Capital Health

ADMINISTRATIVE MANUAL

Policy and Procedure

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POLICY

1. Capital Health supports the principle that every human being of sound mind has the right to determine what will be done with his/her own body. All actions that involve intentional interference with the person or any significant risk to the person fall under this principle. Such actions include, but are not limited to all surgery, some drug treatments and many diagnostic investigations (see Procedure, Section 1).
2. Consent is obtained when a patient, or someone acting on behalf of the patient (the patient's substitute decision maker), agrees to proceed after being adequately informed of a proposed intervention. The consent process is ongoing. It creates a relationship based on effective communication and trust between the patient and the treating health professional.
3. Capital Health recognizes that the mere signing of a consent form by a patient does not **in itself** provide conclusive proof that the patient in fact consented. Rather, the consent form in the health record acts as a record of the fact that the consent process took place. What matters in assessing whether the patient gave a valid informed consent is the information and understanding that the patient actually had regarding the procedure.
4. It is the intention of Capital Health to provide its treating health professionals with the information required to ensure the validity of a consent to treatment through the information contained in this Policy.

   4.1 This policy is divided into two parts. The first part discusses the general rules of consent to treatment, and the second part discusses more specific situations. Please note that the general rules of consent to treatment must also be applied to the specific situations.

PROCEDURE

1. **Consent to Treatment Required**

   Section 54 of the Hospitals Act R.S.N.S., c. 208, as amended states that, "No person admitted to a hospital or psychiatric facility shall receive treatment unless he consents to such treatment."

   1.1. While consent may be either oral or written, treating health professionals obtain written evidence that the consent process occurred from all patients prior to administration of any treatment, course of treatment such as chemotherapy, operative procedure or diagnostic test (referred to in the policy collectively as "the treatment").

      1.1.1. Unless there is some reason to think otherwise, assume that a patient who has signed the general consent on Capital Health admitting forms has been sufficiently informed about and consented to regular venipuncture and/or non-invasive diagnostic testing.

      Exception to the rule requiring written evidence of consent - If an outpatient comes to Capital Health to have routine lab work (***not*** including HIV testing), or non-invasive diagnostic testing, such as routine x-ray, consent can be **implied.**

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Example: If the patient did not intend to have blood drawn he/she would not have come to the Capital Health, registered, and offered his/her arm for blood to be drawn).

1.2. Obtain written consent for (but not limited to) the following:

1.2.1. all surgery;

1.2.2. all procedures requiring general anaesthetic and most procedures requiring local anaesthetic (this will depend on the how invasive the procedure is);

1.2.3. all non-operative procedures which involve more than a slight risk of harm to the patient such as the administration of chemotherapy, blood &/or blood products and diagnostic testing **including HIV testing**; and

1.2.4. all procedures which, in the opinion of the treating health professional, require consent.

If there is any doubt about the need for a written consent, it is prudent to obtain a written consent as evidence that the consent process occurred.

Note: Exceptions to the requirement to obtain written consent under **Procedure Statement #1.2** may be approved by Legal Services in specific circumstances where the obtaining of written consent is impracticable and reasonable alternatives for obtaining and documenting consent are available.

2. **Criteria for a Valid Consent**

2.1. Assess the validity of a consent which depends on a number of criteria having been met as follows:

2.1.1. **Free, Voluntary and Genuine**. Provide the patient the opportunity to choose between consent and refusal without fear, constraint, compulsion or duress;

2.1.2. **Legal Competency** - Consent to treatment can be given only by a person who has the legal competency to give it. Assume that everyone has the legal competency to consent unless there is a court order appointing a guardian to make medical decisions on the patient's behalf.

Note 1: Do not confuse legal competency with mental capacity - if a patient is legally competent does not necessarily mean that he/she has mentally capacity. For further discussion on obtaining consent from an incompetent patient, refer to **Procedure #10**;

Note 2 - The Court Order must specifically state that the guardian is appointed for the purpose of making medical decisions as a person can be declared incapable of making financial decisions, but capable of making health care decisions.

2.1.3. **Mental Capacity** Ensure that the patient is capable of understanding what it means to consent to treatment, the nature of his/her condition, the information and opinions given and the treatment being suggested. If the patient does not

have mental capacity to consent to treatment, obtain consent from a substitute decision maker. Refer to **Procedure #10**.

