Policy Directive: compliance is mandatory

Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained Policy Directive

Objective file number: eA873470
Policy developed by: Legal, Governance and Insurance Services, Finance and Corporate Services
Approved at Portfolio Executive on: 5 December 2014
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Summary
The purpose of the Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained Policy Directive is to assist health practitioners in meeting their legal obligations with respect to providing medical assessment and/or treatment where consent cannot be obtained from a patient.

Keywords
Consent, restrictive practices, reasonable force, seclusion, Restraint, medical assessment, treatment, Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained Policy Directive

Policy history
Is this a new policy? N
Does this policy amend or update an existing policy? Y v3.0
Does this policy replace an existing policy? N
If so, which policies?

Applies to
All SA Health Portfolio

Staff impact
All Staff, Management, Admin, Students, Volunteers
All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology

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Providing medical assessment and/or treatment where patient consent cannot be obtained

Policy Directive
### Document control information

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<th>Document owner</th>
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### Endorsements

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1. **Objective**

The purpose of this directive is to assist health practitioners in meeting their legal obligations with respect to providing medical assessment and/or treatment where consent cannot be obtained from a patient.

As a general rule, consent must be obtained before any type of medical assessment and/or treatment is undertaken, regardless of the type of medical assessment and/or treatment required. Consent is a patient’s agreement for a health practitioner to provide medical assessment and/or treatment.

For consent to be valid, it must be voluntary and clear, and the patient consenting must have decision-making capacity. These terms are explained below.

- **Voluntary**: the decision to consent or not consent to treatment must not be made due to pressure or coercion. Therefore it must not be made due to pressure by health practitioner, friends or family although a patient may choose to have one or all involved in the decision-making process.
- **Clear**: the patient must expressly or implicitly be consenting to all aspects of the treatment.
- **Decision-making capacity**: the person must be capable of giving consent. A person has decision-making capacity, in relation to a specific decision, if they can:
  1. Understand information about the decision.
  2. Understand and appreciate the risks and benefits of the choices.
  3. Remember the information at least for a short time.
  4. Tell someone what the decision is (in any manner).

Further, impaired decision-making capacity must not be inferred simply from the fact that the decision is perceived by staff as being “irrational” in the sense that it is not one that would be made by the vast majority.

The health practitioner has an obligation to provide the patient with full information, in a format they can understand, on the available treatment options and benefits and consequences of each option, including not having any treatment. However, a patient with decision-making capacity may choose to give or refuse consent without the benefit of full information and advice, and the consent will still be valid including when given in advance in a provision of an Advance Care Directive.

Where a patient has decision-making capacity and makes a voluntary decision to refuse medical assessment and/or treatment, despite advice from the health practitioner to the contrary, the decision must be respected even if the treatment is life saving and the patient’s decision ultimately leads to their death.

**The Law**

There are four pieces of legislation that provide lawful authority for the purpose of providing medical assessment and/or treatment where the patient themselves has impaired decision-making capacity to provide consent. The relevant provisions are found in the following Acts:

- *Consent to Medical Treatment and Palliative Care Act 1995*
- *Mental Health Act 2009*
- *Guardianship and Administration Act 1993*
- *Advance Care Directives Act 2013*
This Policy Directive details the legal framework which sets out under what circumstances medical assessment and/or treatment can be administered where consent cannot be obtained from the patient, and also gives guidance to staff on what to do when the legal situation is unclear.

Health practitioners are advised to read this Policy Directive carefully. Continuing to provide treatment where a patient with decision-making capacity, their Substitute Decision-Maker or Person Responsible has refused to consent, or against a relevant refusal in an Advance Care Directive, may constitute assault and battery and/or unlawful imprisonment and could lead to civil or criminal charges being raised against the health practitioner. Where a health practitioner is subject to criminal proceedings (not civil), it is the responsibility of the health practitioner to arrange his or her own legal representation. Refer to section 4.11 Indemnity for further information on this.

This policy should be read in conjunction with the SA Health ‘Guidelines for Consent to Treatment and Related Medical Procedures’ and the ‘Advance Care Directive’ Policy Directive.

2. Scope

This directive applies to situations where medical assessment and/or treatment is required but consent cannot be obtained from the patient. This Policy Directive applies to medical practitioners, Authorised Officers (as defined under the Mental Health Act 2009), health professionals and other health practitioners who may assist in the provision of medical assessment and/or treatment where consent from the patient cannot be obtained. It provides guidance on the legal framework where:

1. Consent is sought from a third party for a patient who is deemed to need medical assessment and/or treatment and is unable to consent.
2. Third party consent cannot be obtained in an emergency.
3. The patient may require the use of restrictive practices to allow medical assessment and/or treatment to occur.

2.1 Nurses, midwives and other health professionals

In circumstances where nurses, midwives and other health professionals have provided medical assessment and/or treatment where the consent of the patient could not be obtained, and utilised restrictive practices to provide the treatment, they will be afforded the same indemnity as set out in section 4.11 of this directive.

3. Principles

This directive is underpinned by the following core principles:

1. A patient (of or over 16) with decision-making capacity has the legal and ethical right to make their own decisions about medical treatment options, including refusal of medical assessment and/or treatment.
2. All patients should have their dignity respected.
3. If it is deemed that a patient has impaired decision-making capacity, it is desirable that they be supported to make their own decision to the extent they are able.
4. A patient who is deemed to have impaired decision-making capacity cannot either give or withhold consent; therefore a provision in an Advance Care Directive (constituting consent), or a Substitute Decision-Maker, or in the absence of an Advance Care Directive, a Person Responsible, can consent to the medical assessment and/or treatment for the patient, including refusing treatment.
5. Medical assessment and/or treatment must be provided in the least restrictive way and in the least restrictive environment that is consistent with the patient’s proper care and protection, treatment efficacy and public safety.
6. A person with lawful authority to consent to medical treatment does not necessarily have the authority to consent to restrictive practices. The hospital must not restrain or use force to treat or assess the patient in the absence of proper authority to do so.

7. The use of restrictive practices to allow medical assessment and/or treatment to be administered must only be undertaken to the extent that it is reasonably necessary.

8. The use of restrictive practices on a patient who does not have capacity must be a last resort and will only occur where the health practitioner believes a failure to do so could put the patient or public at a significant health or safety risk.

4. Detail

4.1 Patients' Capacity to Consent

All patients are presumed to have decision-making capacity about their own medical treatment unless there is significant evidence to suggest otherwise following initial assessment.

A person has decision-making capacity, in relation to a specific decision, if they can:

1. Understand information about the decision.
2. Understand and appreciate the risks and benefits of the choices.
3. Remember the information even if only for a short time.
4. Tell someone what the decision is (in any manner).

A person’s decision-making capacity relates to their ability to make a particular decision. It is not a global assessment of a person’s ability to manage their own affairs and it is not linked to a diagnosis. Determining whether a person has decision-making capacity is not necessarily a medical assessment. It is the ability to think, understand, make a decision and communicate this in some way; it is not dependent on verbal or written communication. A person’s decision-making capacity can fluctuate. A person may have impaired decision-making capacity temporarily or permanently.

See Attachment 1 – What is capacity and how is it assessed Fact Sheet. This Fact Sheet is also available on the SA Health website.

If a patient has given an Advance Care Directive, and time permits, under the Advance Care Directives Act 2013 the Office of the Public Advocate can issue a declaration in relation to the patient’s decision-making capacity, eg a declaration stating that the patient does/does not have impaired decision-making capacity in relation to the decision.

Health practitioners and staff in emergency departments may encounter aggression and violence at some stage. In these circumstances health practitioners will need to make an initial assessment based on the patient’s physical and mental wellbeing and factoring in the patient’s behaviour and information from third parties (including ambulance officers or police), and decide whether to proceed with medical treatment without the consent of the patient. Such behaviour may be caused by a physical illness, a psychiatric illness, drug induced mental illness, extreme alcohol or drug intoxication, intellectual impairment or acquired brain injury. These problems can occur in combination. However, of itself, the patient’s behaviour may not be indicative of his or her decision-making capacity.

