be transferred solely to the Director-General of the Community Services Directorate (CSD), however parental responsibility may be shared with the CSD Director-General in certain circumstances.

The Director-General may authorise a kinship or foster carer to exercise certain aspects of parental responsibility for the child or young person on their behalf. The legislation has two kinds of parental responsibility: daily care responsibility for the child or young person and long-term care responsibility for the child or young person.

*Kinship and foster carers*

Where kinship and foster carers have daily care responsibility they can provide consent for routine health care including treatment - not surgery (except for minor dental surgery).

Where kinship and foster carers also have long-term care responsibility they can consent to other decisions around healthcare including sexual health care, gender reassignment, the use of medication to treat mental health conditions, health care treatment that requires surgery and immunisation. They can also follow religious observance related to medical treatments.

The Director-General may override any decision by a carer that is not considered to be in the best interest of the child or young person in care.

Where kinship and foster carers consider that making a daily care decision for a child or young person may be controversial or if they are unsure about what decisions can be made, they can contact either CYPS or their out of home care agency for advice.

Where further clarification is required clinicians can contact:

* Child and Youth Protective Services (CYPS) Intake Team – 1300 556 728 (24 hours), or
* CYPS Health Liaison Officer, Office of Children Youth and Family Support – 6205 3693 (business hours)
* [healthliaisonchildprotection@act.gov.au](mailto:healthliaisonchildprotection@act.gov.au) (email not to be used in time limited circumstances e.g. during an emergency)

## 6.4 Mature Minor

Older children and young people may access clinicians for health advice and information without parental consent.

Clinicians should encourage the child or young person to communicate with parents or guardians, unless there are concerns around their safety or wellbeing, however where the child or young person requests confidentiality, and/or if the need for examination, treatment or a procedure is identified, the clinician should consider Gillick Competence of the child or young person to seek legally valid consent. The views (if known) of the parent or guardian to the proposed examination, treatment or procedure, and any alternatives should also be considered.

The clinician should be mindful not to cause undue distress or create barriers for an older child or young person who is seeking access to health care.

*Gillick Competence*

In determining whether an older child or young person is capable of providing consent, clinicians need to consider whether they have sufficient understanding and intelligence to:

* Comprehend the medical advice being given, including the nature, consequences and implications of the proposed examination, treatment or procedure,
* Comprehend the potential risks to health with or without the examination, treatment or procedure and,
* Manage the emotional impact of either accepting or rejecting the advised examination, treatment or procedure.

Documentation should clearly include the clinician’s determination of Gillick competence.

## 6.5 Blood transfusions without parental consent

Pursuant to section 23 of the *Transplantation and Anatomy Act 1978*, where a parent of a child refuses to consent to a blood transfusion for a child or it is not practicable to delay the administration of a blood transfusion until consent of the parent is obtained, a blood transfusion for a child may be administered without parental consent provided:

* at least two medical officers are of the opinion that the child is in danger of dying and that the administration of a blood transfusion to the child is the best means of preventing the death of the child, and
* the treating medical officer is satisfied that the blood to be transfused is compatible with the blood of the child.

If a blood transfusion is administered to a child without parental consent, the medical officers involved must clearly and thoroughly document:

* the reasons for their view that the child was in danger of dying
* the reasons for their view that the blood transfusion was the best means of preventing the death of the child
* that the blood to be transfused is compatible with the blood of the child
* if the parent refused to provide consent, the discussion which occurred with the parent including all questions asked of the parent and their responses, steps taken to ascertain why the parent refused to consent and the discussion regarding the risks and benefits of the transfusion, and
* if it is not practicable to delay the administration of the blood transfusion until consent can be obtained, the reason why it is not practicable to delay.

