14th October 2020

[redacted]

Email: [redacted]

Dear [redacted]

Official Information Act Request for – Endoscopy Procedures (MoH Ref: H202006963)

I write in response to your Official Information Act request received by us 15th September 2020 you requested the following information:

Please note that all my questions relate only to endoscopy procedures:

1. **In the last five years how many endoscopy consents were undertaken by nurses and could I please get a breakdown of the procedures these consents related to (e.g, gastroscopy, colonoscopy, ERCP, etc? I also want to know who conducted the procedure.**
2. **In the last five years how many endoscopy consents were done by doctors and could I please get a breakdown of the procedures these consents related to? I also want to know who conducted the procedure.**
3. **For the last five years, can you please state how many high-risk endoscopy procedures (based on what you classify as high-risk procedures) nurses consented patients to?**
4. **In the last five years, how many deaths have been attributed to endoscopy procedures?**
5. **What is best practice in terms of who (i.e. doctors or nurses) should be consenting patients to endoscopy procedures? Should consent be obtained by the clinician conducting the procedure?**

Counties Manukau Health Response:

1. **In the last five years how many endoscopy consents were undertaken by nurses and could I please get a breakdown of the procedures these consents related to (e.g, gastroscopy, colonoscopy, ERCP, etc? I also want to know who conducted the procedure.**
   All outpatient upper endoscopies and colonoscopies are consented by nurses. Counties Manukau Health (CM Health) employs one Trainee Nurse Endoscopist who under supervision of a Senior Medical Officer (SMO) completes around 10 routine procedures (e.g. not interventional) per week on a training list. All other endoscopy procedures are completed by Junior and Senior Medical Officers (RMO/SMO).

   We do not routinely collect the exact information requested and to obtain it would involve manually searching the file of each patient. We can however provide the following as an estimation:

Estimated Outpatient Nurse Consented Endoscopy						
	2015	**2016**	**2017**	**2018**	**2019**	**2020**
Colonoscopy	2704	3659	3495	3985	3998	2483
Colonoscopy of Post-surgical Anatomy	14	42	10	11	9	6
Upper GI endoscopy	2920	3200	3200	3910	4178	2774
Total	**5638**	**6901**	**6705**	**7906**	**8185**	**5263**

Table 1: Data Sourced Provation 25.09.2020

2. **In the last five years how many endoscopy consents were done by doctors and could I please get a breakdown of the procedures these consents related to? I also want to know who conducted the procedure.**
   As mentioned in the above answer, we do not routinely collect the exact information requested and to obtain it would require manual review of hundreds of individual clinical files of patients, we can however provide the following as an estimation:

Estimated Outpatient Doctor Consented Endoscopy						
	2015	**2016**	**2017**	**2018**	**2019**	**2020**
Colonoscopy	45	80	75	100	100	40
Colonoscopy of Post-surgical Anatomy	14	42	10	11	9	6
ERCP	109	148	136	142	133	102
Flexible Sigmoidoscopy	204	230	220	239	254	187
Ileoscopy	5	2	4	5	4	3
Ileoscopy with Pouchoscopy	2	2	1	2		
Lower Device-Assisted Enteroscopy with Fluoroscopy		2			1	
Lower Device-Assisted Enteroscopy without Fluoroscopy		2	4	2	4	
Lower EUS	2	2	1	2	1	
PEG insertion	6	11	6	7	1	3
Pouchoscopy	4	3		2	9	6
Small bowel enteroscopy	5	5	1	4	10	
Upper Device-Assisted Enteroscopy with Fluoroscopy	2	4		1	3	1
Upper Device-Assisted Enteroscopy without Fluoroscopy	8	7	11	12	5	3
Upper EUS	100	143	169	187	188	131
Upper GI endoscopy	57	70	70	120	120	70
Peroral Endoscopic Myotomy (POEM)					2	7
Upper Balloon-Assisted Enteroscopy without Fluoroscopy	3					
Lower Balloon-Assisted Enteroscopy with Fluoroscopy	1					
Lower Balloon-Assisted Enteroscopy without Fluoroscopy	4					
Colonoscopy via Stoma with Endoscopy of Hartmann Pouch						
Upper Balloon-Assisted Enteroscopy with Fluoroscopy						
Ileoscopy via Stoma with Pouchoscopy						
	571	**753**	**708**	**836**	**844**	**559**

Table 2: Data Source Provation 25.09.2020

3. **For the last five years, can you please state how many high-risk endoscopy procedures (based on what you classify as high-risk procedures) nurses consented patients to?**
   None.

4. **In the last five years, how many deaths have been attributed to endoscopy procedures?**
   We do not collect this information.