Where a patient is assessed to have impaired decision-making capacity, is exhibiting challenging behaviours, and de-escalation techniques have no effect, the use of restrictive practices may need to be considered to allow a more detailed assessment and medical treatment to take place.

It should be noted that a health practitioner’s initial assessment may change following a more detailed medical assessment and it is vital that the initial assessment, as well as
subsequent assessments, are documented in the patient’s medical record (refer to part 4.10 of this Policy Directive).

For more information regarding aggression and violence in the workplace please refer to the SA Health Prevention and Management of Workplace Violence and Aggression Policy.

Where a patient who has decision-making capacity refuses a medical assessment and/or treatment the health practitioner must not proceed with treatment, authorise any restrictive practices or prevent the patient from leaving. The same applies to a relevant refusal of health care in an Advance Care Directive or where a Substitute Decision-Maker or Person Responsible has refused health care on behalf of the person.

4.2 If emergency medical treatment is required and a patient cannot consent—Consent to Medical Treatment and Palliative Care 1995 (The “Consent Act”)

Section 13 of the Consent Act sets out the circumstances in which a medical practitioner can lawfully administer emergency medical treatment without the patient’s consent:

- the patient is incapable of consenting whether or not they have impaired decision-making capacity (e.g. unconscious, excruciating pain from major trauma); and
- the medical practitioner who administers the treatment is of the opinion that the treatment is necessary to meet an imminent risk to the patient’s life or health and that opinion is supported by the written opinion of another practitioner who has personally examined the patient (a written supporting opinion is not necessary if in the circumstances it is not practicable to do so); and
- the patient (if of or over 16 years of age) has not, to the best of the medical practitioner’s knowledge, refused to consent to the treatment; and
- the medical practitioner proposing to administer the treatment has made, or has caused to be made, reasonable inquiries to ascertain whether the patient (if the patient is 18 or more years of age) has given an Advance Care Directive (if time permits) and
- an appointed Substitute Decision-Maker (under an Advance Care Directive) or a Person Responsible (s14 of the Consent Act) is not available to consent to the emergency treatment.

Note:
In the above instance, an ‘emergency’ is described as being a situation where the treatment is needed to save the patient’s life, to prevent serious future harm or danger to the patient’s health.

Section 13 of the Consent Act applies only to emergency treatment provided by a medical practitioner. However, other hospital staff acting at the direction of the practitioner in the provision of treatment will in general incur no liability.

Impaired decision-making capacity is defined as when the patient is not capable of—

- understanding information that may be relevant to the decision (including consequences of having or not having the treatment/health care); or
- retaining such information even if for a limited time; or
- using such information in the course of making the decision; or
- communicating his or her decision in any manner.

It may be deemed the patient has impaired decision-making capacity by reason of being comatose or otherwise unconscious.
The patient will not be taken to be incapable of understanding or retaining information merely because they do not understand technical or trivial matters or because they can only retain the information for a limited time.

A patient’s decision-making capacity may fluctuate between being capable and incapable.

A patient’s decision-making capacity will not be taken to be impaired merely because a decision made by the person results or may result in an adverse outcome for the person.

Examples of when a patient may have impaired decision-making capacity include: the patient is comatose or otherwise unconscious, has end-stage dementia, or is under the influence of drugs or alcohol.

A provision of an Advance Care Directive comprising a refusal of particular health care will be taken to be a binding provision. A failure to comply with a valid and applicable refusal of treatment may result in the health practitioner incurring criminal or civil liability for providing the treatment without consent, or may risk a complaint being made to the relevant health practitioner Board for unprofessional conduct.

If a health practitioner has a conscientious objection to complying with a person’s Advance Care Directive/Substitute Decision-Maker’s decision, the practitioner must hand over the care of the person to another practitioner in accordance with the practitioner’s professional Code of Conduct (issued by the relevant health practitioner Board).

A medical practitioner may lawfully administer medical treatment despite a provision of an Advance Care Directive given by the patient comprising a refusal of medical treatment if—

- the patient is incapable of consenting (whether or not the patient has impaired decision-making capacity in respect of a particular decision); and
- the medical practitioner who administers the treatment is of the opinion that the treatment is necessary to meet an imminent risk to life or health and that opinion is supported by the written opinion of another medical practitioner who has personally examined the patient (a written supporting opinion is not necessary if in the circumstances it is not practicable to do so); and
- the medical practitioner who administers the treatment reasonably believes that the provision of the Advance Care Directive is not intended to apply—
  - i. to treatment of the kind proposed; or
  - ii. in the circumstances in which the proposed medical treatment is to be administered; and
- it is not reasonably practicable in the circumstances of the case to have the matter dealt with using the advice or mediation service provided by the Office of the Public Advocate as set out under Part 7 of the Advance Care Directives Act 2013 - see part 4.6 of this Policy Directive for Dispute Resolution processes.

This may be the case if the refusal is ambiguous, and there is no time to clarify the Advance Care Directive provision/s or the person’s condition, or to discuss it with an appointed Substitute Decision-Maker (if any) or a Person Responsible.

This means that a medical practitioner must comply with a binding refusal of health care unless it is an emergency and the medical practitioner is of the opinion that the refusal was not intended by the person to apply to the current condition or circumstance.

The reasons for ignoring a refusal of health care should be clearly documented in the patient’s medical record.

See below for emergency treatment of children (patients 15 years or younger)
4.3 Non-emergency treatment where patient consent cannot be obtained because of impaired decision-making capacity - Consent Act

In a non-emergency situation, if a patient cannot consent to medical treatment because of impaired decision-making capacity, a medical practitioner must seek consent from a Substitute Decision-Maker appointed to make decisions relating to health care in an Advance Care Directive or in accordance with a relevant provision in an Advance Care Directive (constituting consent). A decision by the Substitute Decision-Maker, and/or a relevant provision in an Advance Care Directive is deemed to have the same effect as if the patient gave the consent, or refused consent themselves.

NOTE: For further information about the application of Advance Care Directives, including health practitioners’ obligations and protections, refer to the Advance Care Directives Policy Directive.

In the absence of a Substitute Decision-Maker appointed under an Advance Care Directive or a relevant provision in the Advance Care Directive, Part 2A of the Consent Act provides that, where it is proposed to administer medical treatment or health care to a patient (of or over the age of 16) with impaired decision-making, a Person Responsible can consent/withhold consent to the medical treatment/health care being proposed. Part 2A of the Consent Act does not relate to patients under the age of 16.

Person Responsible for the patient means a person below listed in the following legal order:

a) A guardian appointed by the Guardianship Board; or if a guardian has not been appointed
b) a prescribed relative* with a close and continuing relationship with the patient who is available and willing to make the decision; or if none of the above apply
c) an adult friend who has close and continuing relationship with the patient who is available and willing to make the decision; or if none of the above apply
d) an adult charged with overseeing the day to day supervision, care and wellbeing of the patient who is available and willing to make the decision; or

e) If none of the above apply, or otherwise with the permission of the Guardianship Board - the Guardianship Board on application of-
   (i) a prescribed relative of the patient; or
   (ii) the medical practitioner proposing to give the treatment; or
   (iii) any other person who the Board is satisfied has a proper interest in the matter.

*A prescribed relative of the patient includes the following:
   a) A person who is legally married to the patient;
   b) An adult domestic partner of the patient;
   c) An adult related by blood or marriage;
   d) An adult related to the patient by reason of adoption;
   e) An adult related to the patient according to Aboriginal kinship rules or Torres Strait Islander kinship rules.

There is no hierarchy within the list of prescribed relatives.

In order to provide guidance to health practitioners a flowchart has been developed to help determine from who/where to obtain consent. Refer to Attachment 2 – Consent to Medical Treatment and Healthcare – (Flow Chart for patients 16 years or over).

