Consent for medication in aged care

Informed consent

Informed consent is a person's decision, given voluntarily, to agree to a healthcare treatment, procedure or other intervention that is made:

- *following the provision of accurate and relevant information about the healthcare intervention and alternative options available; and*
- *with adequate knowledge and understanding of the benefits and material risks of the proposed intervention relevant to the person who would be having the treatment, procedure or other intervention.*

Good clinical practice involves ensuring that informed consent is validly obtained and appropriately timed.[1]

Informed consent of a person must be sought before any treatment, medical or otherwise, is provided, administered, or given.

Consent is not only agreeing to a treatment or intervention, it should be given in an informed way, with consideration given to all available options.

Informed consent in aged care

Consent is a key issue of quality and safety in aged care, and is referenced directly in the Aged Care Quality Standards, under Standard 1. Consumer dignity and choice. Providers should have processes in place to support receipt, and subsequent recording of, informed consent for any treatment for an aged care consumer. This includes for the use of restrictive practices.

These processes are also referenced under Standard 8. Organisational governance and should be supported under Standard 7. Human resources.

Informed consent involves the person being able to:

- understand the reason for the proposed medication/intervention
- understand the available options (including not taking or using the medicine or intervention)
- understand the risks and benefits of those options
- come to a considered decision
- communicate the decision.

That decision is then recorded.

1 Australian Commission on Safety and Quality in Health Care https://www.safetyandquality.gov.au/our-work/partnering-consumers/informed-consent

Informed consent and restrictive practices

Amendments to the Quality of Care Principles 2014 clarify existing provider obligations to obtain and record consent prior to the use of restrictive practices. These changes **reinforce the rights** of all aged care consumers in making decisions about their own care, as listed in the Charter of Aged Care Rights.

Informed consent is not ongoing

Consent can be withdrawn at any time.

Informed consent is normally time limited and reviewed, taking into account:

- the risks of the medication, or intervention, or restrictive practice,
- the expected duration of the condition being treated, or issue or behaviour being managed,
- the monitoring for effectiveness and side effects, including that the intervention is not successful, and,
- the concerns and wishes of the person who is providing consent.

The person who gives consent can also withhold consent, in other words, NOT agree to any treatment or intervention, even after it has been used or applied in the past.

A provider, a staff member (paid or unpaid) or any treating professional **cannot give consent on behalf of the person**.

Capacity to give consent

Consent for any treatment or intervention should always be given by the person themselves unless they lack the capacity to do so.

Consent for medication, including chemical restraint

For prescription and administration of medication, consent is governed by State and Territory laws covering who may give consent and in what circumstances. These laws differ somewhat between jurisdictions. It can be unlawful to administer medication without consent, and it is important that prescribers and people who administer medication are aware of the legal requirements in the relevant State or Territory.

Determining a person's capacity to consent for a particular medication at the relevant time, and keeping appropriate documentation, is the responsibility of the prescriber. Prescribers and people who administer medication need to be confident that the person is capable of giving informed consent, if that consent is to be relied on for the administration of the medication. If there is doubt about a person's capacity to consent, then further advice should be sought.

Where the prescribing doctor (or other prescribing professional) has determined that the person cannot give their own fully informed consent, then consent should be sought from the person's legally defined substitute decision maker (SDM). This is sometimes called their Person Responsible, Guardian, Health attorney or Medical treatment decision maker depending on the jurisdiction. See Table 1 on page 4.

In every case it is important to ensure that the SDM is the person who is authorised to consent to administration of medication or treatment in the particular circumstances and jurisdiction. In some cases, special authority from a tribunal or a court may be required before a guardian or other SDM has authority to consent to a medication or procedure that extends beyond 'medical treatment' and is administered as a restrictive practice.

In the case of a person lacking capacity to give their own consent and without any identifiable representative, there are processes in State and Territory legislation to gain consent or appoint a SDM.

The SDM must themselves have capacity to consent, must be fully informed in the manner outlined for 'informed consent', and should make the decision they believe the person themselves would have made had they been able.

If the person refuses treatment including medication, even if a SDM has given consent, then the treatment cannot be given under normal circumstances. Urgent treatment provisions, and authority to override the person's objection need to be dealt with under local State and Territory legislation.

Table 2 on page 5 provides an overview of State and Territory legislation relating to who can give consent to the prescribing of medications for the purpose of chemical restraint, where the individual is assessed as lacking that capacity.