5. **What is best practice in terms of who (i.e. doctors or nurses) should be consenting patients to endoscopy procedures? Should consent be obtained by the clinician conducting the procedure?**
   As per our informed consent policy and guideline (attached), primary responsibility for ensuring information is given to the patient and for obtaining consent sits with the staff member who is to carry out the treatment or procedure. In some situations, it is impractical for all information to come from the health professional conducting the treatment or procedure. In such cases, an appropriate health professional familiar with the treatment or procedure, and with adequate knowledge of the risks and benefits of the treatment or procedure, should impart the information.

   The consent process in the Gastroenterology Service is currently under active review and new consent forms are being developed for the consent process. For your information, we have also attached our Endoscopy Nurse Consenting Policy.

For context CM Health employs over 7,500 staff and provides health and support services to people living in the Counties Manukau region (approx. 569,400 people). We see over 118,000 people in our Emergency Department each year, and over 2,000 visitors come through Middlemore Hospital daily.

Our services are delivered via hospital, outpatient, ambulatory and community-based models of care. We provide regional and supra-regional specialist services i.e. for orthopaedics, plastics, burns and spinal services. There are also several specialist services provided including tertiary surgical services, medical services, mental health and addiction services.

I trust that this information is helpful. You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or Freephone 0800 802 602.

Please note that this response or an edited version of this may be published on the Counties Manukau Health website. If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider this.

Yours sincerely

Dr Peter Watson
Acting Chief Executive Officer
Counties Manukau Health

Policy: Informed Consent

Purpose

The purpose of this policy is to enable Counties Manukau DHB and its staff comply with relevant legal, ethical and professional standards when providing services and treatment to patients.

Note: This policy must be read in conjunction with the Guideline: Informed Consent.

Scope

This policy is applicable to all CMDHB employees, (full-time, part-time and casual (temporary) including contractors, visiting health professionals and students working in any CMDHB facility and to all organisations providing services and treatment on behalf of CMDHB.

Policy Statements

Health care services should be provided only where the patient has given informed consent to receiving the treatment or some other appropriate legal basis exists for providing treatment.

All individuals and organisations providing services and treatment on behalf of CMDHB are expected to comply with the associated policies, procedures and guidelines.

Associated Documents

Other documents relevant to this policy are listed below:

Document ID:	A5528	**CMH Revision No:**	1
Service :	N/A - Controlled document used across the organisation	**Last Review Date :**	9/07/2018
Document Owner:	Chief Medical Officer (CMO) - Executive Management	**Next Review Date:**	19/01/2021
Approved by:	Clinical Governance Group (CGG)	**Date First Issued:**	16/01/2013

Policy: Informed Consent

NZ Legislation	Care of Children Act 2004 Children, Young Persons and Their Families Act 1989 Contraception, Sterilisation, and Abortion Act 1977 Coroners Act 2006 Crimes Act 1961 The Code of Health and Disability Services Consumers' Rights 1996 Health Information Privacy Code 1994 Health Act 1956 Human Rights Act 1993 Human Tissue Act 2008 Land Transport Act 1998 Mental Health (Compulsory Assessment and Treatment) Act 1992 New Zealand Bill of Rights 1990 Privacy Act 1993 Protection of Personal and Property Rights Act 1988
NZ Standards	None
CMDHB Policies / Procedures	Guideline: Informed consent Documentation in the clinical record Providing services without informed consent to an adult patient with diminished competency Advanced Directives Cultural Safety – Linguistic Interpreters Summary of statutory exceptions to the need for informed consent Guidance notes: Enduring power of attorney and Welfare Guardian Do not attempt resuscitation Informed Consent: Children and Youth Clinical Photography Tikanga Best Practice
Other related documents	SouthNET – Legal and Privacy website

Guideline: Informed consent

Purpose

The purpose of this guideline is to:

- provide guidance about what constitutes informed consent and its key role in the provision of healthcare services; and
- enable Counties Manukau District Health Board (CMDHB) and its staff to comply with relevant legal, ethical and professional standards.

Scope of Use

This policy is applicable to all CMDHB employees, contractors, visiting health professionals and students working in any CMDHB facility.

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GENERAL INFORMATION

What is informed consent?

Informed consent is a process whereby a competent patient (or an incompetent patient's legal representative), who has been given sufficient information, is in a position to make an informed choice and in turn decide voluntarily whether or not to agree to a proposed healthcare service. Consent is founded on ethical obligations and professional standards and is supported by legislation.

NB Throughout this document the terms "informed consent" and "consent" will be used interchangeably.

Where the term "Right" or "Rights" is used, this refers to a Right(s) stated in the Code of Health and Disability Services Consumers' Rights.

Why is consent required?

