Frequently asked questions about consent

What should be discussed when consent for a treatment, including use of a restrictive practice, is sought?

Conversations should cover the condition or behaviour being managed and the risks of this condition or behaviour, the options and alternatives for treatment, the risks and benefits of each option, including the risks and option of not treating the condition or taking action. The side effects, potential harms and what monitoring will occur must be clearly conveyed.

Proposed action to determine the effectiveness and impact of the treatment if started should also be discussed. The consumer or substitute decision maker must have sufficient information and time, including the opportunity to ask questions, and must come to an independent decision about the treatment/s being offered and consent to this.

For prescription of medications, the fact that a sufficient conversation has taken place with the prescriber to enable fully informed consent to be given should be conveyed in some way to the aged care provider and documented with a date.

Is it possible to obtain indefinite and/or blanket consent for treatment or medications, including restrictive practices?

No. Forms giving blanket and/or indefinite consent are insufficient for medical treatment or to allow for administration of medication. They clearly cannot allow for informed consent to be given in advance for unknown matters.

The information relevant to the individual circumstances and individual risks and benefits of each option needs to be communicated and discussed as clinical issues develop and change. This can only be done at the time a new treatment is offered or considered and should be reviewed as and when things change.

Seeking and accepting blanket consent for treatments including medications is contrary to law, the Aged Care Quality Standards and goes against the principles of person centred care.

When is a signed consent form *not* valid?

Forms asking a consumer or substitute decision maker to sign that they are giving informed consent are not valid if the informing and consenting process has not been properly completed. Signing of such forms will be invalid if no conversations take place with the appropriate professional(s) about the medication, treatment or restrictive practice.

These forms will also be invalid if the person who signs does not have the capacity or authority to make the decision being asked of them.

Does consent have to be in writing?

No. Consent can be given in person or in writing or over the phone to the prescriber, after the informing process has taken place with the consumer or identified correct substitute decision maker.

For prescription of medication, and where a consumer lacks capacity, the prescriber will need to establish the identity of the substitute decision maker before confidential information is discussed by phone. The conversation, or outcome of it at the very least, will of course be documented.

Aged care providers need to be satisfied that consent has been obtained from the correct decision maker.

Where a consumer lacks the capacity to consent to a decision, aged care providers have a responsibility to know who the substitute decision maker is and the types of decisions they are authorised to make on behalf of the person.

How will a provider know if informed consent has been obtained?

Providers need to have systems in place to ensure (and be able to demonstrate) that the following processes are occurring:

- Documenting provision of informed consent for a treatment or practice, including for use or application of restrictive practices
- Understanding and documenting who a substitute decision maker may be for a person, and what they are authorised to consent for on behalf of that person
- Documenting that the prescribing professional has gained appropriate informed consent
- Communicating with family members or substitute decision makers that consent for a practice is or may be required
- Communicating with a substitute decision maker that a restrictive practice, which may include a medication, has been used or administered for a consumer in an emergency situation, and documenting that communication.

Each provider should determine how this system works for their service and consumers, including links with medical professionals who may prescribe, recording methods and practices for clinical notes, and the preferred method of communication between the service, each consumer and their family.

Can consumers or their family members request specific medical treatments/practices?

Consumers, substitute decision makers and family members can suggest or request options for treatment, including prescription of medications. They can also raise concerns about treatments being offered or used. They cannot however compel a GP or other professional to prescribe a medication if the professional is of the view that it will not be of potential benefit to the person, taking into account all relevant considerations including clinical and financial harm.

Can consumers or their substitute decision makers (SDMs) seek a second opinion?

Yes. Consumers and SDMs have the right to ask for, and should be supported to seek, a second opinion for any treatment, including for use of medications or restrictive practices.

When should the Guardianship Tribunal be contacted?

Sometimes there are complexities or matters of dispute about treatment such as between family members, or where the substitute decision maker identification is not clear, or where the substitute decision maker is manifestly making decisions based on conflicts of interest or is acting contrary to the consumer's best interests. These matters may need advice from or referral to the relevant Tribunal to determine the best course of action to protect the consumer's interests.

Referral to a guardianship tribunal should not occur if a family member simply does not agree to a course of action chosen by a consumer, when the consumer has capacity to provide informed consent for treatment or interventions themselves.

Is informed consent required for medications which are not being used as a chemical restraint?

Yes. The legislation about restrictive practices in aged care clearly specifies the need for fully informed consent for use of chemical restraint (as well as other forms of restrictive practices). However, this must not be taken to imply that informed consent is required only for medication used as chemical restraint.

The requirement for informed consent more broadly has been included in State and Territory legislation for many years, and treatments including medications continue to require informed consent by the person receiving the treatment or a substitute decision maker. This is especially important for high risk medications such as psychotropics or anticoagulants where the person giving consent needs to clearly understand the risks and benefits in their individual circumstances, in an ongoing way.

Acknowledgment

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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