2.1.4. **Adequately Informed –** Ensure that **the patient is** adequately **informed** about the proposed treatment, including:

2.1.4.1. the nature and purpose of the proposed treatment;

2.1.4.2. the intended benefits;

2.1.4.3. material or probable risks or complications;

2.1.4.4. the consequences of foregoing all treatment; and

2.1.4.5. alternatives available.

2.2. The treating health professional provides the patient with the relevant information necessary to make the decision to undergo the treatment, i.e. **What would a reasonable person in this patient's situation want to know before consenting?**

> The Supreme Court of Canada has stated that a risk is material or probable in direct relation to its incidence and the severity of the consequences should the risk materialize (*Reibl v. Hughes*,[1980] 2 S.C.R. 880). Therefore, if the chance of a risk occurring is high, the patient must be informed about it. Also, if the chance of a risk occurring is not high, but the risk itself is serious (e.g. - death, paralysis etc.), it too should be disclosed.

2.2.1. Ensure the consent is **specific to the treatment to be performed**. In the case of surgery, advise the patient of any possible alternative procedures, extensions and additional procedures and specifically ask the patient to consent to them as well.

Note: Additional procedures that have nothing to do with the original operation but are discovered to be convenient at the time, or even beneficial, may not be performed except in the case of an emergency.

2.2.2. Give the patient the **opportunity to ask questions** and to receive understandable answers.

2.2.3. Do not **misrepresent** any important information.

3. Responsibility of Obtaining Consent

3.1. The treating health professional ensures that the patient or his/her substitute decision maker has given an informed consent to treatment.

3.1.1. The treating health professional may be a physician, therapist, nurse or technician - whoever is proposing the treatment and is in the best position to explain the risks/benefits/alternatives to the patient, and answer the questions of the patient.

Note: A printed explanation sheet for a particular treatment is an acceptable tool to assist the treating health professional in disclosing the information

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required for a patient to give an informed consent. However, it does not absolve the treating professional from responsibility for ensuring that the patient has been adequately and correctly informed.

3.2. Do not delegate the task of obtaining consent to learners who do not possess the knowledge necessary to adequately present all the pertinent risks, benefits and alternative treatments.

3.2.1. In general, most residents could be expected to have sufficient knowledge. However, the ultimate responsibility for ensuring that a valid consent has been obtained remains with the treating health professional.

Note: Consent cannot be delegated to health professionals for treatment to be performed by a physician.

4. Documentation of Consent

4.1. Although consent is a communication process and not just a piece of paper, ensure there is documentation of some form to ensure proper treatment is received by the patient.

4.1.1. The consent form may be used as evidence that the patient, or his/her substitute decision maker, actually consented.

4.2. After the patient has been informed and has had an opportunity to ask questions concerning the proposed treatment and any alternatives to the proposed treatment, get a consent form signed. Fill in **all blank spaces on the consent form**. If "none" or "not applicable" is the appropriate entry, state so.

4.3. ***For consent to treatment, use only consent forms approved by Capital Health.*** **(Refer to Related Documents)**.

Exception: Consent to research and quality studies.

4.3.1. Legal Services approves all consent to treatment forms. Capital Health Research Ethics Committee approves all consent to research forms.

4.4. Treating health professionals record in the patient's health the content of the conversation with the patient explaining the proposed treatment, the anticipated benefits and the reasonably probable risks and the fact that the patient appeared to understand and knowingly consented to the treatment.

5. Witnessing

5.1. **In signing as a witness, the witness certifies that the patient named on the form was the person signing it. (The witness is not certifying the validity of the consent itself.)**

5.1.1. While any competent adult can witness the signature, where possible, the person obtaining the consent should complete the consent form and witness the patient's signature.

5.2. If the patient or his/her substitute decision maker is unable to physically sign the form (e.g. illiterate), obtain the signature of a second witness on the consent form.

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Make a notation on the consent form to indicate that the form was read to the patient.

6. Duration of Consent

6.1. A consent is valid until:

6.1.1. the treatment consented to is performed;

6.1.2. the patient's condition changes;

6.1.3. the patient withdraws the consent; or

6.1.4. further risks become known, or alternative treatments become available.

6.2. Unless the patient explicitly states that his/her consent is being withdrawn, presume that the patient's consent is in force and that there is no need to explicitly verify it.