If the medical practitioner is made aware that an adult patient has an Advance Care Directive and/ or has appointed a Substitute Decision-Maker, any medical treatment must only be administered in line with a relevant provision of the Advance Care Directive (constituting consent) or with the consent of the patient’s Substitute Decision-Maker(s). A
Substitute Decision-Maker cannot refuse the natural provision of food and water or pain/distress relieving drugs.

In the absence of a Substitute Decision-Maker or relevant provision in an Advance Care Directive, a Person Responsible can consent to the medical treatment. A decision by a Person Responsible is deemed to have the same effect as if the patient gave the consent/withheld consent themselves.

Protection will be afforded to health/medical practitioners who comply with a patient’s Advance Care Directive in good faith and without negligence, including compliance with the consent (or withholding of consent) of the patient’s Substitute Decision-Maker or Person Responsible.

As a routine part of the admissions process, identify and document in the person’s medical record, the patient’s Person Responsible or Substitute Decision-Maker (when appointed in an Advance Care Directive) and their current contact details.

Systems and practice for collecting and recording patient and Person Responsible or Substitute Decision-Maker information should undergo monitoring and evaluation through quality improvement activities and action taken on identified issues.

4.6 Dispute Resolution under the Consent Act and the Advance Care Directives Act 2013

Local Health Networks should have staged dispute resolution processes locally, such as Advance Care Directive/Consent Mentors or Advisers or clinical ethics committees, to assist in resolving disputes about consent and/or Advance Care Directives. This service should be available 24/7.

If disputes, including those related to children, cannot be resolved locally, the Office of the Public Advocate is able to provide advice or mediate disputes onsite through a 24 hour service. The Office of the Public Advocate can be contacted on Toll Free (for country SA only) 1800 066 969 or 8342 8200 and has fact sheets about this service available on its website: http://www.opa.sa.gov.au/what_we_do/dispute_resolution_service

NOTE: This is a 24hr service (emergency matters only after hours).

It is not appropriate for the Guardianship Board to be the first point of contact to resolve disputes. Rather the Guardianship Board should be the last resort point of contact to assist in resolving disputes. Applications can be made or disputes can be referred to the Guardianship Board by the Office of the Public Advocate on the grounds that it is more appropriate for the matter to be dealt with by the Guardianship Board, or if certain persons are dissatisfied with a decision by the Office of the Public Advocate. If a decision cannot be made, problems arise with decisions made under an Advance Care Directive and/or by a Substitute Decision-Maker, or there are concerns about the decision of a Person Responsible, the wishes (whether expressed or implied) of the person who gave the Advance Care Directive are of paramount importance and should, as far as is reasonably practicable, be given effect.

4.7.2 Restrictive practices and the Guardianship and Administration Act 1993

It may be necessary for a Substitute Decision-Maker appointed under an Advance Care Directive or a guardian to seek extra powers to authorise the use of restrictive practices to allow medical treatment to occur. A Person Responsible (not including an appointed guardian or the Guardianship Board) cannot apply to the Guardianship Board for extra powers without first (or at the same time) applying to be appointed as a guardian of the patient.

A Substitute Decision-Maker, guardian or applicant for guardianship can apply to the Guardianship Board for additional powers (under s 32 of the Guardianship and
Administration Act 1993) which can authorise the use of restrictive practices to facilitate the treatment or care of the patient.

Following an order from the Guardianship Board if a Substitute Decision-Maker appointed under the Advance Care Directive, or a guardian or medical practitioner is uncertain of what restrictive practices can be consented to, they should be advised to contact the Office of the Public Advocate.

When acting in anticipation of guardianship orders, it is vital that the health practitioner ensures that the medical records of the patient reflect the issues and support the decision to seek extra powers to use restrictive practices under section 32 of the Guardianship and Administration Act 1993, and that this is formally supported (with notes signed) by another medical practitioner and is clearly documented in the medical record of the patient.

Non urgent applications to the Guardianship Board must be in writing and will be considered by the Guardianship Board before a hearing. Application forms are available:
1) via the website at the following link:
2) Level 8, ABC Building, 85 North East Road, Collinswood, 5081,
   • Telephone- 8368 5600
   • Toll Free- 1800 800 501

4.8 If a person cannot consent because of mental illness – Mental Health Act 2009

If upon initial assessment by a Psychiatrist, Medical Practitioner or an Authorised Officer/Health Professional, it appears that a person presenting to the health site is suffering from a mental illness that requires treatment to protect the person or others from harm, the health practitioner may make an inpatient treatment order for the patient to receive involuntary treatment in accordance with section 21 of the Mental Health Act 2009.

Section 21 of the Mental Health Act 2009 provides for the involuntary inpatient treatment of individuals under an inpatient treatment order made by a Psychiatrist, Medical Practitioner or Authorised Health Professional when:-

- the person appears to have a mental illness; and
- because of the mental illness, the person requires treatment for the person’s own protection from harm (including harm involved in the continuation or deterioration of the person’s condition) or for the protection of others from harm; and
- there is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person’s illness.

In deciding whether there is no less restrictive means of treatment, the Mental Health Act 2009 states consideration must be given, amongst other things, to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis or on a community treatment order.

NOTE: Schedule 1 of the Mental Health Act 2009 lists certain types of conduct that may not indicate mental illness (refer to Attachment 4 for a copy of this schedule).

An inpatient treatment order authorises the involuntary inpatient treatment of a patient in a treatment centre so that psychiatric treatment can be given. People who are subject to inpatient treatment orders are required to stay in the centre and receive treatment for a mental illness, even if they do not want to.

People who are involuntary inpatients can also be required to receive medical treatment for any other illness.

Treatment centre staff may take measures for the confinement of a person subject to an inpatient treatment order and may use such force as is reasonably necessary to treat the
person or to maintain order and security at the centre or to prevent harm or nuisance to others.

Section 42 of the Mental Health Act 2009 provides specific consent requirements for administering Electro-convulsive therapy (ECT).

ECT must not be administered to a patient unless:
- the patient has a mental illness; and
- ECT, or a course of ECT, has been authorised for treatment of the illness by a psychiatrist who has examined the patient; and
- written consent to the treatment has been given:
  (a) by the patient (including a relevant provision in an Advance Care Directive), if the patient has attained 16 years of age and has decision-making capacity; or
  (b) if the patient has attained 16 years of age and is incapable of making decisions, by a Substitute Decision-Maker or Person Responsible, or by the Guardianship Board
  (c) if the patient is under 16 years of age, by a parent or guardian of the patient or by the Guardianship Board.

If a person has refused ECT in their Advance Care Directive and the refusal is applicable to the current clinical situation, then it cannot be provided.

If the treating team or a person with a proper interest has concerns about the decision to refuse ECT, advice can be sought from the Public Advocate, who can mediate with the dissenting parties and/or refer the matter to the Guardianship Board to consider the validity of the Advance Care Directive, or the decision-making capacity of the person or their Substitute Decision-Maker.

However if there is an imminent risk to the person’s health or life, and the medical practitioner believes the Advance Care Directive was not intended to apply in the current circumstances, and the patient is incapable of consenting, and there is no guardian, Substitute Decision-Maker or Person Responsible available to consent, emergency ECT may be provided in accordance with section 42 of the Mental Health Act 2009.

For more information see the Advance Care Directives and Mental Health Treatment Orders Fact Sheet:

4.8.2 Powers of Authorised Officers relating to persons who appear to have a mental illness

Authorised Officers are a category of people described in section 3 of the Mental Health Act 2009 who may exercise the following listed powers in relation to a person where it appears to an Authorised Officer that the person has a mental illness; and the person has caused, or there is significant risk of the person causing, harm to himself or herself or others or property, or the person otherwise requires medical examination, or that the person is a patient subject to an inpatient treatment order and is at large, or that the person is the subject of a patient transport request under s55 of the Mental Health Act 2009:
- Take the person into his or her care and control
- Transport the person from place to place
- Restrain the person and otherwise use force in relation to the person as reasonably required in the circumstances
- Restrain the person by means of the administration of a drug when that is reasonably required in the circumstances

1 If authorised to do so under the Controlled Substances Act 1984
• Enter and remain in a place where the Authorised Officer reasonably suspects the person may be found

• Search the person’s clothing or possessions and take possession of anything in the person’s possession that the person may use to cause harm to himself or herself or others or property.