## 6.6 Paediatric Magnetic Resonance Imaging (MRI) with General Anaesthetic (GA)

As not all children referred for an MRI under GA will see an anaesthetist prior to their procedure, a specific consent process has been established. When a child is referred for MRI with GA, the referring paediatrician must provide the child and their parent or carer with relevant information about the main benefits and risks of the procedure and the associated anaesthetic, and provide them with contact options for asking further questions. Any high anaesthetic risk patients will be referred to pre-admission clinic to be reviewed by an anaesthetist prior to their imaging procedure. The anaesthetist on the day of the procedure is ultimately responsible for ensuring that appropriate anaesthetic informed consent has been provided before the procedure. Refer to Attachment 5 for further details.

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| Section 7 – When a person declines information, treatment or withdraws their consent |

A person can decline all or part of any care and may withdraw previously given consent at any time. This can occur even when this decision differs from clinician recommendations and where the decision to decline care may result in a deterioration in the person’s health or their death. The clinician must discuss the implications of not receiving the recommended care with the person to ensure they have all the relevant information to make a considered decision. This discussion must be clearly documented in the clinical record.

If a person is assessed as competent and declines to sign a written consent form for non-urgent treatment, the clinician should not proceed with treatment, until, or unless, consent has been validly obtained.

The person may be advised to obtain a second opinion from another qualified clinician.

If a person declines recommended diagnostic and therapeutic interventions, particularly when the decision involves potentially life-threatening conditions, this should be clearly documented in the person’s clinical record.

Where the person continues to decline to receive recommended care, the issue must be reported and escalated through line management. With advice from clinical and legal experts as necessary, the CHS Executive will provide direction to the relevant clinicians and treating teams regarding any further actions to be taken.

Where the person identifies as Aboriginal and/or Torres Strait Islander, it is imperative at this point of care that a Cultural Consultation be conducted with either the Canberra Hospital Aboriginal and Torres Strait Islander Liaison Officer (ALO) Team (if patient of Canberra Hospital) or MHJHADS ALO Team (if client/patient within MHJHADS services) to assist and provide Cultural Translative supports accordingly.

## 7.1 When a person declines information in relation to consent and treatment

Some people will state that they do not want to be burdened with a large amount of information and they would prefer to leave the treatment decision to the clinician. In these circumstances the clinician should encourage the person to reconsider a wish not to receive information about the treatment proposed. However the person should not be coerced and if there is a continued reluctance on the person’s part to receive information the clinician should:

* try and determine why the patient does not want to be informed and attempt to address the underlying concern, and
* if the patient feels unable to deal with the matter, ensure that the person understands, at least broadly, what is involved

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| Section 8 – Aboriginal and Torres Strait Islander Peoples |

Where the person identifies as Aboriginal and/or Torres Strait Islander, it is imperative at this point of care that a Cultural Consultation be conducted with either the Canberra Hospital ALO Team (if patient of Canberra Hospital) or MHJHADS ALO Team (if client/patient within MHJHADS services) to assist and provide Cultural Translative supports accordingly.

**The Canberra Hospital Aboriginal and Torres Strait Islander Liaison Service can be contacted on 5124 2055, the MHJHADS Aboriginal Liaison Officer Team can be contacted on 5124 4137, for advice and support as required throughout the consent process.**

Staff should be aware that when seeking consent from Aboriginal and Torres Strait Islander peoples, there may be certain cultural practices and sensitivities that need to be considered.

For an individual who is a member of an Aboriginal community or a Torres Strait Islander, this means the importance of maintaining the individual’s Aboriginal or Torres Strait Islander cultural and linguistic environment, and their values (including Aboriginal tradition or Island custom) must be taken into account.

Some points to note:

* Cultural translation, which can be facilitated by the ALO service, is a very important element not to be overlooked when it comes to the holistic patient care of our Aboriginal and Torres Strait Islander people and community. This ensures clinicians and Aboriginal and Torres Strait Islander people can communicate effectively and understand the information provided.
* Next of kin: In Aboriginal and Torres Strait Islander families next of kin may not necessarily be the family spokesperson. Next of kin details in the clinical record must be checked prior to determining who receives patient information. The treating team together with the ALO Service can culturally assist in determining who is appropriate to share patient information with and any decision making concerns. However in cases where there is conflict between NOK and family (this includes cultural definition of family) the listed NOK should be the first contact around any decisions.
* The Aboriginal and Torres Strait Islander concept of health encompasses physical, social, emotional and cultural wellbeing of the individual and of the whole community. Aspects of Aboriginal and Torres Strait Islander cultures must therefore be considered in the person’s clinical care to ensure their holistic and individual health needs are met.
* Be aware of the importance of extended family and kinship structures and who needs to be consulted regarding critical decisions. Consultation with extended family members may be required.
* Segregated practices such as Men’s and Women’s Business are an integral part of Aboriginal and Torres Strait Islander cultural practice. Whilst it is not always practical, ask a woman if they would prefer to be treated by a female clinician. If this is not possible, ask them if they would prefer someone such as a partner or relative, to be present. The same gender appropriateness applies for men’s business.
* In Aboriginal and Torres Strait Islander societies, lengthy periods of silence are the ‘norm’ and are expected during conversation, particularly during information sharing, information seeking, discussion of ‘sensitive’ or ‘shame’ issues and especially surrounding ‘Sorry Business’. Aboriginal and Torres Strait Islander people use silence to listen, allow for consensus or to indicate non–commitment. The positive use of silence should never be interpreted as lack of understanding or agreement. There are times when silence needs to be observed and taking your time before verbally responding is a mark of respect.

Note that while the ALO service can assist and support consent processes, the responsibility for obtaining informed consent still rests with the clinician.

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| Section 9 – Culturally and linguistically diverse peoples and those with special needs |

Staff should be aware of a person’s cultural and linguistic background and whether they have special needs, so that information can be provided in a form and manner that is understood. Ways to achieve this may include:

* use of an accredited interpreter if English is not the person’s first language or an Auslan interpreter for people who are D/deaf. Refer to the *Language Services Policy* and *Language Services Interpreters Procedure* for more information regarding the use of interpreters.
* providing information in the person’s preferred format e.g. large print
* using non-verbal tools, e.g. use of communication boards, to facilitate the person’s understanding.

Staff should consider the following cultural considerations:

* the person may advise staff that they are not be the sole decision maker in relation to their future health management
* attitudes to death and dying
* attitudes around gender
* attitudes around religion and religious needs
* complex family and support structures.

People who rely on non-verbal means of communication must be given every opportunity to express their consent decision. In these cases, the standard consent documentation may be used to acknowledge written consent by writing ‘Patient unable to sign’ in the space for the signature, and signed by the clinician and a witness. This should also be documented in the clinical record.

When a person cannot communicate with staff using verbal or non-verbal means or other types of supported decision making, for clinicians to be sure consent can be gained, the substitute decision making process should be followed (please see section 4 of this policy). The reasons why the person cannot provide consent must be documented in the clinical record.

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| Section 10 – Consumer Handouts |

Where available, clinicians may provide appropriate written or audio-visual information resource materials to supplement their discussion of the benefits and risks of a proposed treatment or procedure. Consideration should be given to the person’s individual preferred method of communication, as well as providing information in languages other than English. Any information resources developed for use must be appropriately endorsed by the CHS Consumer Handouts Committee to ensure accuracy and relevance to the needs of people seeking care and treatment. Appropriate processes should be maintained to ensure resources are continually reviewed and updated to ensure currency.

People need to be provided with the opportunity to ask questions after they have looked at any information resource materials provided.

When using previously prepared information resources, clinicians must be aware that:

* pre-printed information sheets usually refer to the risks facing an “average” person having the treatment, and
* some people (those who are older, chronically ill, have co-morbidities, etc.) will face much higher risks than those shown in the information sheets.

This latter point must be stressed when pre-printed material is used during discussions between clinicians and their patients.

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| Evaluation |

**Outcome Measures**

* Number of incidents identified related to a lack of obtaining informed consent.

**Method**

* Audits of patient clinical records to measure compliance with the informed consent process specified in this policy. The focus of the audit is to verify the use of an appropriate consent form and the recording of discussions and/or dialogue between a clinician and patient in the patient’s clinical record.
* Review of reported clinical incidents, consumer feedback and patient survey data.

