Consent to medical treatment: A guide for aged care providers

Obtaining consent to medical treatment is fundamental to good clinical practice in aged and palliative care. It is also a key requirement under the Australian Aged Care Quality Standards.

For a medical examination or treatment to be lawful, consent must be given by the appropriate person, validly obtained, and provided at the right time.

This factsheet explains:

- **Who can provide consent**
- **When consent is required**
- **How consent can be obtained.**

It is designed for aged care providers including residential aged care facilities and home care services.

Important information

As a starting point, please read the End of Life Law Toolkit's factsheet *Overview: Capacity and Consent to Medical Treatment* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment/Overview) to understand the basic legal principles on consent to medical treatment and decision-making capacity.

Each State and Territory has guardianship and medical treatment legislation that outlines the requirements for consent. Learn more about consent in your State and Territory at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/capacity#statetercap)

Different laws apply to consent for restrictive practices and are not discussed in this factsheet.

Who can provide consent?

Who can provide consent to medical treatment or a medical examination depends on whether the person has decision-making capacity.

A person with decision-making capacity can consent to their own medical treatment or refuse it. A person will have capacity if they can:

- **comprehend and retain the information needed to make the decision, and**
- **use and weigh that information when deciding**.

If a **person does not have decision-making capacity**, consent can be provided by either:

- the person, in their Advance Care Directive,
- the person's substitute decision-maker,
- in some States and Territories, the Public Advocate or Public Guardian (as a last resort), or
- by a Court or Tribunal.

Consent given in an Advance Care Directive will not apply unless the person no longer has capacity. The consent must also relate to the specific medical circumstances that have arisen.

Example

Stan, an aged care resident, does not have capacity. He has an Advance Care Directive refusing consent to cardiopulmonary resuscitation (CPR), but not other treatments. If Stan requires a blood transfusion for anaemia, his Advance Care Directive will not apply (i.e. it cannot be used to consent to or refuse the transfusion) because it is a different treatment situation to CPR. Consent for the blood transfusion would need to be given by Stan's substitute decision-maker.

A **person's substitute decision-maker (e.g. an appointed guardian, family member) cannot consent to treatment while the person still has decision-making capacity**. They cannot override a decision made by a person with capacity, even if they do not agree with the decision.

Health professionals working in aged care and residential aged care facilities cannot consent to medical treatment for a person they care for. However, in South Australia, an adult who oversees the person's ongoing day-to-day supervision, care and wellbeing may provide consent in rare circumstances.

Learn more about decision-making capacity, Advance Care Directives, and substitute decision-making in the following **End of Life Law Toolkit factsheets**:

- *Overview: Capacity and Consent to Medical Treatment.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment/Overview)
- *Advance Care Directives.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives/Factsheet)
- *Substitute Decision-Making.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Substitute-Decision-Making/Factsheet)

Which treatment and clinical situations require consent?

When consent is required

Consent is required **before a person receives medical treatment or undergoes a medical examination**. Some examples of situations where consent must be obtained are when the person requires:

- physical examination (e.g. involving touching) or a visual examination that is intrusive (e.g. of the breasts, genitals)
- medical investigation (e.g. medical testing, screening, scans)
- a surgical operation or other invasive treatment
- general anaesthetic
- a medical procedure
- medication or another intervention
- a blood transfusion or administration of blood products.

Consent is also required to transfer a person to hospital.

A health professional who acts without first obtaining consent could be liable under civil or criminal law, or subject to disciplinary action.

Consent is valid only when:

- the **person has capacity**,
- consent is **given freely and voluntarily**, and
- the consent **relates to the proposed treatment or procedure**.

When consent is not required

When a person does not have capacity, **there are some limited situations where consent to medical treatment is not required**. These situations are discussed below.