Consent is a legal requirement before any treatment or procedure can be provided to a patient or service user. Without consent, an alternative legal basis for the provision of any treatment or procedure must be identified.

The failure to obtain consent was one of the catalysts for the enactment of the Health and Disability Commissioner Act 1994 and the issuing of the Code of Health and Disability Services Consumers' Rights (the Code).

Right 7 states:

> *Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or common law, or any other provision of the Code provides otherwise.*

When is consent required?

Informed consent must be obtained prior to any treatment or procedure.

Three key elements of consent:

1. effective **communication** with the patient (Right 5)
2. provision of all necessary **information** to the patient (Right 6); and
3. The patient's **freely** given and **competent** consent (Right 7).

1 Effective communication and manner of information provision

Right 5 states that patients have the right to effective communication in a form, language and manner that enables them to understand the information provided to them.

Information should be given in a language that the patient can easily understand. Where necessary and reasonably practicable it must be translated into the patient's own language by a competent interpreter. Where a professional interpreter is unavailable, the risks associated with deferring treatment must be balanced against the risks associated with using family or friends as interpreters in the specific case.

There should be privacy for discussions of diagnosis and treatment options and consideration should be given to the involvement of support persons and family. The patient should be provided sufficient time to read any written information and to discuss it with whomever they wish. This communication process should be a shared dialogue responsive to the needs, wishes, capabilities, culture, and concerns of the particular patient.

The patient should be advised of how any further questions may be addressed and who to contact.

2 Provision of information

Right 6 states that before making a choice or providing consent, every patient has the right to information that a reasonable patient, in that patient's circumstances, needs to make an informed choice, and, in turn, provide informed consent.

This information will typically include -

- an explanation of their condition;

- an explanation of the options available, including an assessment of the expected risks (including the likely consequences if the treatment is not provided), side-effects, benefits, and costs (where relevant)of each option; and
- advice of the estimated time within which the treatment or procedure will be provided; and
- notification of any proposed participation in teaching all research, including whether the research requires and has received ethical approval; and
- any other information required by legal, professional, ethical, and other relevant standards; and
- the results of tests and the results of procedures.

Every patient has the right to receive on request a written summary of the information provided.

Patients have the right to honest and accurate answers relating to any proposed treatment or procedure or services generally, including:

- the identification and qualifications of the provider; and
- the recommendation of the providers; and
- how to obtain an opinion from another provider; and
- the results of research.

Patients who do not want to be fully informed

Some patients may not wish to be fully informed about their treatment. In this case, document fully in the clinical record what was discussed with the patient and the patient's wish not to be fully informed (and the extent to which they were informed). In some cases, treatment should not proceed unless the patient is willing to receive certain information. This will be a clinical judgement.

How much information is required?

There is no fixed threshold (e.g. a complication occurs in >1% of cases) for defining what must be discussed, but the likelihood of any harm will require greater detail and fuller explanation to enable consent to be properly provided. The provision of information must be patient specific. For example, the risk of bleeding in a patient who is anti-coagulated or a Jehovah's Witness is likely to assume greater significance than in other patients.

Refer to New Zealand Medical Council website (link in the *Associated Documents* below) for more guidance.

3 Presumption of capacity

Right 7(2) of the Code provides that patients are presumed competent (i.e. to have capacity) to make informed choices and give informed consent unless there are reasonable grounds for believing that the patient lacks competence. Competence means that the patient

understands the nature, purpose, effects and likely consequences of consenting to, or refusing the proposed treatment. Competence and the ability to consent may be affected by many factors including pain, medication, intellectual disability, mental illness or physical injuries. Competence may also fluctuate; e.g. patients with delirium.

The clinician is required to make a reasonable judgement as to whether a patient is competent to give informed consent. Competence must be assessed at the time that consent is gained. Relevant factors to determining competence are the patient's ability to:

- understand and retain relevant information; and
- believe the information; and
- understand the nature and consequences of options; and
- weigh the information, balance the risks and arrive at a choice; and
- communicate a decision.

If one of these elements is absent then the patient lacks capacity to provide consent.

Patients with mental illness are also presumed competent to consent to treatment. Sometimes, however, an aspect of mental illness may affect the person's competence to consent. For example, a delusional belief about a treatment may mean that a patient lacks capacity to consent to that treatment. If there is suspicion that a patient's capacity to consent is influenced by their mental illness, it is prudent to obtain the input of a mental health clinician.

Note that the Mental Health (Compulsory Assessment and Treatment) Act 1992 permits compulsory treatment of mental health disorders only.

If a patient is competent then they alone are legally entitled to give, withdraw, or refuse consent. This applies in all cases including emergencies, even if the decision risks death or permanent injury to the patient. A competent patient may make an imprudent decision – for example to discharge themselves against the advice of clinical staff. However, that is their legal right as an autonomous person under the law.