6.2.1. As the length of time between obtaining the consent and performing the procedure increases, so does the likelihood that the patient's condition may have changed. **If performing a procedure, as best practice :**

6.2.1.1. **More than one month - re-confirm that the patient has had the procedure fully explained and had an opportunity to ask questions**

6.2.1.2. **More than 6 months - document the process with a new written consent form.**

Note: The appropriateness of the length of the time between discussing the proposed treatment with the patient, and actually performing the procedure will vary from service to service. It is critical that an assessment of the validity of a consent be based on the principles outlined in this Policy. Bring a consent of questionable validity to the attention of the treating health professional.

According to the law, if a patient loses capacity to consent after consenting to a procedure, the consent continues to be valid, unless there is a change in the patient's medical condition which makes the treatment no longer appropriate.

Depending on the circumstances, best practice may be to complete the consent process with a substitute decision maker.

If the circumstances have changed since the original consent, consent ***must*** be reobtained from the substitute decision maker. (See **Procedure # 10**)

7. Refusal to Consent/Withdrawal of Consent

7.1. As long as a patient has the legal competency and mental capacity, abide by the patient's **right to refuse** a proposed treatment or diagnostic procedure except in the following circumstances:

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7.1.1. the patient is suffering from certain specified communicable diseases for which treatment is mandatory under the *Health Act*; or

7.1.2. the patient has been forcibly confined to a psychiatric institution as per the mental health legislation or the *Criminal Code*.

Note: If a person has been forcibly confined under the *Hospitals Act*, he/she does not automatically lose his/her right to consent to treatment or refuse treatment. Under that Act, a psychiatrist must assess the patient to determine the patient's capacity to consent. If a psychiatrist determines that the patient is capable of consenting, the patient is also capable to refuse treatment.

7.2. **A substitute decision maker cannot give or refuse consent on behalf of a competent patient.**

7.3. To continue without consent is considered **battery**. If a competent patient refuses treatment, explain the clinical consequences of that decision to the patient and document the discussion carefully in the progress notes and on the consent form.

7.4. The principles of consent also encompass the patient's **right to withdraw** consent. Ensure that the patient understands the consequences of withdrawing consent. Include this in any documentation provided to a patient and in discussions with him/her.

7.4.1. Document the withdrawal of consent on the progress notes and on the consent form.

8. Consent by Telephone

8.1. When possible, obtain consent in person from the patient or his/her substitute decision maker. In situations where the patient is unable to consent and treatment is required promptly to prevent the patient's health from deteriorating or to alleviate unnecessary pain and discomfort, as appropriate obtain telephone consent from the patient's substitute decision maker. The treating health professional who has placed the telephone call determines that:

8.1.1. the person to whom the call was placed is the patient's substitute decision maker;

and

8.1.2. the person's willingness to give or refuse consent to treatment on behalf of the patient.

8.2. The same requirements for informed consent exist for telephone consent as for a written document. If the person being called is willing and able to make a treatment choice for the patient, the treating health professional explains the following:

8.2.1. the nature of the patient's condition for which treatment is proposed;

8.2.2. the proposed treatment;

8.2.3. the probable risks and benefits associated with the proposed treatment;

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8.2.4. any reasonable alternative forms of treatment along with the risks and benefits of such alternative treatment; and

8.2.5. the consequences of foregoing all treatment.

8.3. Provide the person to whom the call was placed an opportunity to ask questions regarding the proposed treatment. **A second person monitors this call and acts as a witness to the process, except in urgent circumstances.**

8.4. Due to the importance of documentation with a telephone consent, note the following:

8.4.1. the reason why the patient was unable to consent;

8.4.2. the name of the person placing the call;

8.4.3. the time and date of the call;

8.4.4. the number called and the name of the person to whom the call was placed;

8.4.5. the relationship between the patient and the person to whom the call was placed; and

8.4.6. the name of the person monitoring the call as the witness.

8.5. Place a summary of the information given and received on the patient's health record. The person obtaining consent completes a *Declaration of Substitute Decision Maker (SDM*) form (CD1585MR) with the Substitute Decision Maker by telephone, noting on the form that the information was obtained by telephone.

9. Emergencies

9.1. The only time (apart from legislative authorization) a patient can be treated without consent is in a medical/legal emergency. To determine if a medical/legal emergency exists, check for the following criteria:

9.1.1. the patient is unable to consent, and a substitute decision maker is unavailable;

9.1.2. there is an immediate threat to the life or health of the patient, or danger to others, and

9.1.3. treatment cannot be delayed

9.2. If the procedure ***can*** be delayed, the situation is ***not*** a medical/legal emergency; make arrangements to obtain consent.

