Policy for gaining informed consent

This policy is for medical practitioners (practitioners), administration staff and nurses, nurse practitioners, and anaesthetic assistants (clinical staff).

The purpose is to ensure that every Southern Cross Healthcare (SCH) patient has their right to make an informed choice and give informed consent upheld.

For more information on informed consent:

- External web page: Code of Health and Disability Services Consumer Rights
    - Right 5, 6 and 7
- Associated Documents (SCH):
    - Procedure for checking informed consent
    - Informed consent flowchart
    - Operating theatre Agreement to Treatment Form process
    - Refusal/consent with restrictions for blood products (adult)

Contents

What is informed consent?

Right 7 of the Code of Rights establishes the patient's right to make an informed choice and give informed consent.

Informed consent involves the exchange and understanding of all relevant information so that an informed, reasoned and unpressured decision can be made by the patient or someone who has the competence and legal capacity to make such choices. The informed decision includes the option of refusing the treatment, procedure or intervention. It is an interactive process between the doctor, the patient and sometimes those close to the patient, such as their family or whānau.

Competence describes the person's ability or capacity to make a rational, informed choice about accepting or refusing treatment or service being offered, or authorising the collection and use of information.

It is presumed that every patient is competent to make decisions about treatment and procedures, unless there is clear evidence to the contrary.

When is consent required?

Informed consent must be obtained for each proposed procedure, treatment or intervention. Verbal conversations when a written consent is not required should be documented in the patient's clinical record.

Written consent must always be obtained at SCH for a proposed procedure.

As per the Code of Rights written consent is always required in the following cases:

- the patient is to participate in any research; or
- the procedure is experimental: or
- the patient will be under general anaesthetic: or
- there is a significant risk of adverse effects on the patient

How long is consent valid?

Verbal consent should always be reaffirmed immediately prior to a procedure or intervention. When a period of time has passed since consent was given discuss with the patient that they have signed the Agreement to treatment Form (Agreement to treatment) and ask if they are still happy to proceed with this surgery or do they need to speak with the 'practitioners' again to discuss it. If there are no changes, document in their notes. Consent may need to be revisited depending on the

- The nature of the procedure
- Likelihood of change in health status between consent and procedure
- Progression of condition
- Change in competence
- Significant change in the patient's personal circumstances

Informed consent process

The 'practitioner' undertaking the treatment is responsible for the overall informed consent process. It is the 'practitioners' responsibility to document discussions during the consent process. Due to limited space on the Agreement to treatment Form, there may not be room to record full discussions.The informed consent process often starts in the 'practitioners' rooms and discussions (e.g. relating to surgical risk) that occur prior to patient admission may be recorded in the 'practitioners' patient records.

Informed consent process for SCH patients

The 'practitioner' establishes a suitable environment for providing information and gaining informed consent, including:

- avoidance of interruptions
- maintaining privacy and confidentiality
- the presence of support person
- provision of sufficient time to read and/or understand information
- cultural awareness

The 'practitioner' completes and signs the SCH Agreement to treatment form.

When anaesthesia is part of the procedure, the anaesthetist follows the same process.

The patient, or someone who has the competence and legal capacity to make such choices, completes the:

- Patient/guardian/enduring power of attorney section of the Agreement to treatment
- Blood products consent
- Signs and dates the Agreement to treatment
- Completes patient/guardian enduring power of attorney section of the anaesthesia plan and consent when relevant.

Clinical staff are never involved in gaining consent from a patient.

SCH is responsible for checking that the informed consent process has occurred and the patient has given informed consent for the procedure that is recorded on the Agreement to Treatment, WebPAS and CWS visit summary

Clinical staff check that informed consent has been gained at several stages of the patient's admission.

See: Procedure for checking informed consent

Operating theatre Agreement to Treatment Form process

Informed consent flowchart .

Informed Consent for patients with limited English proficiency

Every consumer has the right to effective communication in a form, language, and manner that enables the patient to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter. Without an interpreter, many of the other consumer rights are not available to a person with limited English proficiency (LEP). Medical Council

While family members may act as interpreters for the patient's support needs, care should be taken with informed consent matters and an official translation service is required. Clinical staff cannot act as interpreters for informed consent. If an official translation service has not been arranged by the 'practitioner', hospitals should discuss with the patient and whānau and arrange an official translation service prior to admission to hospital. In the event that a patient or 'practitioner' refuses an official translation service, or an official translation service is unavailable, this must be clearly documented in the clinical records.

Informed consent for additional procedures

Where additional procedures are to be undertaken, a consenting process is the responsibility of the admitting 'practitioner' (usually surgeon). In the below circumstances if SCH staff are concerned the appropriate informed consent process has not occurred they must immediately escalate to their manager.

Additional procedures

Informed consent for additional procedures

Sometimes the practitioner may consider that an additional procedure not documented on the Agreement to Treatment is required.