A patient who has diminished capacity retains the right to give informed consent *to the extent appropriate to his or her level of competence*: **Right 7(3).** The level of competence required to give valid consent will increase with the complexity and risk of the decision being made.

Treatment without consent - Provision of care pursuant to Right 7(4)

Where a patient isn't competent, Right 7(4) sets out an alternative process allowing the provision of services where a patient is not competent to make an informed choice and give informed consent. There are also a number of statutory exceptions to the requirement for consent (e.g. blood transfusions for persons under 18 years).

Right 7(4) of the Code of Health and Disability Services Consumers' Rights provides:

> When a patient is not competent to make an informed choice and give informed consent, and no person legally entitled to consent on behalf of the patient is available, services may be provided where:
>
> a) it is in the best interests of the patient; and
>
> b) reasonable steps have been taken to ascertain the views of the patient; and
>
> c) either:
>
> (i) if the patient's views have been ascertained, and having regard to those views, the clinician believes on reasonable grounds that the provision of services is consistent with the informed choice the patient would make if he or she were competent; or
>
> (ii) if the patient's views have not been ascertained, the clinician takes into account the views of other suitable persons who are interested in the welfare of the patient and are able to inform them of.

If surgery is proposed then use the **Form: Treatment for Patients without Capacity to Consent** (refer to *Associated Documents* below).

NB. Next of kin cannot consent to treatment on behalf of a patient unless they are legally entitled to do so.

Primary responsibility for consenting the patient and delegation of this role

Primary responsibility for ensuring information is given to the patient and for obtaining consent sits with the staff member who is to carry out the treatment or procedure.

In some situations it is impractical for all information to come from the health professional conducting the treatment or procedure. In such cases, an appropriate health professional familiar with the treatment or procedure, and with adequate knowledge of the risks and benefits of the treatment or procedure, should impart the information.

Where it is impractical for consent to be obtained by the health professional conducting the procedure, an appropriate health professional may be delegated this responsibility. The health professional undertaking the procedure must ensure obtaining consent is delegated only to another health professional who is familiar with the issues above and who also fully understands the associated risks and benefits *for that particular patient*.

Documentation of consent

Consent, whether oral or written, should always be recorded in the patient's record. Signed consent forms are evidence that a patient was informed and consented to the services as described within the consent form. However, consent is an on-going process reflecting the evolving clinical picture and the relevant procedure or treatment that the patient requires, and all clinicians involved in providing information to patients should document any new or revised consent obtained clearly in the clinical record.

Right 7(6) states that consent must be in writing if –

a) the patient is to participate in research; or

b) the procedure is experimental; or

c) the patient will be under general anaesthetic; or

d) there is a significant risk of adverse effects.

Consent must also be given in writing if:

- body parts or tissue are to be removed other than for standard laboratory tests (e.g. for teaching or research purposes)
- video or photographic recordings of the patient will be made
- electroconvulsive treatment (ECT) is to be provided with the consent of the patient
- there is any doubt about the need for written consent or written consent has been requested by the patient or the person providing the service.

Documentation in the clinical notes should include:

- a summary of the information provided to the patient, when provided and by whom;
- the name and designation of the person obtaining consent, and if known the name and designation of the person who will perform the procedure;
- specific queries made by the patient, and the response provided;
- confirmation the patient indicated that they understood the information; and
- a statement that consent was obtained.

Findings during surgery, +/- proceed, returns to theatre

When the possibility of multiple or additional treatments or procedures is anticipated the patient should be fully informed in advance and their consent obtained for each possible treatment or procedure (including the associated risks of each).

If an unexpected event occurs intra-operatively and the patient has not given prior informed consent to additional treatment, no further treatment can be lawfully undertaken without first obtaining consent, unless those treatments are required for the preservation of life or the prevention of a permanent disability such as the loss of a limb. In such a case, treatment will be provided on the basis of Right 7(4).

In all other cases the patient should be stabilised, anaesthesia reversed, the patient informed of the unexpected findings and a new consent process undertaken. This process may require that the patient is re-scheduled for further surgery.

Right to refuse consent to treatment

Every competent patient has the right to refuse services and to withdraw consent for services or treatment: **Right 7(7)** and section 11 of the New Zealand Bill of Rights Act 1990.

The patient should be reassured that they have a right to refuse or withdraw from treatment without the standard of care being provided to them being adversely affected. The refusal of consent should be carefully and fully documented in the patient's clinical record. Consideration should be given to asking the patient to provide a written acknowledgement of their refusal, especially if the risks of not treating the patient are high.

How long is consent valid for?