9.3. In a medical/legal emergency, the treating health care professional:

9.3.1. documents the circumstances in the progress notes, including the medical condition of the patient and all attempts made to contact the patient's substitute decision maker;

9.3.2. proceeds with the treatment to which a reasonable, prudent individual in the patient's circumstances would be expected to consent; and

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9.3.3. obtains consent from the patient or substitute decision maker as soon as is practical.

9.4. If, in a medical/legal emergency, the decision to proceed with a procedure is made after consultation with a colleague, Department Head, etc., document this in the patient's health record.

9.5. In circumstances where the physician has knowledge of the patient's prior refusal to consent to the proposed treatment, the physician should not provide the treatment against the express known wishes of the patient.

9.5.1. Seek information from the patient's personal directive if one exists. (See **Procedure #11and** CC 90-005 *Personal Directives (formerly Advance Directives)*)

10. **Patients who lack capacity to make decisions**

10.1. In Nova Scotia, a person in hospital can be presumed to be competent and to have the capacity to make treatment decisions unless:

10.1.1. the patient is an involuntary patient as per the Involuntary Psychiatric Treatment Act and therefore has been deemed incompetent by a psychiatrist;

or

10.1.2. the patient is not an involuntary patient as per the Involuntary Psychiatric Treatment Act, but has been found by their attending physician or a suitable healthcare professional as determined by the hospital to be incapable of consenting to treatment under section 52 of the Hospitals Act.

10.2. Whenever capacity to consent is in question, document the circumstances in the health record. Record the reasons for any decision about capacity, and if the patient is found to lack capacity then seek consent from another person, the patient's substitute decision maker.

10.3. If a patient has been found to lack capacity to consent to treatment, complete *a Form A - Declaration of Capacity to Consent to Treatment (Section 53 – Hospitals Act)* as per the regulations under the *Hospitals Act* and place on the patient's health record.

10.4. If a patient has been found to lack the competency to administer their estate, complete a *Form C-Declaration of Competency (Section 53 – Hospitals Act)* as per the regulations under the *Hospitals Act* and place on the patient's health record.

10.5. In determining whether or not a person in a hospital or a psychiatric facility is capable of consenting to treatment, the examining psychiatrist, attending physician or suitable healthcare provider as determined by the hospital considers:

10.5.1. whether the patient understands the condition for which the specific treatment is proposed;

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10.5.2. the nature and purpose of the specific treatment;

10.5.3. the risks and benefits involved in undergoing the specific treatment; and

10.5.4. the risks and benefits involved in not undergoing the specific treatment.

10.5.5. whether the patient suffers from a mental disorder which affects the patient's ability to appreciate the consequences of making the treatment decision.

10.6. If there is reason to believe that there is a capacity issue **which requires the opinion of a psychiatrist.** , the attending physician or the suitable healthcare professional as determined by the hospital requests a psychiatric consultation.

10.7. If the patient is not capable of consenting, obtain consent from the patient's Substitute Decision Maker ("SDM").

Substitute Decision Maker:

10.8. Before seeking the decision of a substitute decision maker, the treating health professional inquires if the patient lacking capacity has a Personal Directive.

10.8.1. If the patient has a Personal Directive, the treating health professional requests a copy and places it in the patient's health record.

10.9. Refer to Table 1 (page 11) to determine the patient's SDM.

Table 1
Order of Priority – Determination of SDM

- a person who the patient, when competent, appointed as his/her delegate under the *Medical Consent Act or under the Personal Directives Act.* This may also be referred to as a medical power of attorney, an advance directive or a living will.
- legally appointed guardian;
- the spouse, common-law partner or registered domestic partner if the spouse, common-law partner or registered domestic partner is currently cohabitating with the patient in a conjugal relationship, and in the case of a common-law partner has cohabitated with the patient for at least one year.
- an adult child of the patient
- a parent of the patient
- an adult brother or sister of the patient
- grandparent
- adult grandchild

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- adult aunt or uncle
- adult niece or nephew
- any other adult relative of the patient;
- the Public Trustee.

Note: Staff at Long Term Care Institutions, or homes for the developmentally disabled cannot give consent for patients under their care unless they have been formally appointed as a delegate while the patient had capacity or where appointed guardians of the patient by the court.

10.10. The treating health professional ensures that the SDM consenting on behalf of the patient understands:

10.10.1. the nature of the condition for which the treatment is proposed;

10.10.2. the proposed treatment;

10.10.3. the probable benefits and risks of the proposed treatment;

10.10.4. any reasonable alternative forms of treatment, along with the risks and benefits of such alternative treatments; and

10.10.5. the consequences of foregoing all treatment.