When the patient is under sedation or anaesthesia

When the patient is under sedation or anaesthesia and the additional procedure is deemed to be in the best interest of the patient and cannot be deferred, right 7(4) of the code must be satisfied.

Right 7(4) involves:

- *The surgeon confirming that they consider it is in the best interests of the patient to have the surgery*
- *Take into account the patient's view (if it is obtainable)*
- *Confirm that taking into that view, that it is thought the patient would want the surgery if they competent to make the choice*
- *If the patient's view cannot be ascertained, take into account the views of the Whānau, EPOA or other substituted decision maker.*

In addition:

- A decision to proceed beyond any documented consent should also be discussed with a clinical colleague or the SCH Chief Medical Officer (CMO)
- The medical practitioner must also clearly document the process they relied on to satisfy right 7(4) of the code, in the patient's clinical notes.
- If SCH staff are concerned that the appropriate informed consent process has not occurred, they must immediately escalate these concerns to their manager. It is the manager's responsibility to seek further guidance from General Manager or National Resource Team if required.

See: Operating theatre Agreement to Treatment Form Process

Return to theatre:

If the patient is competent to provide consent to additional treatment (e.g. return to theatre, blood patch post-epidural), the treating doctor must obtain informed consent on a new Agreement to treatment and document appropriately.

Clinical emergency:

If the patient requires emergency surgery there should be an attempt to gain consent from the patient or family before the patient is transferred to surgery. However in order to save a life or prevent serious injury or harm in an emergency, in the best interest of

the patient treatment may be undertaken by the 'practitioner' without informed consent or a signed Agreement to treatment.

Complex informed consent situations

Where there is uncertainty about any patient or situation, contact the National Clinical Quality and Risk team. After hours escalate to the on – call nurse manager after hours.

Waiver of rights

"I don't want to know..."

If the patient chooses to waive the right to discuss or be provided with details of a treatment, this should be documented in their hospital clinical record. The opportunity to seek further information, reconsider and change their mind should be provided.

Children and young adults

At SCH when person is less than 16 years of age, the consent of an adult parent / guardian or a personal and welfare EPOA is required.

Young people over the age of 16 are considered legal adults. For a young person up to 18 years who is not competent to make an informed choice a parent or guardian can provide informed consent.

The Code of Rights does not specify an age for consent and makes a presumption that every patient of health services is competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the patient is not competent. Therefore, a child retains their right to information at a level they can understand, even when unable to consent.

A child / young adult with a disability has the right to be treated with the same respect for personal integrity, autonomy and self-determination as any other person. Practitioners and caregivers / parent / guardian / EPOA must judge carefully the level of information the patient can understand. Care must be taken not to assume lack of capacity to consent.

The views of parents, caregivers, child / young adult and practitioner may not always coincide. Each situation will be treated with sensitivity and respect, and time allowed for issues to be discussed. In some situations, an independent advocate can be sought to represent the views and/or interests of the child / young adult.

Advance Directive and Personal and Welfare EPOA

Advance Directive (Code of Rights, Right 7 (5))

An Advance Directive is defined as a written or oral directive by which a patient makes a choice about a possible future health care procedure/s that is intended to be effective only when he or she is not competent.

Advance Directives are valid only if they are signed at a point in time when all parties were competent to do so and if the patient intended their directive to apply to the present circumstances.

The General Manager or delegate must sight the documented evidence of the Advance Directive and record this in the patient's hospital clinical record along with a copy of the documentation.

All patients are 'for resuscitation' except where there is a written Advance Directive completed and signed by both the patient and their medical practitioner.

No hospital employee may participate in the completing or witnessing of any patient Advance Directive.

Personal and Welfare EPOA

A patient may have appointed someone to act as their Enduring Power Of Attorney (EPOA) in regards to personal and welfare.

Note: a 'Property EPOA' has no standing in any healthcare situation.

A Personal and Welfare EPOA arrangement is only valid when it is signed at a point in time where all parties were competent to do so. The agreement must be in place prior to admission to hospital.

The Personal and Welfare EPOA is able to agree and sign consent for treatment on the patient's behalf only in the event the patient is incompetent to make their own healthcare choices. Incompetency to make healthcare choice may occur where:

- a patient lacks the capacity and is deemed 'mentally incompetent' to make a decision
- a patient is unable to understand the nature of the decisions
- a patient is unable to foresee the consequence of decisions
- a patient is unable to communicate decisions.

The General Manager or delegate must sight the documented evidence of:

- the appointment of the Personal and Welfare EPOA; and
- the medical certificate which deems the patient mentally incapable.

This must be documented in the patient's hospital clinical record along with a copy of the certificate.

The law prohibits any EPOA from refusing any standard medical treatment or procedure intended to save the life of the patient. Therefore the only means by which a patient can exercise Right 7 (5) of the Code of Rights to refuse lifesaving treatment in the event of future incompetence is by way of an advance directive.