The duration for which consent is valid must be considered on a case-by-case basis, taking into account:

- the nature of the procedure
- time elapsed since consent was given progression of the patient's condition and current health status
- patient's competence
- availability of, or a change in service or treatment options
- a change to the clinician who will be undertaking the procedure.

Ongoing treatment

In the case of ongoing treatments requiring repeated intervention, for example multiple surgeries for debridement of burns, dialysis, blood transfusions, it is acceptable to obtain informed consent for the overall treatment plan. Should the treatment plan change then consent should be obtained again.

CHILDREN AND YOUNG PERSONS

The general principles as stated above apply to children and young people. The presumption in **Right 7(2)** of the Code that all consumers are presumed competent applies to children for the purposes of liability under the Code.

Children of or over 16 years old

Section 36 of the Care of Children Act 2004 (COCA) provides that a child of or over 16 years old may consent or refuse consent to:

(a) donation of blood; or

(b) any medical, surgical, or dental treatment or procedure (including the transfusion of any blood or blood products) to be carried out on the child for the child's benefit by a person professionally qualified to carry it out.

Children 0 to 15 years old

Children under 16 years can consent to treatment if they are competent to make a decision about the particular treatment. The assessment of competence is a question of fact for the health professional to determine in each case. As a rule, the younger the age of the child, and the greater the significance of the treatment decision, the less likely it is that the child will have capacity to give legally effective consent.

The test for competence is the same as for an adult – a child is competent to consent to, or to refuse, treatment if they understand the nature, purpose, effects and likely consequences of consenting to, or refusing the proposed treatment. The child must have sufficient maturity to understand the nature of the proposed treatment, its purpose, and consequences (including intended and possible side-effects and anticipated consequences of treatment).

Where a child is competent to consent, involvement of the parents should be encouraged. However if the competent child refuses to involve the parents, or the parents disagree with the competent child's decision, the child's decision must be respected with the proviso that the health professional considers treatment to be in the child's best interests.

Who may consent to treatment of a child?

Section 36(3) of the COCA provides that if consent of another person to a medical, surgical, or dental treatment or procedure (including blood transfusion) to be carried out on a child is necessary, that consent may be given –

(a) by a guardian of the child; or

(b) if there is no Guardian in New Zealand or no Guardian of that kind can be found with reasonable diligence or is capable of giving consent, by a person in New Zealand who has been acting in the place of a parent; or

(c) if there is no person in New Zealand who has been so acting, or if no person of that kind can be found with reasonable diligence or is capable of giving consent, by a District Court Judge or the chief executive [of the Ministry of Social Development].

The consent of both guardians is not required however it is preferable that the guardians agree to treatment. The paramount consideration is the best interests of the child.

Where a child has been placed under Court guardianship, Oranga Tamariki will often be appointed as the Court's agent and be given the power to make decisions about the child's care, including medical treatment.

Note also that in addition to providing information in order for parents/guardians to make a treatment decision on a child's behalf, information must, where practicable, be given to the child patient in a way that the child can understand.

Consent to abortion

Section 38 of the COCA provides that a female child (of whatever age) may consent, or refuse, to the carrying out on her of any medical or surgical procedure for the purposes of

terminating her pregnancy by a person professionally qualified to carry it out. This section specifically overrides section 36 of the COCA, cited above.

Blood transfusion without consent

Section 37 of the COCA permits the administration by a health practitioner of blood or blood products by transfusion to a patient under 18 without consent where, in the circumstances it is reasonable to administer the transfusion and:

(a) the transfusion was, in the opinion of the health practitioner, necessary to save the life of the patient or to prevent permanent injury to the patient's physical or mental health, or to save the patient from prolonged and avoidable pain and suffering: and

   a. reasonable attempts were made to obtain the consent of the person appearing to be legally entitled to consent to the transfusion; or

   b. the circumstances were such that it was necessary to administer the transfusion promptly, and it was impracticable, in the time available, to attempt to obtain the consent of the person appearing to be legally entitled to consent.

CONSENT AND THE INCOMPETENT PATIENT

When a patient is deemed to lack capacity (to be incompetent), consent to treatment may be given:

- according to **a valid advance directive**; or
- with the consent of a **person legally entitled to consent** on the patient's behalf (i.e. an attorney appointed under an Enduring Power of Attorney or a Welfare Guardian appointed by the Family Court); or
- according to **a court order**; or
- without consent, where the requirements of **Right 7(4)** are met (see above).

NB. Next of kin, unless they are empowered by a valid legal mechanism such as an EPOA that has been activated, cannot consent on behalf of their relative/the patient. If the patient is incompetent and no one is legally entitled to consent on behalf of the patient, Right 7(4) provides an appropriate basis for treatment without patient consent.