An Authorised Officer who takes a person into their care and control must, as soon as practicable:

• In the case of a person who is subject to a Patient Transfer Request, transport the person, or arrange for the transport of the person by some other Authorised Officer or police officer, in accordance with the request,

• In the case of a person who is subject to an inpatient treatment order and is absent without leave from an approved treatment centre, transport the person, or arrange for the transport of the person by some other Authorised Officer or police officer, to a treatment centre,

• In the case of a person who appears to have a mental illness and is at risk to themselves or others or property, transport the person, or arrange for the transport of the person by some other Authorised Officer or police officer, to a treatment centre or other place for medical examination.

4.8.3 Who is an Authorised Officer?
Authorised Officers are determined by the Mental Health Act 2009 to be:

• **Mental health clinicians** (a person or a class of persons who are engaged in the treatment or care of a patient and classified by the Chief Psychiatrist as a mental health clinician for the purposes of the Mental Health Act 2009), which include:
  o Employees of public mental health services, comprising: Aboriginal health workers, occupational therapists, psychiatrists, psychologists, registered nurses and social workers.
  o Employees of public emergency departments as authorised by the Director of an emergency department, comprising: medical practitioners and registered nurses.
  o Employees of public country hospitals as authorised by the CEO of Country Health SA, comprising: medical practitioners and registered nurses.
  o Employees of the prison health service, comprising: medical practitioners and registered nurses.
  o Experienced custodial officers as authorised by the General Manager of a prison.
  o Privately employed psychiatrists.

• **Ambulance officers**
  o A person employed or volunteering as an Ambulance Officer and authorised by the CEO of the SA Ambulance Service to exercise the powers of the Act
  o The paramedic officers present on all MedSTAR retrieval teams.

• **Royal Flying Doctor Service medical officers or flight nurses**

• **Police officers**, although separately empowered under the Mental Health Act 2009, have a range of powers similar to Authorised Officers, with the exception of not being able to administer medication and the addition of being able to use reasonable force to break into a place to take someone into care and control.

Refer to Attachment 5 for a summary of authorised powers in Emergency Departments.
4.8.4 If a person cannot consent because of intoxication

The consumption of drugs or alcohol does not, in and of itself, indicate that a person is suffering from a mental illness.

However a patient presenting with serious temporary or permanent physiological, biochemical or psychological effects from taking drugs or alcohol may be placed on an inpatient treatment order and treated in accordance with the Mental Health Act 2009 if the effects of the drugs or alcohol are producing symptoms that appear to be symptoms of a mental illness.

Note: where a patient does not appear to be suffering from a mental illness however the clinician believes the high level of intoxication poses an imminent threat to life or health, a patient may be provided medical treatment in accordance with section 13 of the Consent Act:  See part 4.3.1 of this Policy Directive

Refer to Attachment 4: Schedule 1—certain conduct may not indicate mental illness.

4.9 If a person with decision-making capacity refuses to consent to treatment

If a patient with decision-making capacity refuses medical assessment and/or treatment, then the health practitioner should not proceed with the medical assessment and/or treatment or authorise any restrictive practices or prevent the patient from leaving. It is the responsibility of the health practitioner to ensure the patient is informed of any risks associated with not having the assessment and/or treatment and subsequent leaving of the health service. If necessary, the health practitioner should suggest that the patient obtain a second opinion from another health practitioner.

It is recognised that in some circumstances health practitioners will feel that although they have no legal authority to provide medical assessment and/or treatment without the consent of a patient they feel that should the patient leave the premises against medical advice the patient may be a risk of harm to themselves or others. For example, a patient who is intoxicated but not to a level that poses an imminent threat to their life or health (Consent Act) or they do not appear to be suffering from a alcohol/drug induced mental illness (Mental Health Act 2009).

If a patient continues to refuse the recommended treatment, then this refusal should be clearly documented using the Acknowledgment of Medical Advice Form (refer to Attachment 2) and recorded in the patient’s file. The patient should also be encouraged to inform his or her family, Substitute Decision-Maker and Person Responsible of this decision.

If a patient with decision-making capacity chooses to leave against advice and the health practitioners believes the patient is at risk to him/herself or others then the SA Police should be contacted and advised of the circumstances.

SA Police have various powers that allow them to approach a person and either bring them back to facilitate a medical examination (under section 57 Mental Health Act 2009) or transport them to a sobering up centre (under the Public Intoxication Act 1984) if applicable.

4.9.1 Patients whose decision-making capacity is in doubt

Where the patient’s decision-making capacity is in doubt and the legal authority to provide medical treatment may not be clear, health practitioners should assess if the person has decision-making capacity (see Attachment 4) and/or seek further expert clinical advice on the options available. It is essential that the assessment process is documented in the patient’s medical record. Refer to part 4.10 of this Policy Directive.

For more information see Attachment 1 - Assessing Capacity Fact Sheet.
4.10  Documentation

Factual documentation in the patient’s medical record outlining the clinical reasons and circumstances in which the medical assessment and/or treatment was provided without consent or whether third party consent was obtained, is essential. It is vital information in the event of any legal proceeding that may arise as a result of the provision of the medical assessment and/or treatment of a patient without the patient’s consent and/or with the use of restrictive practices.

The documentation must include as a minimum:

- the time and date of clinical assessment of the patient
- if the patient consented themselves and when
- description of the advice given by staff to the patient, including the risks and the language used to describe the risks
- the outcome of a decision-making capacity assessment
- outcome of clinical assessment of the patient e.g. patient appears to be with/without decision-making capacity/ patient appeared to understand and accept risks explained/ patient was confused and didn’t appear to understand the risks explained, therefore third party consent was sought
- if a Substitute Decision-Maker or Person Responsible consented on behalf of the person, when and why
- if the health care is administered in accordance with the wishes and instructions of the patient’s Advance Care Directive
- the reasons for administering health care contrary to the wishes and instructions of the patient’s Advance Care Directive or Substitute Decision-Makers decision
- where relevant, note if patient refused to sign Acknowledgment of Medical Advice Form (refer to Attachment 3)
- any witnesses to the discussion with the patient/Substitute Decision-Makers/Persons Responsible
- reasons for any restrictive practices that may have been utilised in the provision of medical treatment
- signature (where appropriate) of medical practitioner supporting reason to use restrictive practices on the patient to provide medical treatment.

4.11  Indemnity

In accordance with section 16 of the Consent Act, a medical practitioner responsible for the treatment or care of a patient, or a person participating in the treatment or care of the patient under the medical practitioner’s supervision, incurs no civil or criminal liability for an act or omission done or made—

(a) with the consent of the patient or the patient’s representative (third parties set out above) or without consent but in accordance with an authority conferred by this Act or any other Act; and
(b) in good faith and without negligence; and
(c) in accordance with proper professional standards of medical practice; and
(d) in order to preserve or improve the quality of life.

In accordance with section 41 of the Advance Care Directives Act 2013 a health practitioner, Substitute Decision-Maker or other person incurs no criminal or civil liability for an act or omission done or made in good faith, without negligence and in accordance with, or purportedly in accordance with, an advance care directive.
A patient with decision-making capacity may refuse medical assessment and/or treatment at any time before and during the assessment or treatment. Continuing to provide the assessment and/or treatment when the patient has refused to consent may constitute assault and battery and/or unlawful imprisonment and could lead to civil or criminal charges being actioned against the health practitioner.

4.11.1 Civil claims regarding alleged unlawful treatment, detainment or other restrictive practices

In accordance with section 74 Public Sector Act 2009, no civil liability attaches to a public sector employee for an act or omission in the exercise or purported exercise of official powers or functions.