10.11. A person may only act as SDM if the person:

10.11.1. has been in personal contact with the patient over the preceding twelve-month period or has obtained a court order to waive or shorten that period;

10.11.2. is willing to assume the responsibility for consenting or refusing consent;

10.11.3. knows of no person of a higher category who is able and willing to make the decision; and

10.11.4. makes a statement in writing certifying the person's relationship to the patient and the facts and beliefs set out in **Procedure Statements 10.5.1 to 10.5.3**.

10.12. When obtaining consent from an SDM, ensure that a *Declaration of Substitute Decision Maker (SDM)*, (Form CD1585MR) is completed by the SDM and place on the patient's health record.

10.12.1. A Declaration of Substitute Decision Maker (SDM), *Form CD1585MR* is valid for the duration of the patient's admission. The appropriate SDM executes a new form for each admission.

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Note: In those limited circumstances where a *Declaration of Substitute Decision Maker (SDM)*, (Form CD1585MR) is in place with respect to an outpatient who is receiving ongoing treatment, Form *CD1585MR* may be considered valid for up to six months.

10.13. Treating Health Professionals rely on *the Declaration of Substitute Decision Maker* as evidence that the SDM is the appropriate person to give consent, unless it is not reasonable in all the circumstances to believe the SDM's written statement.

10.14. The attending physician ensures that consent was obtained from the appropriate SDM.

10.15. The SDM makes the consent decision as per the patient's prior capable informed expressed wishes unless:

10.15.1. the patient subsequently expressed a contrary wish;

10.15.2. technological or medical advances make the instruction inappropriate as to the intentions of the patient; or

10.15.3. circumstances exist that would have caused the patient to set out a different instruction based on what the SDM knows of the patient's wishes,

10.16. In the absence of awareness of a prior capable informed expressed wish, the SDM makes the consent decision in accordance with what the SDM believes to be in the patient's best interest.

10.17. In determining the patient's best interest, the SDM considers:

10.17.1. whether the condition of the patient will be or is likely to be improved by the specified medical treatment;

10.17.2. whether the condition of the patient will improve or is likely to improve without the specified medical treatment;

10.17.3. whether the anticipated benefit to the patient from the specified medical treatment outweighs the risk of harm to the patient; and

10.17.4. whether the specified medical treatment is the least restrictive and least intrusive treatment that meets the requirements of Procedure Statements 10.17.1 to 10.17.3.

10.18. Where an SDM approves or refuses treatment on behalf of a patient, the Supreme Court of Nova Scotia (Family Division) or the Family Court if there is no Supreme Court (Family Division) may review the provision or refusal of consent when requested to do so by the psychiatrist or the patient to determine if the SDM has provided a capable informed consent.

10.19. Direct any questions in relation to determination of the proper SDM or decisions by the SDM to Legal Services at 473-2626

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11. Personal Directives (Advance Directives, Living Wills)

11.1. A treating health professional follows:

11.1.1. the instruction of a delegate named in a Personal Directive; or

11.1.2. if no delegate, the instructions in the Personal Directive; or, if no Personal Directive,

11.1.3. instructions by the SDM

Note: Delegates, SDMs and treating health professionals are to follow the express wishes of patient given while capable. These wishes can be expressed verbally or documented in a personal directive, a living will or instructional advance care directive. (See CC 90-005 *Personal Directives (formerly Advance Directives)*)

12. Minors

12.1. *There is no designated "age of consent" in Nova Scotia*. If, in the judgment of the treating health professional, the patient has the capacity to consent (e.g. is mature enough to understand the nature and consequences of the treatment decision), the patient can give her/his own consent. In making the decision, also consider if the minor (a person under 19 years of age) is living on his/her own, self-supporting or married (emancipated minor).

Note 1: ***The Human Tissue Gift Act, R.S.N.S., c.215*** requires that all persons consenting to tissue donation must have reached the age of majority – 19 years of age in Nova Scotia.

Note 2: A minor who is a ward of a Children's Aid society or for whom a guardian has been appointed has all the rights a child would have if living with his/her parents. The organization or guardian having custody of the child has as much right, duty and responsibility as a parent has, but no more. Therefore, a minor in such circumstances may consent to treatment just as any minor might do.

12.2. The younger the patient is and the more significant the procedure, take greater care to evaluate capacity. If necessary, obtain a second opinion from another physician and document the assessment of the second physician.