Advance Directives

Right 7(5) provides that a patient may use an advance directive.

An advance directive is a patient's instructions to consent to or to refuse treatment given at a time when the patient was competent, for use when they are subsequently lacking capacity. An advance directive should be followed unless there are reasonable grounds for believing it is not valid.

To be valid the advance directive:

- must have been made when the patient was competent; and
- the patient must have anticipated and intended their decision to apply to the prevailing circumstances; and

- the patient must have been sufficiently informed to make a decision; and
- the patient's decision must have been reached without undue influence.

Refer to the Guideline: Advance Directives for more information (see link below).

Persons legally entitled to consent on the patient's behalf

The Protection of Personal and Property Rights Act 1988 (PPPR Act) allows for the appointment of attorneys and welfare guardians who are legally empowered to make care and welfare decisions for patients who are incompetent. They are different:

- *An EPOA for care and welfare* is set up while a patient is still competent. The EPOA comes into effect once the patient has been assessed as lacking capacity and the EPOA has been activated by virtue of a medical certificate.
- *An order appointing a Welfare Guardian* made by the Family Court when a patient has been assessed as "wholly incompetent" in relation to their personal care and welfare.

Before either an EPOA or a personal order appointing a Welfare Guardian is relied upon the legal paperwork should be sighted and a copy of it added to the patient's notes. If there are doubts as to the validity of the documents the Legal Service should be consulted.

EPOA for care and welfare

A person is mentally incapable ("incompetent") in relation to their care and welfare if they lack capacity to:

- make a decision about a matter relating to their personal care and welfare; or
- understand the nature of the decision about matters relating to their personal care and welfare; or
- foresee the consequences of decisions or of not making such decisions; or
- communicate decisions about matters relating to their welfare.

The EPOA may give the attorney broad or specific powers, so the wording of the EPOA needs to be checked to ensure the attorney is acting within the ambit intended by the patient. The attorney must always act in the person's best interests and they have a duty to encourage the person's independence as much as possible.

Refer to Guideline: Enduring Powers of Attorney for more information on EPOAs and their activation (link below).

Welfare Guardian

A Welfare Guardian is appointed by the Family Court when a patient wholly lacks capacity to make decisions relating to their care and welfare and the appointment of a welfare Guardian is the only satisfactory way to ensure the appropriate decisions are made.

"Wholly lacking capacity" means that a patient wholly lacks capacity to make or to communicate decisions relating to any particular aspect or particular aspects of their personal care and welfare. A welfare Guardian must promote and protect the interests and welfare of the subject person while encouraging them to develop their capacity to make their

own decisions. Decisions made by a welfare Guardian have the same effect as if the patient had made them.

Refer to Guideline: Personal Orders under the PPPR Act for further information (see link below).

Limits on the powers of attorneys appointed under EPOAs and Welfare Guardians

An attorney appointed under an EPOA or a Welfare Guardian appointed under the PPPR Act does not have unlimited powers to consent to treatment on behalf of a patient. Section 18 of the PPPR Act provides that an attorney or Welfare Guardian does not have the power to –

- refuse consent to any standard medical treatment or procedure intended to save the patient's life or to prevent serious damage to the patient's health;
- consent to the administration of electroconvulsive treatment or treatment designed to destroy any part of the brain or brain function for the purpose of changing the patient's behaviour; or
- consent to the patient taking part in any medical experiment other than one to be conduct for the purpose of saving the patient's life or preventing serious damage to the patient's health.

TEACHING AND RESEARCH

Patients have the right to be notified of proposed participation in teaching or research: **Right 6(1)(d)**.

Patients participating in research must provide written consent (**Right 7(6)(a)**) and they have the right to the results of research (**Right 7(3)(d)**).

Refer to policy: Clinical Teaching and Research (see link below).

Students should comply with policy requirements including the presence of a chaperone where indicated.

Chaperones

Patients have the right to have a chaperone present during sensitive/intimate examinations such as breasts and genital/anorectal areas.

Cultural and religious beliefs of patients need to be taken into account.
Sensitivity is also required to the feelings of vulnerable patients, such as those with a history of sexual abuse.

Assumptions should not be made about the preferences of different groups of patients based on their age, ethnicity, or gender. There are no upper or lower age limits.
Clinicians should not assume that a chaperone is not required if the clinician and patient are of the same sex.

Choosing an Appropriate Chaperone
The most appropriate person to be a chaperone is a member of the clinical team.
The patient must be introduced to the chaperone and informed what their position is within the team.
A patient's friends and relatives should not ideally be used as chaperones due to potential embarrassment and inadvertent breaches of confidentiality.