Urgent (emergency) treatment

Treatment and/or hospital transfer needed urgently to save a person's life, or prevent serious injury can be provided without consent to a person who does not have capacity, so long as there is no:

- Advance Care Directive refusing the treatment/transfer, or
- substitute decision-maker to provide or refuse consent at that time. However, it is good clinical practice to obtain a substitute decision-maker's consent if possible and time permits.

Sometimes in an emergency a person may still have capacity. In this case, the person's consent is required before treatment can be provided.

Example

Maria has advanced pancreatic cancer. One day Maria advises care staff at the residential aged care facility (RACF) she resides in that she has bad chest pain.

Paramedics are called to examine Maria. They suspect she is at risk of cardiac arrest and advise her that they want to transfer her to hospital for treatment. Maria says that she does not want treatment or to be transferred, and that she wishes to stay where she is.

The paramedics are confident Maria has decision-making capacity. They proceed according to the law by complying with Maria's refusal of treatment and not transferring her to hospital. With Maria's consent, appropriate pain and symptom relief is provided to her at the RACF.

Minor or routine treatment

In **Victoria, New South Wales, Queensland, Tasmania, and the Northern Territory**, medical treatment or health care that is minor or routine can be given without consent to a person without capacity in some limited situations. Examples of treatment that may be minor or routine include suturing or dressing a wound or providing Ventolin.

In **New South Wales, Queensland, and Tasmania**, first aid, administration of non-prescription medication, and visual examinations e.g. of the mouth, throat, nasal cavity, eyes, or ears can be given or undertaken without consent.

In **Western Australia, South Australia, and the Australian Capital Territory**, consent is required from the person (or, if they lack capacity, their substitute decision-maker) for all types of treatment or health care, even if it is minor or routine in nature.

Learn more about minor or routine treatment or health care in the ELDAC End of Life Law Toolkit factsheet *Consent for minor or routine treatment in aged care*. (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/Consent-for-minor-or-routine-treatment-in-aged-care.pdf)

Withholding or withdrawing futile or non-beneficial treatment

Generally, a health professional **does not need to obtain consent from a person or their substitute decision-maker to withhold or withdraw futile or non-beneficial treatment**.

In **Queensland**, however, where a person does not have capacity, consent from a substitute decision-maker is required. This issue is complex. Visit *End of Life Law in Australia* (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/queensland#QLDfutile) for further information.

Though consent is generally not required in this situation, it is **good clinical practice for health professionals to engage in shared decision-making with the person or their substitute decision-maker about treatment considered to be futile or non-beneficial**.

Example

Hugo has dementia, coronary heart disease, and hypertension. One afternoon a care worker discovers Hugo in his room, unconscious. Hugo is transferred to hospital where he is diagnosed as having had a cardiac arrest with several minutes of cerebral hypoxia. He remains comatose and is placed on artificial ventilation in the Intensive Care Unit.

Due to the extent of his brain damage and pre-existing chronic conditions, the treating team believe Hugo is unlikely to significantly improve or be able to survive without artificial ventilation.

They explain to Hugo's family that continuing to provide ventilation would be invasive, of little benefit in improving his condition, and may cause him pain and suffering. They discuss withdrawing ventilation and providing comfort care. The family agrees.

Palliative care

In Victoria and the Northern Territory, consent is not needed for a health practitioner to administer palliative care to a person without capacity. This is the case even if a person's medical treatment decision-maker refuses palliative care for the person. The health professional must however take into account any values or preferences expressed by the person (e.g. a refusal of palliative care in the person's Advance Care Directive) and consult with the person's decision-maker.

In **other States and Territories the normal rules for consent to treatment - as set out above – apply to palliative care**.

At what point in time should consent be obtained?