13. Foreign Patients (Non-Canadians)

13.1. Whenever a non-Canadian patient receives care or treatment at Capital Health, the patient (or the patient's legally authorized Substitute Decision Maker) signs the **Supplementary Consent Form for Non-Canadian Patients**.

13.1.1. Ensure that this form is signed in all cases when a non-Canadian patient is treated at or receives care at Capital Health, regardless of how the individual came to be a Capital Health patient.

13.1.2. The treating physician ensures that this form is completed prior to any *elective* care, and as soon as possible/appropriate following *emergency* care.

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Note: This is an attempt to ensure that any law suits resulting from the care given to patients from outside Canada will be commenced in Nova Scotia, not the foreign jurisdiction.

14. Medications

14.1. Do not obtain consent after the administration of sedating medication, or while the patient is under the influence of drugs, alcohol or in shock, as the patient may be incapable of giving an informed and voluntary consent.

Note: A consent given under any of these circumstances is ***not*** automatically invalid. However, as the circumstances may raise the possibility, obtaining consent in these circumstances is only to be done under extenuating circumstances.

14.1.1. Assess the capacity to consent at the time that consent is sought; the deciding factors are the ability to understand the nature, risks and benefits of the proposed treatment. Be sure to document the following:

14.1.1.1. the circumstances surrounding obtaining consent after the administration of medication; and

14.1.1.2. the assessment of capacity.

15. Anaesthetic Consent

15.1. As the administration of anaesthetics is considered to be an invasive procedure independent of the actual surgery, all the principles of an informed consent apply. The anaesthetist should discuss the form of anaesthesia proposed, alternative methods if any, any exclusions imposed by the patient and any material risks of the proposed anaesthesia.

15.1.1. The anaesthetist documents in the patient's health record, indicating that the discussion took place and the patient agreed.

16. Consent for Organ Donation

16.1. Organ donation in Nova Scotia is allowed only if the requirements of the *Human Tissue Gift Act* are met. Adhere to the consent requirements as described in the Act for live donors, and for donation after death as follow:

16.1.1. **Inter Vivos Transplant (live donor) -** As per the *Human Tissue Gift Act* any person who is:

- nineteen years of age, or older;
- mentally competent to consent; and
- able to make a free and informed decision

may, in a written, signed document consent to the removal from his/her body tissue specified in the consent, and its implantation into the body of another living person. **All the criteria for informed consent apply.**

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16.1.2. **Post-Mortem Gifts for Transplant and Other Uses (donation after death)** - As per the *Human Tissue Gift Act*, any person who is nineteen years of age or older may consent in a written, signed document, or orally in the presence of at least two witnesses during his/her last illness, that his/her body or parts be used after death for therapeutic purposes, medical education or scientific research.

16.1.2.1. If a patient who has not given consent, and has not voiced any objection to consenting to organ donation, dies, then obtain written consent from:

- the patient's spouse of any age

  Note: Unlike the *Hospitals Act*, the term "spouse" is not defined in the *Human Tissue Gift Act*.

- if there is no spouse, or the spouse is not readily available, any of the patient's children who are 19 or over;
- if there are no children over 19, of if they are not readily available, either of the patient's parents;
- if the patient has no parents, or if they are not readily available, any brothers or sisters who are 19 or over;
- if there are no siblings or if they are not readily available, any one of the next of kin who is 19 or over; or
- if there are no other next of kin readily available, the person lawfully in possession of the body (except the administrative head of the hospital). This has generally been interpreted to mean that there is no one available to consent, and therefore, donation is not appropriate.

16.2. If the patient had not previously completed an organ donation card complete the *Consent to Organ Donation* form. **All the criteria for an informed consent apply**.

16.2.1. Whoever is in the best position to explain organ and/or tissue donation obtains the consent to organ/tissue. This may be, but does not necessarily have to be, the treating health professional or the Transplant Coordinator.

17. Consent for Autopsy

17.1. When necessary, the attending physician or his /her delegate approach the substitute decision maker for permission to perform an autopsy. **All criteria for an informed consent apply**. Pay particular attention to documenting the extent of the autopsy to which the substituted decision maker has consented.

17.2. In Nova Scotia, the Medical Examiner takes charge of a body if it appears that:

17.2.1. there is a reasonable cause to suspect that the person died by violence, undue means or culpable negligence;

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17.2.2. the person died in a place or under circumstances requiring an inquest under any statute;

17.2.3. the cause of death is undetermined; or

17.2.4. the person died in a jail or prison. (see the *Fatality Inquiries Act*, section 5(1))

Under any of these circumstances, a consent for autopsy is not required.