An action that would lie against a public sector employee lies instead against the Crown i.e. the relevant Government Agency, in this instance the relevant Local Health Network (LHN) or SA Ambulance Service (SAAS).

This section does not prejudice rights of action of the Crown or a public sector agency in respect of an act or omission of a public sector employee that is not in good faith.

4.11.2 Criminal proceedings regarding alleged unlawful imprisonment or assault

Where a health practitioner is subject to criminal proceedings, for example a patient claims he or she has been unlawfully imprisoned or assaulted; the conditions for reimbursement of costs associated with defending the allegation will be in accordance with Legal Bulletin 20 as outlined below:

Due to a potential conflict of interest, the Crown will not represent an employee charged with an offence arising out of the performance of his or her duty. It is the responsibility of the employee to arrange his or her own legal representation. The employee must immediately report, in writing, the charge to his or her department or employer in accordance with standard procedures.

The decision as to whether or not the costs of the employee will be paid by the Government will be made on the completion of the case.

The Government may meet reasonable legal costs and expenses where:

1. the employee has been charged on information or complaint after a Police investigation where the charge relates directly to an incident arising from the discharge of the employee’s duties; and
2. the employee has been acquitted, the Court has found there is no case to answer or the prosecuting authority has withdrawn the charge; and
3. no dereliction of duty or other conduct on the part of the employee has been revealed rendering it inappropriate for him or her to be indemnified in respect of costs.

The Attorney-General will decide whether costs should be met having regard to the above criteria. Where the Attorney-General is of the opinion that costs should not be met, the Attorney-General will give the employee or his or her representatives the opportunity to make a written or oral submission before reaching a final decision.

4.11.3 Complaints to Statutory Authority

Health practitioners are entitled to seek their own legal and/or industrial representation in the case of any disciplinary proceedings.

As with medical malpractice, disciplinary proceedings in relation to false imprisonment and assault will not be covered by the Department for Health and Ageing.
4.12 Further Information

If a health practitioner requires further information or advice in relation to this area they are encouraged to contact the Department for Health and Ageing Legal and Governance Unit via mailto:Healthlegalrequests@health.sa.gov.au.

5. Roles and Responsibilities

5.1 Chief Executive SA Health is responsible for:

- Ensuring SA Health is aware of its legal obligations and potential consequences relating to the use of restrictive practices on patients and consent for medical assessment and/or treatment, including via third parties, and the legal circumstances under which treatment can be provided without consent and where applicable the use of restrictive practices.
- Ensuring appropriate training and support is provided to staff across SA Health to understand the application of this directive.
- Reporting to the Minister on compliance with this directive.

5.2 Executive Director, Public Health and Clinical Systems will:

- Monitor the implementation of this directive across SA Health.
- Ensure this directive is promoted across SA Health to increase awareness.
- Report to the Chief Executive on the compliance with this directive.

5.3 Chief Executive Officers – Local Health Networks & SAAS will:

- Ensure this directive is distributed across their health services.
- Provide necessary training to staff to ensure an understanding of this directive across the health services.
- Ensure health practitioners are well trained in the use of de-escalation techniques and associated tools, particularly within Emergency Departments.
- Ensure health practitioners are well trained in the application of restrictive practices and that other staff are aware of which clinicians have had such training, particularly in the Emergency Department.
- Report to the Department for Health and Ageing in relation to non-compliance with this Policy Directive as required.

5.4 Senior Managers (clinical services) will:

- Report any incidents or near misses through the Safety Learning System.
- Monitor incidents of the use of restrictive practices to debrief staff where required and inform future training of staff.
- Monitor incidents where treatment was provided without patient or third party consent.

5.5 Clinical Staff will:

- Adhere to the principles and aims of this directive and ensure they operate within the legislative framework detailed in this directive.
6. Reporting

- Reporting on compliance with this directive.
- Report to the Department for Health and Ageing in relation to non-compliance with this Policy Directive as required.
- Reporting of incidences where consent was not effectively obtained or incorrect processes of consent through the Safety Learning System
- Consumer experiences in relation to consent etc should be regularly reported

7. EPAS

N/A

8. Exemption

N/A

9. Associated Policy Directives / Policy Guidelines

- Guideline for Consent to medical treatment and health care (updated 2014)
- Your Rights and Responsibilities: A Charter for Consumers of the South Australian Public Health System
- SA Health’s Health Policy for Older Persons
- SA Health Prevention and Management of Workplace Violence and Aggression Policy

10. References, Resources and Related Documents

- Advance Care Directives Act 2013
- Consent to Medical Treatment and Palliative Care Act 1995
- Mental Health Act 2009
- Guardianship and Administration Act 1993
- Code of Ethics for the South Australian Public Sector
- SA Charter Health & Community Services Rights
- Criminal Law Consolidation Act 1935
- Public Sector Act 2009
- Office of the Public Advocate Restrictive Practices in Disability Settings Policy (July 2011 Version)
- Advance Care Directive fact sheet (PDF 80KB)
- Advance Care Directive frequently asked questions (PDF 96KB)
- Assessing Capacity fact sheet (PDF 87KB)
- How to certify copies of Advance Care Directives fact sheet (PDF 58KB)
- How to file hard copy Advance Care Directive, Advance Care Plan and Resuscitation Alert forms in medical records (PDF 371KB)
- Advance Care Directives and Mental Health Treatment Orders fact sheet (PDF 74KB)
- Supporting a person to make a decision fact sheet (PDF 65KB)
11. Other

N/A

12. National Safety and Quality Health Service Standards

The Australian Commission on Safety and Quality in Health Care has developed 10 National Safety and Quality Health Service Standards (the Standards).

The Standards provide a nationally consistent and uniform set of measures of safety and quality for application across a wide variety of health care services. They propose evidence-based improvement strategies to deal with gaps between current and best practice outcomes that affect a large number of patients.

Please identify how this policy directive contributes to any of the below listed standards:

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<td>Preventing &amp; Controlling Healthcare associated infections</td>
<td>Medication Safety</td>
<td>Patient Identification &amp; Procedure Matching</td>
<td>Clinical Handover</td>
<td>Blood and Blood Products</td>
<td>Preventing &amp; Managing Pressure Injuries</td>
<td>Recognising &amp; Responding to Clinical Deterioration</td>
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13. Risk Management

The risks associated with the non-compliance with this directive include:

- Potential risk to health practitioners and others assisting health practitioners in regards to legal proceedings related to alleged assault and battery, or unlawful imprisonment if an employee acts outside of the prevailing legal framework explained in this policy.
- There is a risk of adverse media attention for health services relating to any legal proceedings regarding allegations of assault and battery, or unlawful imprisonment if a health practitioner provides treatment without consent and or detains a patient without the lawful authority to do so.
- Failure by LHN/SAAS to ensure adequate training of staff in relation this directive.
- Failure by LHN/SAAS to ensure staff are well trained in de-escalation techniques and the use of restrictive practices.

14. Evaluation

Determine level of understanding by clinical staff following training regarding consent and lawful detainment of patients.

- Number of training sessions conducted regarding this directive.
- Increase understanding by clinicians of the legal framework governing the provision of medical assessment and/or treatment without consent.
- Number of staff attending training on use of restrictive practices/de-escalation techniques/determining decision-making capacity.
15. Attachments

Attachment 1: What is decision-making capacity and how is it assessed

Impaired Decision-Making Factsheet
A clear path to care

What is impaired decision-making capacity and how is it assessed?

The Advance Care Directives Act 2013 and the Consent to Medical Treatment and Palliative Care Act 1995 now specify when a patient is unable to consent/refuse. This is called impaired decision-making capacity. Assessing decision-making capacity is not a global assessment but decision specific and should be determined at the time consent is being obtained.

In respect of a particular decision, impaired decision-making capacity means the person is not capable of:
> understanding any information that may be relevant to the decision, including the consequences
> retaining such information, even for a short time
> using information to make decisions
> communicating the decision (in any way).