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| Legislation, Policies and Procedures |

**Standards**

* Australian Commission on Safety and Quality in Health Care (2018) National Safety and Quality Health Services Standards, second edition
* Australian Commission on Safety and Quality in Health Care (2018) Advisory 18/10: Informed Financial Consent

**Legislation**

* *Age of Majority Act* 1974
* *Children and Young People Act* 2008
* *Civil Law (Wrongs) Act* 2002
* *Guardianship and Management of Property Act* 1991
* *Health Practitioner Regulation National Law (ACT) Act* 2010
* *Health Records (Privacy and Access) Act* 1997
* *Human Rights Act 2014*
* *Human Rights Commission Act 2005*
* *Medical Treatment (Health Directions) Act* 2006
* *Mental Health Act* 2015
* *Powers of Attorney Act 2006*
* *Transplantation and Anatomy Act* 1978 (2.2, 2.3, 2.5)
* *Rogers v Whittaker* (1992) 175 CLR 479. High Court of Australia

**Policies and procedures**

* Clinical Governance Policy
* Partnering with Consumers Policy
* Clinical Record Management Policy
* Clinical Record Documentation procedure
* Consumer and Carer Participation policy
* Elective Surgery Access Policy and guidelines
* Electroconvulsive therapy (ECT) Adults and Children over 12 years procedure
* ACT Language Services Policy
* Language Services – Interpreters, Multilingual Staff and Translated Materials Procedure
* Patient Identification and procedure matching policy and procedure
* Release or Sharing of Clinical Records or Personal Health Information procedure
* Clinical Placement Procedure

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| Definition of Terms |

**Advance Agreement:** for people with a mental disorder or illness contains ‘everyday’ matters such as who will look after a person’s house/cat. An advance agreement can also contain treatment options/ preferences that should be considered by the treating doctor.

**Advance Care Plan/Planning:** Refers to a process enabling a person (aged 18 years and over) to express and document their wishes about their future care. This phrase includes a number of legal and non legal documents. One or more of the following may be included in an Advance Care Plan or Advance Care Planning: Enduring Power of Attorney, Statement of Choices, Health Direction.

**Advance Consent Direction:** for people with a mental disorder or illness, thiscontains directions if the mental disorder or illness results in them not having capacity in relation to:

* The treatment care or support the person consents to or does not consent to receiving
* Particular medications or procedures that the person consents to or does not consent to receiving
* The people who may or may not be provided with information about the treatment, care or support the person requires

**Capacity:** Legally, capacity is present if the person is able to understand the nature, effect and consequences of the decision to be made, rationally weigh up the options and understand the implications of his or her decision. The clinician needs to take into consideration individual circumstances, illness and treatment. For example, a mental disorder/illness or drugs may affect a person’s capacity to consent in the short or long term.

A person has capacity to make a decision if they can, with assistance if needed:

* understand when a decision about treatment, care or support needs to be made
* understand the facts related to that decision
* understand the main choices available in relation to the decision
* weigh up the consequences of the main choices
* understand how the consequences of the main choices affect them
* on the basis of the above elements, make the decision, and
* communicate the decision they make in whatever way they can.

Note that:

* capacity refers to a particular decision at a particular time and should not be generalised.
* if clinically safe, a decision can be delayed until a person regains capacity.

The type of assessment required in relation to someone’s capacity will vary depending on the type of decision being made, and is left to the treating clinician to determine. Clinicians caring for people with a mental disorder or illness are provided with training and tools to assist with assessing a person’s capacity to make a decision.

**Care Coordinator, mental health:** Is appointed by the Minister and has the following functions under section 205 of the Mental Health Act 2015 to:

* coordinate the provision of treatment, care or support to people with a mental disorder in accordance with community care orders made by the ACAT
* coordinate the provision of appropriately trained people for the treatment, care or support of people with a mental disorder who are subject to community care orders
* coordinate the provision of appropriate residential or detention facilities for those people with a mental disorder who are under a community care order, a restriction order or a forensic community care order
* coordinate provision of medication and anything else required to be done for people with a mental disorder in accordance with community care orders and restriction orders made by the ACAT
* makes reports and recommendations to the Minister about matters affecting the provision of treatment, care or support, control, accommodation, maintenance and protection for people with a mental disorder, and
* undertake any other function given to the care coordinator under the *Mental Health Act 2015*.