18. Consent for Research

18.1. As with all consents, ensure that consent to research is voluntary and informed. If a patient is to participate in a research study, make available **additional information**, over and above the information required for a valid consent to treatment.

18.1.1. Provide a complete and candid disclosure of **all** the facts and probability of risk which a reasonable person in the patient's position may be expected to consider before consenting to participation in a research study.

18.2. Document the consent for research separately from any treatment consents, and ensure it complies with the consent requirements both as discussed in this Policy and as outlined by the Research Ethics Committee of the Capital Health.

18.3. **The research participant is free to withdraw consent at any time**. Ensure that the participant is aware of any consequences of withdrawing consent during the research study.

18.4. Designate one person on the research team to inform potential research participants and to answer any questions, i.e.: the person who is in the best position to discuss with the participant the possible harms, benefits and uses of the research.

18.4.1. If the research involves a medical intervention/treatment component as well as a research component, the treating health professional obtains the consent. If the researcher is also the treating health professional, take particular care to ensure a voluntary consent as the patient may feel an undue influence to participate. Such undue influence may act to invalidate consent.

19. Consent for Photography

19.1. If the treating health professional requires a photograph or video of a patient for the patient's health record for clinical teaching or for reproduction in a medical publication, the health professional explains the purpose of the request to the patient and obtains the patient's consent on the form intended for this purpose.

Note: Refer to the Media Relations policy for consent to interviews and photography for public relations purposes.

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20. Transfusion of Blood Components and Blood Products

For definitions of **Blood Components**, **Blood Products,** and **Authorized Prescriber** please refer to the *Blood Component/Product and Plasma Derivative Administration policy CC 75-005*.

20.1. Adhere to all of the Principles and General Procedures as set out in this Policy for consent for transfusion of blood components or blood products. Ensure that consent or refusal of blood components and blood products is voluntarily given based on an informed choice.

20.2. Whenever there is a reasonable possibility that a transfusion of blood components or blood products may be necessary for a patient (inpatient or outpatient) as a result of a medical or surgical procedure, the Authorized Prescriber who makes that determination obtains and documents informed consent or refusal.

Note: Informed consent or refusal may be obtained for a series of or future transfusions provided the other requirements of this Policy are met.

20.3. Obtain consent or refusal for blood components or blood product transfusions as early as possible to allow patients an opportunity for a full exploration of alternatives and to ensure documentation of patient wishes.

20.4. Obtain written confirmation of informed consent or refusal for blood components or blood product transfusions prior to transfusion and at a minimum :

20.4.1. Prior to every surgical procedure.

20.4.2. Whenever a patient's circumstances change such that they materially affect the nature and/or of the risk of the transfusion.

20.4.3. Once per year for outpatients and inpatients undergoing medical procedures that require continued or ongoing transfusions.

20.4.4. Each admission for non-surgical patients.

20.5. Document consent for transfusion on a *Consent for Transfusion of Blood Components or Blood Products* (CD2632MR) or in the blood transfusion section of the Capital Health *Consent for Investigation, Treatment or Operative Procedure* (CD0301MR), or a consent form approved by Legal Services which contains specific reference to blood transfusion and the associated risks, benefits and patient education information availability. Document confirmation of ongoing consent in a progress note.

20.6. A patient may give consent to blood transfusions for the entire course of treatment or for a shorter period or specific number of treatments provided the consent meets the provisions of **Procedure # 2** – Validity of Consent.

20.6.1. If there is any doubt as to whether the patient consented to ongoing transfusions, discuss with the patient, confirm patient directions and

document again the scope and nature of the patient's consent or refusal. See also **Procedure #1** – Consent to Treatment Required.

20.7. If the patient is unable to consent to transfusion of a blood component or product, obtain consent from the SDM as outlined in **Procedure Statement #10** – Patients Who Lack Capacity to Make Decisions.

20.8. When obtaining informed consent or refusal to blood component and blood product transfusions, provide the patient or SDM with a copy of or instructions for obtaining a copy of Patient Guide –*Blood Transfusion: Blood, Blood Components and Plasma Derivatives*"(WH85-1200).

20.9. In any discussion of informed consent to blood component and blood product transfusions, include a discussion of available products and alternatives to transfusion.