When determining if a person has decision-making capacity you may want to consider the following questions:

Does the person understand the nature and effect of the treatment at the time that the medical or dental decision is required, not hours or days before or after it is made?

Does the person know the ‘nature’ of the treatment? That means, do they understand broadly and in simple language:
> What the medical or dental treatment is?
> What the procedure involves?
> That there are other options? If choosing between options, the person must understand what each option is, what it involves, the effect of each option, and the risks and benefits of each option.
> What it will mean if they don’t have the treatment?

Does the person understand the ‘effect’ of the treatment? Are they aware, in simple terms, of the main benefits and risks of the treatment?

Does the person have the ability to indicate whether they want the treatment? Can they communicate any decision made, with assistance if necessary?

Has the person made the decision freely and voluntarily?

A person has a right to refuse treatment. If they have refused, consider the following:
> Is refusal of treatment consistent with the person’s views and values?
> Is this behaviour usual for the person?
> Has all the relevant information been given to the person in a way they can understand?

Tips on Questioning

Remember, when assessing whether a person has the capacity to make medical or dental decisions, it is important you:
> ask open-ended question
> do not ask leading questions
> try to quickly identify whether a person needs support or help to make the decision or requires a Substitute Decision-Maker to make a decision for them. In some circumstances the person may need support from a neutral person such as an advocate or an interpreter
> ensure it is the person being assessed who answers the questions.
Factsheet: What is impaired decision-making capacity and how is it assessed?

Questions to ask the patient
Here are some specific questions you may ask as part of the assessment process to determine if the person has capacity to make medical and dental decisions.

> Tell me about your health or teeth and why you need medical or dental treatment?
> What is the medical or dental treatment that you might be having? Can you explain it to me?
> Where will you be having the treatment? How long will it take?
> How will the treatment help you? What are the good things about the treatment?
> Will there be any bad things about the treatment? What are they?
> How do you think you will be able to deal with these?
> What are the risks of having the treatment?
> Is there any other treatment you might be able to have? Can you tell me about it?
> How would this other treatment help you?
> What are the risks of having this other treatment?
> Which do you think is the best treatment? Why?
> What would happen if you didn’t have any treatment at all?
> What do your family and friends think of the treatment?
> What do they want you to do? Why?

Case Study

Medical Decisions
‘Jovesa and I were visiting the doctor because he had developed tremors and a very fast heartbeat. The doctor explained that the problem was actually because of a part of his body in his neck called his thyroid. He needed medication and regular blood tests to monitor whether his new medication was working.

The blood tests showed that things were not settling down. The doctor then talked about what he could do next to stop the thyroid from causing these things to happen. He gave Jovesa a pamphlet to explain:
> why the thyroid was playing up and why the medication wasn’t working
> the different things that he could do to stop the thyroid causing problems
> the treatment he recommended for Jovesa and why
> the risks of having or not having the treatment
> that Jovesa has a right to decide whether or not to have the treatment.

The pamphlet used really simple language and photos to explain everything. When I took Jovesa home we went through the pamphlet together on a few occasions. I asked him various questions to work out whether he understood the information or not. Then we went back to the doctor. Jovesa told the doctor that he had decided to have the treatment, even though he was scared about it.

The doctor asked Jovesa some questions about how the treatment worked and why he had decided to have it, and came to the conclusion that he had the capacity to make the decision about the treatment himself.’

Felise, carer
Factsheet: What is impaired decision-making capacity and how is it assessed?

Other health decisions

There may be a need to assess the capacity of a person to make other health decisions, such as whether to:

- have a non-intrusive examination by a doctor or dentist, for example, having the mouth, teeth, throat, nose, ears or eyes looked at
- take over the counter chemist medication
- have alternative therapies.

The person needs to understand the nature and effect of the type of examination, medication or therapy that they are deciding upon.

You can use the capacity test (checklist and questions) above, as a guide to capacity assessment for other health decisions.

For more information

SA Health
Policy and Commissioning Division
Email: policy&legislation@health.sa.gov.au
Subject line: Advance Care Directive
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Providing Medical Assessment and/or Treatment where patient consent cannot be obtained Policy Directive Page 21 of 33
Appendix B- Consent to Medical Treatment and Health care – Adults Flow chart

Consent to Medical Treatment and Healthcare – Adults
From 1 July 2014, in accordance with the Advance Care Directives Act 2013 and the Consent to Medical Treatment and Palliative Care Act 1995

1. Does the patient have decision-making capacity to consent?  
   In relation to this particular decision, can they:  
   - Understand the information?  
   - Retain the information (even if only for a short time)?  
   - Use the information to make a decision?  
   - Communicate the decision (in any manner)?
   
   **YES**
   Seek consent from the patient
   
   **NO**

2. Can the decision be delayed until the patient regains decision-making capacity?
   
   **YES**
   Defer decision
   
   **NO**

3. Does the patient have an Advance Care Directive appointing a Substitute Decision-Maker (inc. Medical Agent or Enduring Guardian)?
   
   **YES**
   Seek consent from the Substitute Decision-Maker.  
   They must try and follow any relevant instructions.  
   Relevant refusals of health care are binding.
   
   **NO**

4. Does the patient have an Advance Care Directive (inc. Anticipatory Direction) with relevant instructions but with no appointed Substitute Decision-Maker.
   
   **YES**
   - Provide treatment in accordance with the relevant instruction.  
   - Comply with any relevant (binding) refusal of health care.  
   (Do not provide the health care that has been refused).
   
   **NO**

5. Seek consent of the Person Responsible*
   
   *See Fact Sheet: Who can consent? for more information.

**A Person Responsible is in the following legal order:**
1. a guardian (appointed by the Guardianship Board)
2. a spouse/domestic partner**
   - adult related by blood or marriage, or adoption**
   - Aboriginal or Torres Strait Islander kinship/marriage**
3. an adult friend**
4. an adult charged with overseeing the day-to-day care of the person
5. the Guardianship Board, upon application (this is a last resort)

**the person must have a close and continuing relationship with the person and be available and willing to make the decision

IN AN EMERGENCY
If the patient does not have decision-making capacity, and it has not been possible to find one of the above documents or individuals in time, or the Advance Care Directive is not relevant, or is unclear, provide treatment in line with section 13 of the Consent to Medical Treatment and Palliative Care Act 1995

For more information


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Providing Medical Assessment and/or Treatment where patient consent cannot be obtained Policy Directive Page 22 of 33
Attachment 3: Acknowledgment of Medical Advice form

**ACKNOWLEDGMENT OF MEDICAL ADVICE**

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**Patient, Substitute Decision-Maker or Person Responsible to tick the boxes on the side of the form to affirm the following:**

**SECTION 1. DISCHARGE AT OWN RISK**

- I ................................................................................................................................. am removing (First or Given names) (Surname) myself/ my dependant*** (specify name) from ................................................................................................................................. (Insert name of Local Health Network or Health Service) (“the Local Health Network”) at my own insistence and against the advice of the medical practitioner and other Local Health Network staff.

- I have had the consequences and risks of discharging myself/dependent*** explained to me.

- I hereby agree to release and discharge the Local Health Network, its servants or agents, from and against any and all claims arising out of my decision to discharge myself/dependent.***

- I also agree to indemnify the Local Health Network, its servants or agents from and against any and all claims arising out of my decision to discharge myself/dependent.***

**Signature:** .................................................................................................................. Date: ........../........./........

Witnessed by Medical Practitioner (Signature): ........................................................................ Date: ........../........./........

Witnessed by Registered Nurse (Signature): ........................................................................ Date: ........../........./........

In the event that the medical practitioner is not available, a registered nurse may witness the form.

**SECTION 2. OWN RISK BEHAVIOUR**

- I ................................................................................................................................. am a patient/Substitute Decision-Maker/ or Person Responsible of a patient*** at ................................................................................................................................. (“the Local Health Network”) wish to conduct the activities outlined below (specify activities):

**SIGNATURES**

- Signature: .................................................................................................................. Date: ........../........./........