Where consent to medical treatment or examination is required, **consent should be sought immediately before any treatment is provided**. Seeking consent at the time treatment is needed allows (1, 2):

- Health professionals and the person or their substitute decision-maker to **discuss the reasons for the treatment, treatment options and alternatives, and the risks, benefits, and burdens** of the treatment. Health professionals have a duty to warn the person or their substitute decision-maker of any risks of the treatment prior to obtaining consent.
- The person or their substitute decision-maker to **ask questions, seek further information if they wish, and communicate their decision** to the health professional.
- Health professionals to **determine whether the person has decision-making capacity** to consent to the treatment, or whether a substitute decision-maker must decide. **A person's capacity can only be determined at the time a decision is required**. This is particularly important where a person in aged care has fluctuating capacity due, for example, to dementia or cognitive impairment. In these situations, **the person can still provide consent if they have capacity at the time the decision about medical treatment or examination is required**. Capacity must be determined each time a decision is required.
- The person or their substitute decision-maker to **refuse treatment**.

How can consent be given?

Consent can be given verbally, in writing, or implied (e.g. where a person offers their arm so a nurse can take blood). Written consent should be obtained for significant treatment e.g. surgical procedures, general anaesthesia, other invasive procedures, or where there are risks to the person e.g. chemotherapy, blood transfusions.

Health department consent policies may provide guidance on processes for obtaining consent in your State or Territory.

A person with capacity may want to decide about treatment independently, or may choose to involve their family, substitute decision-maker, or support network or community in decision-making.

A person e.g. someone with cognitive impairment can be supported to provide consent using supported decision-making approaches.

Example

Richard is in the early stages of dementia and has type 2 diabetes. He resides at home where he is visited several times a week by his home care nurse for medication management. His understanding is always better in the mornings, especially if his daughter is visiting and can help explain information to him.

Richard has been experiencing abdominal pain and passing blood. The home care nurse arranges an early morning GP appointment for Richard and, with Richard's agreement, suggests to Richard's daughter that she might want to accompany him.

At the appointment the GP advises Richard needs a colonoscopy. Richard's daughter helps Richard to understand the information provided by the GP about the colonoscopy by explaining in simple language what it involves, so that Richard can decide whether to have the procedure.

Learn more about supported decision-making at *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/treatment-decisions/adults#supporteddecisionmaking)

Can consent be given in advance?

Consent should be obtained from a person with capacity immediately prior to examining them or providing medical treatment. Forms or documents signed by a resident or their family giving a 'blanket' consent to treatment or administration of medication indefinitely are unlikely to be lawful.

A person cannot provide a blanket consent for medical treatment or for unknown situations. This practice is also contrary to the Aged Care Quality Standards. It is best practice for health professionals to seek consent to treatment each time a resident requires medical examination, medical treatment (including minor or routine treatment), or hospital transfer i.e. at the time it is required.

However, a person with capacity can consent to future treatment using an Advance Care Directive, which will operate once they lose decision-making capacity. A person may also make an Advance Care Plan in which they express their treatment values or preferences.

Learn more about Advance Care Directives and Advance Care Plans in the **End of Life Law Toolkit factsheet *Advance Care Directives.*** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives/Factsheet)

How long is consent valid?

Consent is valid until:

- **it is withdrawn by the person or their substitute decision-maker**, or
- **the person's circumstances change**. For example, their condition may deteriorate or improve, or their treatment goals or regime may change e.g. they decide to cease curative treatment and commence palliative care.

Consent can be withdrawn by the person or their substitute decision-maker at any time.

Practice tips: Obtaining consent in aged care

Aged care providers can effectively manage consent by:

- **Developing clear policies, procedures, and processes** to support obtaining and recording of consent. All staff and visiting health professionals should be provided with education and training on these.
- Ensure staff and visiting health professionals:
  - **Always obtain consent from the person (or if they cannot consent, their substitute decision-maker) immediately prior to providing any treatment or health care** (unless one of the exceptions discussed in this factsheet applies).
  - **Contemporaneously document consent discussions** and include written consent forms (where appropriate) in the person's records.
- **Clearly documenting in all residents' or home care recipients' records**:

- whether or not the person has decision-making capacity, of if their capacity fluctuates
- whether the person has an Advance Care Directive or Advance Care Plan
- any treatment they have objected to or refused
- details of the person's substitute decision-maker/s.