**Chief Psychiatrist**: Is appointed by the Minister and has the following functions under section 197 of the *Mental Health Act 2015*:

* Provision of treatment, care or support, rehabilitation and protection for persons who have a mental illness.
* Reports and makes recommendations to the Minister with respect to matters affecting the provision of treatment, care or support, control, accommodation, maintenance and protection for persons who have a mental illness.
* Undertake any other function given to the Chief Psychiatrist under the *Mental Health Act 2015*.

**Clinical Activity:** Clinical activities assess, improve or maintain the health of a person in a clinical situation and may include invasive and non-invasive procedures (including those performed in settings other than the operating room). Some examples are:

* Invasive:
* taking a specimen of blood
* giving medication via an intravenous, intramuscular or subcutaneous route
* inserting intravenous access, or
* performing a surgical procedure, including a procedure performed in medical imaging.
* Non-invasive
* interventions such as evaluating, advising, planning (E.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling, a procedure in medical imaging) and giving medication.

**Clinician:** For the purpose of this document a ‘clinician’ includes all doctors, dentists, nurses and allied clinicians engaged by CHS to care for people accessing care. This definition is supported by the *Medical Treatment (Health Directions) Act* *2006* and the *Health Practitioner Regulation National Law (ACT) Act* 2020.

**Decision making capacity**: A person has decision-making capacity if the person can make decisions in relation to the person’s affairs and understands the nature and effect of the decisions. A person has impaired decision-making capacity if the person cannot make decisions in relation to the person’s affairs or does not understand the nature or effect of the decisions the person makes in relation to the person’s affairs. Refusal to accept treatment does not imply a lack of capacity. A person has the right to be assumed to have decision-making capacity, unless it is established that the person does not have decision-making capacity even when support is provided.

**Enduring Power of Attorney**: In the ACT, the *Powers of Attorney Act 2006* allows a person to appoint an Enduring Power of Attorney/s for healthcare and other matters to make decisions on their behalf in the event that they do not have the capacity to make decisions for themselves.

**Experimental healthcare**: means research that has not yet gained the support of a substantial number of practitioners in that field of health care and is delivered as part of a test or trial.

**Family** (Aboriginal and Torres Strait Islander Peoples): Culturally Aboriginal and Torres Strait Islander Peoples cultural definition of family may include but are not limited to extended family and close community members.

**Health Direction:** In the ACT people may also give legally binding directions about medical treatment that they do not want now, and for the future, by completing a Health Direction under the *Medical Treatment Act (Health Directions) 2006.*

**Health care matter**: Refers to a matter other than a special health care matter, relating to the persons health care. Examples of health care matters a power of attorney may deal with include:

* Consenting to lawful medical treatment necessary for the principal’s wellbeing
* Donations (other than donations of non-regenerative tissue) under the *Transplantation and Anatomy Act 1978* by the principal to someone else
* Withholding or withdrawal of medical treatment for the principal.

**Medical emergency:** is defined as a situation where urgent treatment is necessary to avert a serious and imminent threat to the person’s life, physical or mental health.

**Medical research**: is defined as research in relation to the diagnosis, maintenance or treatment of a medical condition that the person has, has had, or has a significant risk of being exposed to, including:

* Experimental health care,
* The administration of medication or the use of equipment or a device as part of a clinical trial,
* Research prescribed by regulation as medical research.

**Medical research matter**: refers to a matter relating to participation in medical research or low-risk research. Medical research is defined as research approved by a human research ethics committee established in compliance with the NHMRC National Statement on Ethical Conduct in Human Research. Low risk research means research carried out for medical or health purposes that poses no foreseeable risk of harm to the person, other than that usually associated with the person’s condition. It does not include any activity that is part of a clinical trial.