How to use a Chaperone
Confidentiality of the patient needs to be preserved in the presence of a chaperone.
The name and designation of the chaperone needs to be documented in the patient's notes.
If the offer of a chaperone is declined, this needs to be documented in the patient's notes.
If the clinician does not want to proceed with the examination in the absence of a chaperone, the patient needs to be asked to reconsider or accept a referral to another clinician.

HUMAN TISSUE

Right 7(9) provides that all patients have the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a healthcare procedure.

Right 7(10) provides that no body part or bodily substance removed or obtained in the course of a healthcare procedure may be stored, preserved, or used otherwise than –

(a) with the informed consent of the consumer; or

(b) for the purposes of research that has received the approval of an ethics committee; or

(c) for the purposes of one or more of the following activities, being activities that each undertaken to assure or improve the quality of services:

i. a professionally recognised quality assurance programme;

ii. an external audit of services:

iii. an external evaluation of services.

The Human Tissue Act 2008 sets out a statutory regime to help ensure that the collection or use of human tissue from a person (before or following their death) recognises, among other things, the:

- autonomy and dignity of that person
- cultural and spiritual needs, values and beliefs of their immediate family, and
- public good associated with the use of human tissue (whether for health practitioner education, the investigation of offences, research, transplantation or other therapeutic purposes, or for other lawful purposes), and
- health and safety of the public.

The Human Tissue Act 2008 makes informed consent the fundamental principle underpinning the lawful collection and use of human tissue. The primary consent will be from the deceased, if formally recorded before death, or from someone nominated by the

deceased to make the decision on their behalf after death. In the case of organ donation, the objection of immediate family may override the deceased's consent to donation.

Refer to Policy: Human Tissue for further information (see link below).

STATUTORY EXCEPTIONS TO CONSENT

There are a number of statutory exceptions to the requirement for informed consent, including:

- court orders made pursuant to a variety of legislation – e.g. under the Oranga Tamariki Act 1989 requiring children or young persons to be medically examined without parental consent, under the Tuberculosis Act 1948 detaining a patient with TB for treatment, and under the Criminal Procedure (Mentally Impaired Persons) Act 2003 ordering a person to undergo a psychiatric evaluation;
- legislation that permits compulsory assessment and treatment – e.g. under the Mental Health (Compulsory Assessment and Treatment) Act 1992;
- legislation that permits actions that otherwise would amount to assault – e.g. use of reasonable force to prevent suicide or an offence which would be likely to cause immediate and serious injury: section 41 of the Crimes Act 1961;
- legislation that authorises the taking of bodily samples to detect offences – e.g. blood samples taken by a health professional when that health professional is asked to do so by an enforcement officer: section 72 of the Land Transport Act 1998; and
- legislation that authorises the treatment and prevention of the spread of infectious diseases – e.g. Health Act 1956.

Contact the Legal Team for further information.

Definitions/Description

Term/Abbreviation	Description
Code, Code of Rights	Code of Health and Disability Services Consumers' Rights
COCA	Care of Children Act 2004
PPPR Act	Protection of Personal and Property Rights Act 1988

Associated Documents

NZ Legislation	Care of Children Act 2004 Oranga Tamariki Act 1989 Contraception, Sterilisation, and Abortion Act 1977 Coroners Act 2006 Crimes Act 1961 Criminal Investigations (Bodily Samples) Act 1995 The Code of Health and Disability Services Consumers' Rights 1996 Health Information Privacy Code 1994 Health Act 1956 Human Rights Act 1993 Human Tissue Act 2008 Land Transport Act 1998 Mental Health (Compulsory Assessment and Treatment) Act 1992 New Zealand Bill of Rights 1990 Privacy Act 1993 Protection of Personal and Property Rights Act 1988
CM Health policies	Guideline: Advanced Directives Guideline: Enduring Powers of Attorney Guideline: Applications under the Protection of the Personal and Property Rights (PPPR) Act Policy: Adult - Do not attempt resuscitation order Policy: Clinical Photography Policy: Clinical Teaching and Research Policy: Human Tissue
Other sources	HDC Code of Health and Disability Services Consumers' Rights NZ Medical Council guidance on consent Medical Students and informed consent – A consensus statement (2015), NZMJ Vol 128 No 1414.
Clinical Forms	Form: Request for Treatment/consent form Form: Treatment for patients without capacity to consent

Policy: Endoscopy Nurse Consenting

Purpose

The purpose of this protocol is to provide Counties Manukau Health (CMH) Endoscopy Unit Staff with the authority to obtain written consent for day case patients undergoing Gastroscopy, Colonoscopy, and Flexible Sigmoidoscopy or Capsule Endoscopy procedures.