Key points to remember

1. Consent must be obtained immediately before medical treatment or health care is provided to a person. Treating without consent could lead to civil or criminal liability, except in some limited circumstances.
2. A person with decision-making capacity can consent to their own treatment and health care. If the person does not have capacity, consent must still be sought from a person's substitute decision-maker.
3. There are limited situations where consent for treatment is not required e.g. urgent treatment, where treatment is minor or routine, or to withhold or withdraw futile or non-beneficial treatment (except in Queensland where the person does not have capacity).
4. Consent can be given orally or be written or implied. Consent must be sought at the time treatment is required, so cannot be provided in advance through 'blanket' consent forms or documents.
5. All aged care providers should develop policies, procedures, and processes to effectively manage obtaining consent.

For more information about consent visit:

- **Aged Care Quality and Safety Commission:**
  - *Consent for medication in aged care*. (https://www.agedcarequality.gov.au/sites/default/files/media/consent-for-medication-in-aged-care-fact-sheet_0.pdf)
  - *Frequently asked questions about consent*. (https://www.agedcarequality.gov.au/sites/default/files/media/frequently-asked-questions-about-consent_0.pdf)
- **Other consent factsheets:**
  - Australian Commission on Safety and Quality in Health Care, Factsheet for clinicians: *Informed consent in health care*. (https://www.safetyandquality.gov.au/sites/default/files/2020-09/sq20-030_-_fact_sheet_-_informed_consent_-_nsqhs-8.9a.pdf)
  - Avant, *Consent essentials factsheet*. (https://www.avant.org.au/Resources/Public/consent-essentials/)
- **State and Territory consent policies and guidelines:**
  - Australian Capital Territory: *Canberra Hospital and Health Services Policy Consent and Treatment*. (https://www.canberrahealthservices.act.gov.au/before,-during-and-after-your-care/staying-at-the-adolescent-mental-health-unit/during-your-stay/participating-in-your-care/consent)
  - New South Wales: *Consent to medical or dental treatment factsheet and person responsible*. (https://www.ncat.nsw.gov.au/ncat/publications-and-resources/fact-sheets/guardianship-division-fact-sheets.html#Consent4)

- New South Wales: *Consent to Medical and Healthcare Treatment Manual – Policy and procedure manuals*. (https://www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx)
- Northern Territory: *Determining decision making capacity for a health care decision guideline.* (https://pgt.nt.gov.au/sites/default/files/pgt_-_determining_decision_making_capacity_for_a_health_care_decision_guideline.pdf)
- Queensland: *Queensland Capacity Assessment Guidelines*. (https://www.publications.qld.gov.au/dataset/capacity-assessment-guidelines/resource/23e5bde1-40d7-4115-a15d-c15165422020)
- Queensland: *Queensland Clinical Excellence Division Guide to Informed Decision-Making in Health Care*. (https://www.health.qld.gov.au/__data/assets/pdf_file/0019/143074/ic-guide.pdf)
- South Australia: *SA Health Policy Guideline: Consent to Medical Treatment and Health Care*. (https://www.sahealth.sa.gov.au/wps/wcm/connect/f0ee918046d8588f8b8ffb22d29d99f6/Guideline_Consent+to+Medical+Treatment+and+Health+Care_June2015.pdf?MOD=AJPERES)
- Tasmania: *TASCAT Guardianship Stream Consent to Medical or Dental Treatment Factsheet*. (https://www.tascat.tas.gov.au/__data/assets/pdf_file/0006/684123/4.-Consent-to-Medical-or-Dental-Treatment.pdf)
- Western Australia: *WA Health Consent to Treatment Policy 2016*. (https://www.health.wa.gov.au/~/media/Corp/Policy-Frameworks/Clinical-Governance-Safety-and-Quality/Consent-to-Treatment-Policy/Consent-to-Treatment-Policy.pdf)