Colleagues,

More than 18 months ago, I was asked to help in providing and supporting physician input to the provincial consent policy implementation group (CPIP) that was struck in response to concerns about the prior development and implementation of a single Alberta Health Services (AHS) consent policy and forms that were created with the initial reorganization to AHS from the former Health Regions and Entities.

Alignment with legislation (Adult Guardianship and Trusteeship Act and the Mental Health Act) and changes to national standards (Blood Transfusion and Tissue and Organ Donation) were part of the drive as well as significant variation in consent practices across the province.

The initial AHS consent form was not found to be practical in different clinical settings such as surgery versus community team assessment programs. Prior surgical consent included items around transfusion, blood-borne virus testing and retention of tissue. There was a need to address increasing requirements to support recently implemented policy specifying the need for a written consent for transfusion of blood and blood products as well as clearer means to document refusal of consent for procedures and blood products. There was concern about the requirement for multiple acknowledgements by specific decision makers in settings where the patient lacked capacity and the role of the physician in determining a lack of capacity for the specified decision only. There was also variability in interpretation of the intent and requirements for 2 signatures in the emergency health care setting. In the emergency health care setting, the 2 physician signature requirement is better framed as a means to capture documentation of an exception to consent rather than being used as a method to address situations where it seems impractical to obtain consent.

A number of consent discussion sessions took place and a number of working groups were formed to identify stakeholder input and clarify solutions. In particular, there was active provincial surgical input from the Surgical Clinical Network to come up with required elements for a surgical/invasive procedural consent. The Transfusion Medicine Network was key to identifying a way to support a specific written consent for blood products within the surgical consent and identifying better documentation for refusal of blood products. Provincial Workplace Health and Safety (WHS) provided support for development of a consistent approach to consent for blood borne virus testing after blood and body fluid exposure when outside surgical consent. Representation from the Critical Care Network met to discuss and create process maps and decisions support tools to clarify when and how consent is obtained within the critical care environment; acknowledging that the majority of health care procedures are being appropriately provided under emergency health care provision.
After revisions were identified it was then necessary and important to work with Forms Management, Clinical Legal and Clinical Policy to ensure that the new forms were clear and consistent and easier for patients and clinicians to use. Unfortunately, multiple changes to the organization fettered the progress and contributed to the long delay from input to final sign-off.

While it seems like a difficult time to roll-out any initiative, and communication is always a challenge, it was clear that getting the requested revisions out to support users remained the priority. There will need to be time for the local education and process to be set up to enhance the implementation of the revised consent forms. The policies themselves have not changed. However, different operation groups (including the Most Responsible Health Practitioner) will have to identify what will be their main consent form and when and how to incorporate the others as needed. Currently, available versions of the original consent form (09741), and forms that have already been completed, will still be valid. Once areas have established their process with the revised consent forms, the old consent forms should be removed.

There may be some remaining concerns related to consent and, in some cases, there may be a need to develop and implement additional forms for aspects of care that cannot be supported with the current versions or addition of program-specific patient information. For example, there is still a need to develop a province-wide Consent to Autopsy form as well as an enhanced process and form to support clarification of accepted therapies where there is refusal of blood products. This work will continue and further considerations where gaps may exist should be forwarded to Clinical Policy or Forms Management.

There may be need for the local consent working groups to reconvene briefly to ensure that local operations are able to develop and support necessary processes for implementation of the revised consent forms.

Please contact myself or clinicalpolicy@albertahealthservices.ca if concerns arise without clear solutions.

Sincerely,

Elizabeth MacKay

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