See Informed consent flowchart

Sterilisation of a patient

Caregiver convenience is not a valid reason for performing sterilisation. The responsibility lies with the 'practitioner' to assess the capacity and wishes of the patient thoroughly, to assess the viability of alternatives, to assess the risks and to examine the motivation of the person seeking the sterilisation.

The Protection of Personal and Property Rights Act 1998 requires that it is necessary to have a court order to sterilise an adult with a disability.

Informed consent for other services

Blood products

It is the 'practitioners' responsibility to provide the patient with sufficient information in relation to the administration of blood components/blood products should these be necessary. Clinical staff must not be involved in the process of consenting a patient for blood products including, ticking the blood box and/or asking a patient to tick the blood box. Where consent has not been obtained and blood products may be considered necessary for the procedure, clinical staff must escalate to the admitting medical practitioner who will then undertake an informed consent process. Where a patient does not consent for blood transfusion (e.g. Jehovah's Witness), the medical practitioner should complete the Refusal/consent with restrictions for use of blood products form, and the admitting nurse adds an alert to indicate this status in the patient's hospital clinical record (stickers / CWS alerts).

Where the planned treatment holds a high risk of the need for transfused blood products, the 'practitioner' may decline to provide elective surgical services based on the risk to life.

Implants

The procedure description should include the intention of using implants, such as human tissue, surgical mesh, allograft implants and other devices.

Return of body parts or tissue

Where a patient requests return of body parts / tissues or explanted devices the admitting nurse ensures a 'Release of surgically removed tissue' form is completed (see Guidelines for return or disposal of tissue/body parts and explanted devices -) appropriately and checks the patient is aware of all requirements.

Self-medication

Where a patient wishes to self-medicate preparations that are not part of the usual or current treatment, such as medicines, remedies or supplements, approval from their 'practitioner' is required.

Where these medicines, remedies or supplements are contraindicated or are not accepted medical practice, the 'practitioner' cannot be forced to provide treatment they do not agree with.

If a patient wishes to go against the advice of their 'practitioner', all advice and information must be documented in the clinical notes so that it is clear the patient understands the information and accepts the risks and the patient confirms they understand the implications.

Research

The undertaking of research requires written informed consent prior to patient admission to the hospital.

The Chief Executive Officer (CEO) and National Clinical Medical Committee (NCMC) must approve all research involving patients prior to the study commencing.

Clinical photography

Refer to NZMA clinical images and use of personal mobile devices guide.

Document patient consent using the Authority for filming recording and photography in hospitals.

Access to patient notes for PDRP, teaching and learning

Access to patient hospital records for the purposes of writing exemplars, case studies or journals must adhere to all of the following:

- Code of Health and Disability Services Consumers' Rights
- Health and Information Privacy Code
- Nursing and/or Midwifery Councils' of New Zealand Codes of Conduct.

Informed consent from the patient or their authorised representative must be sought by the 'clinical staff' to access the clinical notes and to use the details of a patient's case / condition.

Written consent is preferred, however verbal consent that is subsequently documented and witnessed by a third party is acceptable.

Careful anonymisation is required to protect the identity of any patient.

Student health care practitioners

The Patient Admission Form includes the following:

'I understand that other clinical team members such as student nurses and qualified medical trainees may have supervised involvement with my care and that I have the right to decline their presence or contribution to my care delivery.'

If a patient chooses to opt-out, this is documented on the patient's hospital clinical record.

Invitees to the patient care environment

Please refer to Medical company representatives or technical support persons in the operating room

Observers, trainees and media

The presence of other observers and trainees who are not eligible for credentialling can occur only with prior written consent of the patient, 'practitioner' and hospital management.

Media personnel have no rights of access to Southern Cross Healthcare facilities without the written informed consent of the patient, admitting specialists, General Manager, National Chief of Quality and Risk and CEO. See also Media relations.

Patient requested support person/visitor

At the patient's request, a support person or visitor may be granted limited access during direct patient treatment or care.

For instance, caregivers of children or special needs patients may be given restricted access to the operating suite before induction and the recovery room once consciousness is regained.

Approval from the 'practitioner' and OR/PACU manager is required for any support person / visitor to be permitted into the OR during a procedure.**To go further**

To go further

NZ Standard: NZS 8134:2008 Health and Disability Consumer Rights standards

MCNZ: Informed Consent: Helping consumers make informed decisions about their care

MCNZ: Cole's Medical Practice in New Zealand

NZMA: Advance Directive Information and Sample Forms

MoH: Principles & Guidelines for Informed Choice & Consent (1991)

MoH: Consent in Child and Youth Health: Information for Practitioners (1998)

HDC: Advance Directives & Enduring Powers of Attorney

Training on LMS: Medico Legal DVD

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Published Date: **17 Apr 2023**
Version: **4**
Site: **Network**

Content Owner: **Victoria Aliprantis**
Authorised By: **Chief of Quality & Risk**

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