Witnessed by Medical Practitioner (Signature): ........................................................................ Date: ........../........./........

Witnessed by Registered Nurse (Signature): ........................................................................ Date: ........../........./........
ACKNOWLEDGMENT OF MEDICAL ADVICE

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Patient, Substitute Decision-Maker or Person Responsible to tick the boxes on the side of the form to affirm the following:

SECTION 2. OWN RISK BEHAVIOUR (continued)

- [ ] I have had the nature, consequences and risks of my/ my dependant's behaviour explained to me.
- [ ] I hereby agree to release and discharge the Local Health Network, its servants or agents, from and against any and all claims arising out of my/ my dependant's decision to undertake the activity described above on behalf of myself/ my dependant.
- [ ] I also agree to indemnify the Local Health Network, its servants or agents from and against any and all claims arising out of my/ my dependant's decision to undertake the activity described above on behalf of myself/dependent.
(specify name of dependent if applicable***)

(First or given names) (Surname)

Signature of patient/ Substitute Decision-Maker/ Person Responsible: .......... Date: ........../........../.........

Witnessed by Medical Practitioner (Signature): ................. Date: ........../........../.........

Witnessed by Registered Nurse (Signature): ................. Date: ........../........../.........

In the event that the medical practitioner is not available, a registered nurse may witness the form.

*** DELETE WHERE NOT APPLICABLE
ACKNOWLEDGMENT OF MEDICAL ADVICE

Affix patient identification label in this box

UR No: ..................................................................................................................
Surname: .............................................................................................................
Given Names: .....................................................................................................
D.O.B: ................................................................................................................. Sex: ............................................................
Local Health Network: ..................................................................................

Patient, Substitute Decision-Maker or Person Responsible to tick the boxes on the side of the form to affirm the following:

SECTION 3. REFUSAL OF TREATMENT

I ...................................................................................................................................... (First or given names) (Surname)
withhold my consent for myself/my dependent***
............................................................................................................................................. (First or given names) (Surname)
to undergo the following procedure(s)/treatment (specify): .................................................................
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Signature patient/Substitute Decision-Maker/ Person Responsible of patient:  
........................................................................................................................................ Date: ……/……/……  
Witnessed by Medical Practitioner (Signature): .................................................. Date: ……/……/……

Witnessed by Registered Nurse (Signature): ............................ ........................ Date: ……/……/……

In the event that the Medical Practitioner is not available, a Registered Nurse may witness the form.

***DELETE WHERE NOT APPLICABLE

ACKNOWLEDGMENT OF MEDICAL ADVICE

Affix patient identification label in this box

UR No:  ..........................................................................................................................
Surname: ..............................................................................................................
Given Names: ........................................................................................................
D.O.B: ...................................................... Sex: ..................................................
Local Health Network: ......................................................................................

Patient, Substitute Decision-Maker or Person Responsible to tick the boxes on the side of the form to affirm the following:

SECTION 4. (A) REFUSAL OF BLOOD TRANSFUSION

☐ withhold my consent to and forbid under any circumstances the administration of blood or its derivatives to me/my dependent*** during this stay in hospital at

........................................................................................................................................
(specify name of the Local Health Network or Health Service)

The dependents name is***
........................................................................................................................................

☐ Refusal in an Advance Care Directive or Medical Directive Card for Jehovah’s Witness sighted:

☐ Yes ☐ No Type of document.................................................................

by: .................................................................................................................................
(Name of medical practitioner who sights Advance Care Directive/ Medical Directive Card)

☐ The possibilities of serious effects, consequences and risks of not permitting the administration of blood or its derivatives have been explained to me, and I understand them.

☐ I/my dependent*** will, however, accept non-blood plasma expanders.

☐ I agree to release, discharge and indemnify the Local Health Network, attending doctors, and Local Health Network staff from any liability whatsoever to me for any damage or injury which may be caused to me/my dependent*** in any way arising out of, or connected with, this my refusal to consent to receive blood or its derivatives.

Dated this ...................................................... day of ......................................................, 20..............

Signed: ...................................................... Relationship to Patient*: .................................
(Substitute Decision-Maker/ Person Responsible)

Medical Practitioner’s Signature: ...................................................... Date: ……/……/……  

SECTION 4 (B) CONFIRMATION OF REFUSAL OF BLOOD TRANSFUSION

☐ I ........................................................................................................................................

have described to the patient, patient’s Substitute Decision-Maker or Person Responsible the nature
and effect, consequences and risks of the above refusal to receive blood or its derivatives.
The name of the patient/ Substitute Decision-Maker/ Person Responsible is
…………………………………………………………………………………………
(First of given names)                                                                            (Surname)

In my opinion, the patient, patient's Substitute Decision-Maker or patient's Person Responsible,
understood this explanation.

Dated this ………………………………………… day of …………………………………, 20 ………...……

Medical Practitioner’s Signature: …..................................……………………………..……………...……

* Relationship to patient – eg. myself, my child
*** DELETE WHERE NOT APPLICABLE

Attachment 4: Schedule 1—Certain conduct may not indicate mental illness

A person does not have a mental illness merely because of any 1 or more of the following:

(a) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular political opinion or belief;

(b) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular religious opinion or belief;

(c) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular philosophy;

(d) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular sexual preference or sexual orientation;

(e) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity;

(f) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity;

(g) the person engages in or has engaged in a particular sexual activity or sexual promiscuity;

(h) the person engages in or has engaged in immoral conduct;

(i) the person engages in or has engaged in illegal conduct;

(j) the person has developmental disability of mind;

(k) the person takes or has taken alcohol or any other drug;

(l) the person engages in or has engaged in anti-social behaviour;

(m) the person has a particular economic or social status or is a member of a particular cultural or racial group.

However, nothing prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness.
Attachment 5 –Summary of authorised officer powers in Emergency Departments

Emergency Departments are part of general health settings and not considered as a designated mental health service. Therefore the classification of Mental Health Clinician is given to certain staff within the ED, as nominated by the Emergency Department Director or Emergency Department Country Health SA Mental Health, in order to provide them with the powers of an Authorised Officer (AO) in accordance with section 56 of the Mental Health Act 2009.

<table>
<thead>
<tr>
<th>Mental Health Act 2009</th>
<th>PROVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 56</td>
<td>Take a person who appears to have a mental illness into care and control (e.g. accept a patient who has been taken into care and control from SAPOL/SAAS)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>Registrar</th>
<th>Medical Officer</th>
<th>Intern</th>
<th>Registered Nurse</th>
<th>Enrolled Nurse</th>
<th>Allied Health</th>
<th>Aboriginal Health Worker</th>
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</tbody>
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NB: In addition to Authorised Officers powers under s 56, registrars, medical officers and interns have power to make a Level 1 Community Treatment Order or inpatient treatment order – if the criteria for such orders within the Mental Health Act 2009 are met.
16. Definitions

**Advance Care Directive** means an Advance Care Directive given under the *Advance Care Directives Act 2013*. An Advance Care Directive is a legal form written by competent adults. It can record a person's wishes and instructions for future health care decisions, preferred living arrangements and other personal decisions. An Advance Care Directive can also be used to appoint one or more adults to make these decisions for the person (a Substitute Decision-Maker). An Advance Care Directive takes effect if a person has impaired decision-making capacity in relation to decision(s). An Enduring Power of Guardianship, Medical Power of Attorney and an Anticipatory Direction are considered to be an Advance Care Directive for the purposes of the *Advance Care Directives Act 2013* until such time that a new Advance Care Directive is given.

**Authorised Officer** (as per s3 of the *Mental Health Act 2009*) means:
- a) a mental health clinician; or
- b) an employed or volunteer ambulance officer authorised by the CEO of SAAS; or
- c) a person employed as a medical officer or flight nurse by the Royal Flying Doctor Service of Australia (central Operations) Incorporated or the Royal Flying Doctor Service of Australia (South Eastern Section); or
- d) a person of a class prescribed by the regulations.

