Consent for Health Care

Site Applicability

All Vancouver Coastal Health (VCH) and Providence Health Care (PHC) sites

Note: This procedure does not cover consent to Care Facility admission which follows a separate process; please refer to the VCH/PHC Consent to Care Facility Admission Policy for guidance.

Practice Level

Profession	Basic Competency with Additional Education
• All regulated professionals within scope of practice, role and competencies. • All unregulated health care occupations within their entry to practice education, employer training and duties and responsibilities. • All unregulated care staff providing direct patient care, within their education, employer training, duties and responsibilities, and under the direction of appropriate regulated/unregulated health care professionals.	✓

Additional Education

VCH and PHC Staff and Medical Staff (hereafter referred collectively to as "Staff") involved in the direct care of Clients complete LearningHub courses based on the direction of their managers:

- Capability & Informed Consent;
- Emergency or Urgent Care;
- Substitute Decision Making.

Requirements

Review and follow VCH/PHC Consent for Health Care Policy.

Need to Know

The *Health Care (Consent) and Care Facility (Admission) Act* (referred to as the *Health Care Consent Act* in this document) provides the legal framework for obtaining consent for Health Care in British Columbia (BC). It affirms the right of Adults (aged 19 and older) to make their own Health Care decisions and outlines the steps Staff must follow when a person is incapable of giving consent. This legal framework also applies to Mature Minors; for further guidance, refer to consent for minors.

For a visual overview of the Health Care consent process, refer to Appendix A.

Health Care is defined in the legislation as anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other purpose related to health. This includes:

- A series or sequence of similar treatments or care administered to a Client over a period of time for a particular health problem;
- A plan for care that:
  - Is developed by one or more Health Care Providers;
  - Deals with one or more of the health problems that a Client has and may deal with one or more of the health problems that a Client is likely to have in the future given the Client's current health condition; and
  - Expires no later than 12 months from the date of consent; and
- Participation in a medical research program approved by an ethics committee designated by regulation.

The *Health Care Consent Act* further distinguishes Major Health Care and Minor Health Care. Consent is required for Major and Minor Health Care, subject to certain exceptions.

Major Health Care	Minor Health Care
Defined as: (a) Major surgery; (b) Any treatment involving a general anesthetic; or (c) Major diagnostic or investigative procedures, including Major Health Care as designated by regulation: Radiation therapy, intravenous chemotherapy, kidney dialysis, electroconvulsive therapy, or laser surgery.	Defined as any Health Care that is not Major Health Care and includes: (a) Routine tests to determine if Health Care is necessary; and (b) Routine dental treatment that prevents or treats a condition or injury caused by disease or trauma; for example: (i) Cavity fillings and extractions done with or without a local anesthetic; and (ii) Oral hygiene inspections.
This category includes procedures with elevated risk or that may have life-altering consequences. Examples include: Administration of blood and blood products, transplants, chemotherapy and radiation therapy, dialysis treatment, anesthesia administration for major procedures, experimental treatments or clinical trials, major diagnostic procedures with significant risks (e.g., cardiac catheterization, biopsy of vital organs), stem cell therapies, and end of life interventions such as withdrawal of life support.	This category includes procedures that carry low risk and are unlikely to have life-altering consequences. Examples include: Blood tests and routine lab work, administration of over-the-counter medications, wound care (e.g., dressing changes, application and removal of sutures or staples), vaccinations and immunizations, physical examinations, imaging procedures with minimal risk (e.g., X-rays, ultrasounds), and physiotherapy and occupational therapy treatments.

Quick Links

Procedure

Indigenous Cultural Safety

In alignment with VCH Indigenous Cultural Safety and PHC Indigenous Cultural Safety policies, Staff must ensure that Indigenous people receiving care are fully informed and involved in decisions around their own care, with respect for their identities, traditions, and values. This is rooted in Staff reflecting on past and present realities of systemic and interpersonal harm done to Indigenous people and taking action to ensure our care and sites are Culturally Safe for Indigenous people.

Staff should reflect on inherent power imbalances with Clients and uphold their full decision-making power and autonomy. Review Indigenous Cultural Safety (ICS) educational resources such as the Indigenous Cultural Safety Competency Tool to self-check for biases and stereotypes. For complex situations, seek support from VCH Indigenous Health Services and PHC Indigenous Wellness Liaisons.

When is consent needed?

Staff **must obtain consent** before providing Health Care, **unless:**

a. The Health Care is triage or a preliminary examination, treatment, or diagnosis (e.g., a person's initial Emergency Department visit prior to seeing a physician/nurse practitioner);
b. The Health Care is involuntary psychiatric treatment under the *Mental Health Act (MH Act);* or
c. The Health Care is required in emergency situations where immediate treatment is necessary to preserve life, prevent serious harm, or alleviate severe pain for a person incapable of giving consent.

VCH and PHC facilities are teaching facilities. Where possible, Staff must respect a Client's wish that trainees not be involved in providing their Health Care.

Medical Assistance in Dying (MAiD) has different legislative requirements for consent. For support, contact the VCH Assisted Dying Program.