20.9.1. For information for blood components and products refer to Appendix C – Blood Component/Product Administration Quick Reference, *Blood Component/Product and Plasma Derivative Administration policy CC 75-005*.

20.10. In rare cases, when obtaining consent for autologous blood transfusions, inform the patient or SDM that they may require additional units of non-autologous blood. If the patient or SDM refuses non-autologous or allogeneic blood, complete the *Refusal or Limited Consent for Transfusion of Blood Components or Blood Products* form (CD0738MR)

20.10.1. Allow adequate time before the medical procedure or surgery for autologous blood donation to take place unless the patient declines, there is a life-threatening emergency or where there are medical contraindications.

20.11. When it is not possible to obtain the consent of the patient or SDM due to an emergency as described in **Procedure # 9** - Emergencies, the Authorized Prescriber follows the procedures as set out in **Procedure # 9** and proceeds with the transfusion ***unless*** there is:

20.11.1. a Personal directive refusing transfusion (Refer *to Personal Directives CC 90-005*) or

20.11.2. other form of documented refusal (Refer to *Patient Identification for Refusal of Blood/Blood Components/Products CC75-010*)

20.12. Be aware that a patient has the right to choose to decline transfusion. See **Procedure # 7** - Refusal to Consent/Withdrawal of Consent for general direction. If a patient declines transfusion the Authorized Prescriber and team discusses the circumstances of the refusal with the patient or his/her SDM including:

- The diagnosis
- The explanation of the proposed treatment
- The consequences of the refusal

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- Options for a partial refusal
- Information on alternatives and support

20.12.1. In a non-confrontational and respectful manner, clearly explain the implication of refusing a transfusion. Make clear to the patient that in certain circumstances refusing to accept a transfusion could be fatal.

20.12.2. For the appropriate management of any patients refusing a blood transfusion, determine this at the earliest possible stage in treatment.

20.13. As needed, the Authorized Prescriber and team consult either hematology or the Perioperative Blood Management (PBM) service (surgery patients only) for further information on alternatives to blood products and blood components.

20.14. The Authorized Prescriber and team determine if the refusal decision is capable and informed, in which case it must be respected.

20.14.1. If an SDM refuses life saving transfusion, review any prior capable express wishes of the patient to determine whether the decision is in keeping with the patient's wishes and best interest. Consult Legal Services if there is question as to the capacity or appropriateness of the SDM's decision.

20.15. The Authorized Prescriber and team document relevant discussions regarding the refusal in the patient's health record and obtain the *Refusal or Limited Consent for Transfusion of Blood Components, and/or Blood Products* form (CD0738MR).

20.16. The Authorized Prescriber and team follow the procedures for ensuring proper identification of the patient and their refusal as per *Patient Identification for Refusal of Blood/Blood Components/Products CC 75-010*.

20.17. The transfusion or operating room (OR) staff confirm documentation of consent prior to transfusion as per the *Blood/Blood Component/Product and Plasma Derivative Administration policy CC 75-005.*

20.18. A consent or refusal of transfusion is valid for the same time and under the same circumstances as other consents. See **Procedure # 6** – Duration of Consent.

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REFERENCES

Hospitals Act

Medical Consent Act (repealed April 1, 2010)

Personal Directives Act

Canadian Standards Association. C.S.A Standard Z902-10 Blood and blood components. (2010) Mississauga, Ontario

Capital District Health Authority Patient teaching pamphlet - A patient's guide to blood components, products and alternatives, surgery

RELATED DOCUMENTS

Policies

CC 75-005. Blood Component/Product and Plasma Derivative Administration policy

CC 75-010**.** Patient Identification for Refusal of Blood/Blood Components/Products

CC 90-005 Personal (Advance) Directives

CH 04-025 Media Relations

Forms (Obtain from Print Shop)

CD0301MR Consent for Investigation, Treatment or Operative Procedure

CD0737MR Consent to Medical Photography /Videography

CD0738MR Refusal of Blood Transfusion

CD0739MR Consent for Autopsy

CD0741MR Consent for Organ/Tissue Donation

CD0762MR Supplementary Consent Form for Non-Canadian Patients

CD1585MR Declaration of Substitute Decision Maker (SDM)

CD2632MR Consent for Transfusion of Blood Components or Blood Products

CD0738MR Refusal or Limited Consent for Transfusion of Blood Components and/or Blood Products

Brochures

Pamphlet # 1202

A patient's guide to blood components, products and alternatives: surgery

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