Registered Nurses facilitating informed consent do so with the authorisation of the medical practitioner responsible for the patient's procedure.

The responsibility for final verification of the patient's informed consent remains with the medical practitioner responsible for the procedure.

Note: Exclusions to this procedure:

- *Children ages 15 or younger*
- *Adults without the capacity to retain or recall the information given to them*
- *Adults who do not agree for a Registered Nurse to obtain their consent*

Objective

To ensure that patients are provided with information and the opportunity to discuss their planned procedure in preparation for completion of the informed consent process

Scope of Use

This procedure is applicable to Registered Nurses within the Endoscopy Unit who are credentialed as competent to consent for the following procedures:

- Colonoscopy
- Gastroscopy
- Flexible Sigmoidoscopy
- Capsule Endoscopy

Nursing Council Competency Criteria

The following New Zealand Nursing Council Competency for registered nurse scope of practice is demonstrated on completion of this competency.

Domain One: Professional Responsibility
Competencies 1.1, 1.2, 1.4 and 1.5
Domain Two: Management of Nursing Care
Competencies: 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8 and 2.9
Domain Three: Interpersonal Relationships
Competencies: 3.1, 3.2 and 3.3
Domain Four: Inter-professional Health Care and Quality Improvement
Competencies 4.1 and 4.2

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Document Owner:	Clinical Nurse Manager	**Next Review Date:**	
Approved by:		**Date First Issued:**	15/05/2009

Procedure

Step	Action
1	The Registered Nurse (RN) demonstrates competency to participate in obtaining informed consent. The RN must have been employed within the clinical service for a minimum of 3 months
2	**The consent process meets organisational standards:** ▪ Components of the AI²DET communication tool are correctly demonstrated within the clinical setting ▪ Ensures a private space is provided out of the procedure room for completion of informed consent ▪ Ensures that if required, the patient and family have access to interpretation service ▪ Completes a nursing assessment, including comprehensive information about the patients medication, medical and surgical history ▪ Assesses if the patient does not have any contraindications that will place them at risk to undergo the procedure ▪ Checks the treatment and consent forms match the referral documentation for proposed treatment/ procedure ▪ Ensures the patient has received the postal information booklets relevant to their intended procedure ▪ Ensures that all information documents have been reviewed with patient and completed accurately for a patient's procedure. This includes information around the use of conscious sedation ▪ Discusses the risks and complications as well as potential consequences of these complications ▪ Any identified patient concerns are escalated to the registered medical practitioner who verifies consent with the patient prior to commencing the procedure ▪ When the patient has signed the consent form, countersigns that the patient understands the procedure and potential risks

References

- Applebaum, Berg J, Wolidz C, Parker L.S, (2001) Informed Consent Legal Theory and Clinical Practice. New York, University Press
- Leino-Kipli H. (2000). Patients Autonomy, Privacy and Informed Consent. Oxford: IOS Press
- Weber, J. & Kelley, J. (2003). Health Assessment in Nursing (2nd Ed). Lipincott. Williams & Wilkins. Philadelphia

Associated Documents

Other documents relevant to this procedure are listed below:

NZ Legislation / Standards	The Code of Health and Disability Services Consumers Rights 1996 Human Rights Act 1993 Privacy Act 1993
CM Health Documents	CMH Informed Consent Policy (A5528) CMH Informed Consent Guideline (A153992) CMH Effective Use of Interpreters Guideline (A474024) CMH Certification Assessment Form - Endoscopy Nurse Consenting
Other related documents	None

Certification Assessment Form – Endoscopy Nurse Consenting

Employee Name:	Department:

COMPETENCY ASSESSMENT	Yes	No	Comments to support Competency
Components of the AI²DET communication tool are correctly demonstrated within the clinical setting			
Ensures a private space is provided (not in the procedure room) for completion of informed consent			
Ensures that if required, the patient and family have access to interpretation services			
Completes a nursing assessment, including comprehensive information about the patients medication, medical and surgical history			
Assesses if the patient has any contraindications that will place them at risk to undergo the procedure			
Checks the treatment and consent forms match the referral documentation for treatment/ procedure			
Ensures the patient has received the postal information handout relevant to their intended procedure			
Ensures that all information documents have been reviewed with patient and completed accurately for a patient's procedure. This includes information around the use of conscious sedation			
Discusses the risks and complications as well as potential consequences of these complications			
Any identified patient concerns are escalated to the registered medical practitioner who verifies consent with the patient prior to commencing the procedure			
When the patient has signed the consent form, countersigns that the patient understands the procedure and potential risks			

The above employee has demonstrated competency to facilitate the informed consent process

Assessor's Name and Signature: _____ Date: _____

Nurse Manager Name & Signature: _____ Date: _____