**Authorised Health Professional** please refer to Fact Sheet: *Mental Health Act 2009* – means a person determined by the Minister under Part 12, Division 4 to be an authorised health professional under the *Mental Health Act 2009*.

**Chemical Restraint** the use of any medication to modify or control a person's behaviour or bodily function for a non-therapeutic reason. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental illness, a physical illness or physical condition.

**De-escalation** for the purpose of this directive refers to strategies and techniques for responding to and managing aggressive behaviour.

**Detainment** for the purpose of this directive means, to keep in custody or temporary confinement. Restrictive practices may amount to detention after a period of time.

**Guardian** means a person acting or appointed under the *Guardianship and Administration Act 1993*.

**Health** is a state of complete physical, social and mental well-being.

**Health practitioner** means a person who practises 1 or more of the following:
- a) a health profession (within the meaning of the *Health Practitioner Regulation National Law (South Australia)* 2010);
- b) any other profession or practice declared by the Advance Care Directives Regulations 2014 and the Consent Act Regulations 2014 to be included in the ambit of this definition;

Health practitioners include registered practitioners such as medical, nursing and dental practitioners and other registered practitioners who provide health care including Aboriginal and Torres Strait Islander health workers and some allied health staff. It also includes ambulance officers and paramedics.

**Initial clinical assessment** for the purpose of this directive means the first review based on the clinical expertise of the clinician and may be determined on physical, mental and/or behavioural indicators that suggest the patient is unable to provide valid consent for the purpose of medical treatment.
Inpatient treatment order means—
(a) a level 1 inpatient treatment order; or
(b) a level 2 inpatient treatment order; or
(c) a level 3 inpatient treatment order

under the Mental Health Act 2009.

Involuntary inpatient means an inpatient who is subject to an inpatient treatment order under the Mental Health Act 2009.

Impaired decision-making capacity A person’s decision-making capacity relates to their ability to make a particular decision. It is not a global assessment of a person’s ability to manage their own affairs and it is not linked to a diagnosis. Determining whether a person has decision-making capacity is not necessarily a medical assessment. It is the ability to think, understand, make a decision and communicate this in some way; it is not dependent on verbal or written communication. A person’s decision-making capacity can fluctuate. A person may have impaired decision-making capacity temporarily or permanently. Impaired decision-making capacity under the Consent Act means
(a) the person is not capable of
(i) understanding any information that may be relevant to the decision (including information relating to the consequences of making a particular decision) or
(ii) retaining such information or
(iii) using such information in the course of making the decision; or
(iv) communicating his or her decision in any manner or
(b) the person is, by reason of being comatose or otherwise unconscious, unable to make a particular decision about his or her medical treatment.

• a person will not be taken to be incapable of understanding information merely because the person is not able to understand matters of a technical or trivial nature;
• a person will not be taken to be incapable of retaining information merely because the person can only retain the information for a limited time;
• a person may fluctuate between having impaired decision-making capacity and full decision-making capacity;
• a person’s decision-making capacity will not be taken to be impaired merely because a decision made by the person results, or may result, in an adverse outcome for the person.

Imminent risk of harm means likely to occur at any moment; impending, which means that:
• The hazard is clearly present or foreseeable
• The harm would be sufficiently significant as to amount to a high risk of serious impairment of, or significant adverse effect on, the patient’s future health.

Life for the purpose of this directive means the property that distinguishes a living animal or plant, or living portion of organic tissue, from a dead or non living matter

Loco parentis is Latin for “in place of a parent.” A person or institution that assumes parental rights and duties for a minor. This could include a grandparent, sibling or, in rare cases, a director of a treatment facility.

Mechanical restraint means the use of a device to restrict the free movement of a person or to prevent or reduce self-injurious behaviour.2

Medical examination in the context of the Mental Health Act 2009 means examination of a person and the person’s mental health by a medical practitioner.

2 Office of the Public Advocate Restrictive Practices in Disability Settings Policy (July 2011 Version) , pg 2
**Mental health clinician** means a person or a class of persons who are engaged in the treatment or care of patients and classified by the Chief Psychiatrist as mental health clinicians for the purposes of the *Mental Health Act 2009*.

**Mental illness** means any illness or disorder of the mind.

**Medical practitioner** in line with the Consent Act means a person registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than as a student) and includes a dentist.

**Medical treatment** means the provision by a medical practitioner of physical, surgical or psychological therapy to a person (including the provision of such therapy for the purposes of preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life) and includes the prescription or supply of drugs.

**Person Responsible** is a guardian appointed by the Guardianship Board or person close to the patient, who is available and willing to consent to or refuse consent to health care (including medical treatment and life-sustaining measures) when the person has impaired decision-making capacity. The Person Responsible can be a family member, close friend or a culturally acceptable person from the same community.

In the absence of an Advance Care Directive (relevant instructions or Substitute Decision-Maker), the Person Responsible is determined in the following legal order:

1. Guardian (if appointed by the Guardianship Board)

   If not then
2. Prescribed relative* (adult with a close and continuing relationship)

   If none of the above then
3. Adult friend (with a close and continuing relationship)

   If none of the above then
4. Adult charged with overseeing ongoing day-to-day care of the person

   If none of the above then
5. Guardianship Board (as a last resort).

A Person Responsible must try and make a decision that they believe the person would have made if they were capable of making their own decision, not a decision which the Person Responsible thinks is in the person’s best interest.

**Palliative Care** under the Consent Act means measures directed at maintaining or improving the comfort of a patient who is, or would otherwise be, in pain or distress. Generally palliative care is provided to patients living with, or dying from an eventually terminal illness.

*Prescribed Relative* of the patient under the Consent Act includes the following:

a) A person who is legally married to the patient  
b) An adult domestic partner of the patient  
c) An adult related by blood or marriage  
d) An adult related to the patient by reason of adoption  
e) An adult related to the patient according to Aboriginal kinship rules or Torres Strait Islander kinship rules.

**Physical restraint** means the use or action of physical force to prevent, restrict or subdue movement of a person’s body, or part of their body, for the primary purpose of controlling a person’s behaviour. Physical restraint should only be performed by trained staff (eg security, mental health staff, medical staff).³

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³ Office of the Public Advocate, pg 2
**Protected person** means the person the subject of a guardianship or administration order (or both) under the *Guardianship and Administration Act 1993*.

**Public Advocate** means the person holding or acting in the office of Public Advocate under the *Guardianship and Administration Act 1993*.

**Reasonable force** means the use of such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day to day care and wellbeing of the person. It does not mean detainment as defined above.

**Restrictive practices** are acts of removing another person’s freedom. It involves any practice, device or action that interferes with a person’s ability to make a decision or that restricts the person’s movement. For the purpose of this policy restrictive practices include reasonable force, chemical restraint, physical restraint and mechanical restraint as defined in this document.

**Seclusion** means the sole confinement of a person at any hour of the day or night in any room or area in the premises in which that person is detained.⁴

**Substitute Decision-Maker** under the *Advance Care Directives Act 2013* means a Substitute Decision-Maker appointed under an Advance Care Directive. A Substitute Decision-Maker is an adult that a person can choose to appoint in their Advance Care Directive to make decisions about their future health care, living arrangements and other personal matters when the person giving the Advance Care Directive is unable to make their own decision/s.

An Enduring Guardian appointed under an Enduring Power of Guardianship and a Medical Agent appointed under a Medical Power of Attorney are considered to be Substitute Decision-Makers for the purposes of the *Advance Care Directives Act 2013*.

**Terminal Illness** means an illness or condition that is likely to result in death.

**Terminal Phase** of a terminal illness means the phase of an illness reached when there is no real prospect of recovery or remission of symptoms (on either a permanent or temporary basis).

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⁴ Office of the Public Advocate, pg2