Capacity to consent to medication:

- **Autonomy**. If the person can provide informed consent for themselves then nobody else can provide consent for them. A person's substitute decision maker (SDM) does not need to be consulted but the person may want them to be. A SDM should not be consulted without the person's consent or request, and is not able to override a person's own decision. Rights to confidentiality apply.
- A person may have capacity to consent to a medication if the decision is simple (e.g. paracetamol for a headache), but not if the decision is more complex (such as whether or not to commence anticoagulation)
- A person may have capacity to consent at some times but not at others (e.g. if unwell or delirious).
- A diagnosis of dementia or cognitive impairment does not automatically mean the person cannot give their own consent. However it might be a flag for extra caution in assessment of capacity. Capacity for decision-making is typically lost gradually with dementia, not suddenly. Capacity to give consent may also be lost suddenly (e.g. with a stroke). Capacity must be individually assessed in all instances and at a particular point in time.
- If capacity for any decision is in doubt then specialists such as geriatricians, psycho-geriatricians, psychiatrists and neuro-psychologists can assist. Referral will need to include information on what specific decision(s) the capacity assessment relates to.

Table 1. Terminology for substitute decision makers in different states and territories, and hierarchy of who is the defined SDM.

State	Title	Hierarchy
ACT	Health attorney	1. Domestic Partner 2. Carer 3. Close friend or relative
NSW	Person responsible	1. Guardian 2. Spouse 3. Carer 4. Close friend or relative
NT	To be confirmed	To be confirmed
QLD	Health attorney	1. Spouse 2. Primary (unpaid) carer 3. Close friend or relative (not a paid carer) 4. Public guardian
SA	Person responsible	1. Guardian 2. Prescribed relative (spouse, de facto, other relatives) 3. Adult friend 4. Carer
TAS	Person responsible	1. Guardian 2. Spouse 3. Carer 4. Close friend or relative
VIC	Medical treatment decision maker	1. Appointed medical treatment decision maker 2. Guardian 3. Spouse 4. Primary carer 5. Oldest of any of the following, in priority order: adult child, parent, adult sibling
WA	Person responsible	1. Enduring guardian 2. Guardian 3. Spouse 4. Nearest relative, in the following order: spouse, child, parent, sibling 5. Primary (unpaid) carer 6. Any other person with a close and personal relationship with the person

Table 2. State and territory legislation, and relevant organisations for referral for substitute decision making.

State	Legislation	Relevant organisations
ACT	· *Guardianship and Management of Property Act 1991* · *Medical Treatment (Health Directions) Act 2006* · *Public Trustee and Guardian Act 1985 (ACT)* · *Power of Attorney Act 2006 (ACT)*	· Public Trustee and Guardian (ACT) · ACT Civil and Administrative Tribunal (ACAT) · Public Advocate – ACT Human Rights Commission
NSW	· *Guardianship Act 1987* · *Guardianship Regulations 2016* · *Powers of Attorney Act 2003 No 53*	· Public Guardian (NSW) · NSW Civil and Administrative Tribunal · NSW Trustee and Guardian
NT	· *Adult Guardianship Act 2016* · *Guardianship of Adults Regulations 2016* · *Northern Territory Civil and Administrative Tribunal Act 2014* · *Advance Personal Planning Act 2013 (NT) (the Act)*	· Northern Territory Civil and Administrative Tribunal · Office of the Public Guardian (NT)
QLD	· *Guardianship and Administration Act 2000* · *Public Guardian Act 2014* · *Human Rights Act 2019* · *Powers of Attorney Act 1998*	· Office of the Public Guardian (QLD) · Public Advocate (QLD) · Queensland Civil and Administrative Tribunal
SA	· *Consent to Medical Treatment and Palliative Care Act 1995* · *Consent to Medical Treatment and Palliative Care Regulations 2014* · *Advanced Care Directives Act 2013* · *Guardianship and Administration Act 1993* · *Guardianship and Administration Regulations 2015*	· Office of the Public Advocate · South Australian Civil and Administrative Tribunal
TAS	· *Guardianship and Administration Act 1995* · *Guardianship and Administration Regulations 2017* · *Guardianship and Administration (Corresponding Law) Notice 2014* · *Guardianship and Administration (Corresponding Law) Notice 2011*	· Office of the Public Guardian (TAS) · Guardianship and Administration Board
VIC	· *Guardianship and Administration Act2019* · *Guardianship and Administration Board (Application) Regulations 1994* · *Medical Treatment Planning and Decisions Act 2016*	· Office of the Public Advocate (VIC) · Victorian Civil and Administrative Tribunal
WA	· *Guardianship and Administration Act 1990 (WA)* · *Guardianship and Administration Regulations 2005*	· State Administrative Tribunal · Office of the Public Advocate (WA)

Further information

Older Persons Advocacy Network (OPAN), with the Aged Care Quality and Safety Commission, developed consumer resources relating to informed decision making and consent: https://opan.org.au/yourchoice/

Capacity Australia – also references and links to state and territory legislation in each jurisdiction, and includes mini tool kits: https://capacityaustralia.org.au/

Fact sheets and resources are also available at:

- Australian Commission on Safety and Quality in Health Care
- Department of Health

The Aged Care Quality and Safety Commission acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

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