**Nominated person:** A person with a mental disorder or mental illness, who has decision-making capacity, may, in writing nominate someone else to be their nominated person. The nominated person cannot consent on the person’s behalf (unless they have that power in another role such as Power of Attorney). The nominated person’s functions include ensuring that the interests, views and wished of the person with a mental disorder or illness are respected, receiving information under the *Mental Health Act 2015*, and being consulted about treatment, care and support decisions.

**Person or People:** For the purpose of this document, the term ‘person’ or ‘people’ is used to refer to a consumer accessing health services provided by CHS.

**Statement of Choices**: People may choose to record their wishes regarding future medical treatments on a Statement of Choices form. The Statement of Choices is designed to inform their attorney and the doctors of their medical treatment wishes. It is not legally binding, unlike an Enduring Power of Attorney or a Health Direction under the *Medical Treatment Act 2006*. If they become unable to make decisions this information will assist the attorney/s and doctors in making decisions that are in accord with their expressed views and best interests.

**Substitute Decision Maker**: Where it has been identified that an adult does not have the decision-making capacity to provide consent to treatment or procedures themselves the following substitute decision makers can provide consent:

* Health Attorney
* The Attorney, under an Enduring Power of Attorney
* Guardian, if approved
* Public Advocate of the ACT if appointed guardian, and the
* Chief Psychiatrist or Community Care Coordinator (where there are issues relating to mental health or mental dysfunction and the person is under a Mental Health Order).

**Supported Decision Making:** A person must always be given the opportunity to make decisions about their treatment, care or support to the best of their ability and always be supported to contribute to decisions about his/her treatment, care or support to the best of their ability.

**Treatment:** Medical or surgical management of a person (including any medical or surgical procedure, operation, examination and any prophylactic, palliative or rehabilitative care) normally carried out by, or under the supervision of a Clinician.

**Treating Team**: The treating team includes all service providers (located within or external to the ACT) who provide a service for CHS involved in diagnosis, care or treatment for the purpose of improving or maintaining the person’s health for a particular episode of care (*Health Records (Privacy and Access) Act 1997*).

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| Search Terms |

Consent, capacity, competence, capacity, EPA, EPOA, guardian, legal guardian, public, advocate, attorney, shared decision making, supported, shared, decision making, supported decision making, legal

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| Attachments |

Attachment 1: Elective surgical consent process map.

Attachment 2: Quick Guide to Substitute Decision Makers

Attachment 3: Determination of who can provide consent as a Substitute Decision Maker Flowchart.

Attachment 4: Mental Health pathways to consent

Attachment 5: Informed Consent Process for Paediatric Magnetic Resonance Imaging (MRI) with General Anaesthetic (GA)

**Disclaimer**: *This document has been developed by Canberra Health Services specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Canberra Health Services assumes no responsibility whatsoever.*

*Policy Team ONLY to complete the following:*

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| --- | --- | --- | --- |
| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval* |
| *19/08/2020* | *Complete Review* | *Denise Patterson, EGM QSII* | *CHS Policy Committee* |
| *03/04/2021* | *Information pertaining to Aboriginal and Torres Strait Islanders updated in section 8 and definitions* | *Kellie Lang, Director Quality and Accreditation, QSII* | *CHS Policy Committee* |
| *08/04/2022* | *Minor amendments made in the “Documentation of Consent” section on page 6.* | *Alexandra Collins, EBM-QSII* | *CHS Policy Team* | |
| *1*2/08/2022 | *Implied consent where decision maker is not present* | *Kath Wakefield, a/g EBM QSII* | *CHS Policy Team* | |
| *21/08/2023* | *Amendment to document to include information related to The Guardianship and Management of Property Act 1991 amendment and DHR related changes.* | *Cathy Burns, Senior Director of Patient Safety and Experience* | *CHS Policy Team* | |

*This document supersedes the following:*

|  |  |
| --- | --- |
| *Document Number* | *Document Name* |
| *CHHS16/026* | *Consent and Treatment* |
|  |  |

## Attachment 1: Surgical Consent Process Map



## Attachment 2: Quick Guide to Substitute Decision Makers and Supported Decision Making

**Substitute Decision Makers**

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| --- | --- |
|  | **What is it?** |
| Enduring Power of Attorney (EPOA) | Legally appointed individual. Can make decisions about health care, personal care, financial and medical research matters. Excludes removal of non-regenerative tissue, sterilisation, termination of pregnancy, Electroconvulsive Therapy or psychiatric surgery, healthcare prescribed by regulation. |
| Guardian | Legally appointed by ACT Civil and Administrative Tribunal (ACAT) to make decisions including certain health decisions in certain circumstances including when there is no EPOA. |
| Health Attorney | Can make health decisions when there is no EPOA or Guardianship order. Appointed by the senior treating medical officer:   * Domestic partner, * Carer, or * Close relative or friend. |
| Statement of Choices | Document which guides treatment decisions by substitute decision maker. Not legally binding but supports an EPOA |
| Health Direction | Legally binding document containing information about refusal or withdrawal of medical treatment (now or in the future). If it is inconsistent with an existing EPOA, the attorney must comply with the Health Directtion. It can be if the person’s wishes have changed and they have clearly expressed this to a health professional or someone else. |
| Public Trustee and Guardian (PTG) | Acts as guardian where none exist. If a health attorney refuses consent to medical treatment for a person with impaired decision making capacity and a health professional believes the refusal is inconsistent with a health direction, they must refer the matter to the PTG for review. A health professional must also refer a matter involving a disagreement between health attorneys to the PTG. |

**Supported Decision Making and Substitute Decision Makers under the Mental Health Act 2015**

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|  | **Used for:** |
| Nominated Persons | Nominated in writing by a person with a mental disorder or illness to assist clinicians to know about the person’s interests, views and wishes; receive information and be consulted about decsions in relation to treatment, care or support. Cannot make decisions or provide consent. |
| Advance Agreement | Contains information and preferences related to assistance the person may need when they lack capacity due to their mental illness or disorder (e.g. who will look after their house) |
| Advance Consent Directions | Contains consent or refusal for certain clinical activities, procedures or treatments that may occur in future and about people who can be provided information or not if the person lacks capacity due to their mental illness or disorder |
| Chief Psychiatrist | Consenting to Psychiatric Treatment or emergency Electroconvulsive Therapy, only when approved by ACT Civil and Administrative Tribunal (ACAT) |

## Attachment 3: Determination of who can provide consent as a Substitute Decision Maker Flowchart.



## Attachment 4: Mental Health Pathways to Consent



## Attachment 5: Informed Consent Process for Paediatric Magnetic Resonance Imaging (MRI) with General Anaesthetic (GA)

1. Paediatrician refers patient for MRI with GA
2. Paediatrician provides patient and their family with GA and MRI information sheets and discusses the content, main risks and options for asking further questions
3. Paediatrician does a preliminary identification of low risk or high risk for general anaesthesia (examples of high risk: upper airway compromise, chronic cardiac disease, previous anaesthetic issues)
4. If low risk patient normal booking process.
5. Medical Imaging calls to book appointment and asks if patient or family has any questions
6. Any questions about MRI (general) à Medical Imaging to answer
7. Any questions about MRI (patient specific) à ask patient/family to call paediatrician
8. After reading the information sheet if any questions about GA à transfer to pre-admission clinic and ask to speak with the Elective Surgery Liaison Nurse for Paediatrics
9. Anaesthetist completes informed consent (on consent to treatment form) on the day of the procedure
10. If high risk patient: Patient referred to pre-admission clinic by the Paediatrician for anaesthetic review and to complete informed consent (on consent to treatment form)
11. Anaesthetist confirms consent contained in the clinical record is the patient consent on the day of the procedure
12. If patient unable to attend preadmission clinic, the preadmission clinic must notify the Department of Anaesthesia to assess the patient over the phone or on the morning of the procedure and obtain informed consent. Anaesthetist confirms consent contained within the clinical record is the patient consnt on the day of the procedure.