How long does consent last?

a. For the duration of a *single M*ajor or Minor Health Care treatment (e.g., a Client would consent each time they receive an annual influenza vaccination, or once prior to surgery to repair a fractured ankle).
b. For the duration of a *series or sequence of similar M*ajor or Minor treatments over a period of time for a specific health issue (e.g., a Client would consent once to undergo kidney dialysis, with their understanding that this consists of ongoing successive treatments).
c. For the course of a care plan less than 12 months in length that addresses one or more minor health issue (e.g., a prescription for hypertension medication valid for under 12 months, or successive physiotherapy sessions for under 12 months).

A capable Client (or Substitute Decision Maker) can decline or withdraw (revoke) consent at any time.

Note: Once a Client has provided consent for the Health Care, it is not necessary to obtain formal consent again for each routine treatment (e.g., daily medications), as long as the treatment remains within the scope and duration of the original consent. However, Staff should use clinical judgment and regularly check-in with the Client to ensure they still agree with the treatment being provided as appropriate and reasonable to the situation.

Who obtains consent?

The Staff proposing the Health Care is typically responsible for obtaining consent, often the individual who orders or recommends the care. The Staff proposing the Health Care is typically best positioned to provide the necessary information about the proposed treatment and to assess the person's understanding and ability to provide informed consent. For example, a surgeon is primarily responsible for obtaining consent for surgery. A nurse acting within their autonomous scope of practice is responsible for obtaining consent from the Client, as per college practice standards.

In some situations, Staff with specialized knowledge about the Health Care (e.g., a specialist physician like a radiologist) must be included in discussions with the Client. Further, the specialist may be best suited to obtain consent from the Client for the specific Health Care.

Ensuring the Client's Capability to Provide Consent

The Client's capability to make a decision about the proposed Health Care is essential to the informed consent process. While Clients are presumed capable, Staff may have reason to believe that a Client is *incapable* to make a Health Care decision. In such cases, it is the responsibility of the most responsible Staff member – typically the Staff proposing the Health Care – to assess for incapability. Where appropriate, this assessment is supported through team-based collaboration.

Steps:

a. **Presume capability: Every adult is presumed to be capable of giving, declining, or revoking consent to Health Care until it is demonstrated that they are incapable** (unless they have a court-appointed guardian called a Committee of Person; i.e., a court order that confirms the appointed adult is incapable to consent to the Health Care decision). A few common misconceptions:

- Certain factors – such as communication style, appearance, age, diagnosis, behaviour, intellectual disabilities, cognitive test scores, or processing delays – **do not** on their own indicate that the Client is incapable of making Health Care decisions.
- The Client declining Health Care or engaging in behaviours that may lead to negative outcomes **do not** on its own mean they are incapable to make Health Care decisions.
- Capability may **change frequently** with the Client's status over hours or days. When the Client is capable, their decisions must be respected even if a different decision is made on their behalf during a period where they are determined to be incapable.

b. **Use strategies to improve the Client's ability to understand Health Care information as appropriate to the Client's status and situation.**

Indigenous Cultural Safety	• Foster trust with the Client by prioritizing meaningful relationship-building. Trust must precede formal consent because of past and ongoing harms in the health system that Indigenous people continue to face. • For Indigenous Clients, consider providing a Territorial Acknowledgement, followed by a personal introduction that shares who the Staff member is as a human being before stating professional role.

Communication Approaches	• Allow time for relational conversation before discussing Health Care. • Ensure the Client can receive and process Health Care information in a manner appropriate to their language needs, cultural preferences, and learning style. • Ask the Client if it is an appropriate time to have a conversation about their Health Care. • Use clear, plain language when interacting with the Client. Avoid jargon. • Avoid abbreviations. Explain abbreviations when they must be used. • Include different modes of communication (e.g., hand motions, diagrams). • Provide reassurance. Allow the Client to ask questions and tell their story without fear of judgment. • Ask open-ended questions (e.g., "Can you tell me more about…"). Avoid questions that imply a correct answer. • Schedule extra time or a follow-up visit for complex decisions. • Provide summaries that Clients can review. • Use teach-back approach: Ask the Client to repeat or summarize the information provided to them. • Involve Provincial Language Service and Virtual Interpretation (including sign language) as applicable (VCH | PHC). **Note:** The use of Staff as untrained interpreters is discouraged. The Client's family and friends should only be relied on as language interpreters at the Client's request. Family and friends often do not have the understanding or vocabulary to interpret clinical issues. • Use a Trauma and Equity-Informed framework to guide interactions. • Do not use any coercive methods to obtain consent.
Visual and Auditory Aids	• Ensure the Client has access to any visual and auditory aids they require, including glasses, contacts, hearing aids, or an augmentative and alternative communication (AAC) device.
Environment and Time Adjustments	• Consider the influence of physical, geographic, logistical, and financial barriers on informed consent. • Change the setting in which information is provided (e.g., use private space, reduce noise and distractions, offer virtual appointment options). • Adjust timing to suit the Client's needs (e.g., when rested or less distressed). • Ensure basic needs are met (e.g., pain management, nutrition, hydration, toileting, hygiene). • Offer travel vouchers and meal supports for appointments when feasible. • Coordinate appointment times around ferry/flight schedules common in remote areas.

Literacy and Cognitive Accommodations	• Read information aloud for Clients with literacy barriers (e.g., consent forms). • When available, involve expertise of occupational therapists, neuropsychologists, and speech-language pathologists for strategies relating to cognitive difficulties.
Social Supports	• Ask Clients whom they wish to involve as Support People, which may be family members or friends. Many First Nations, Inuit, and Métis people make health decisions collectively with family, elders, and community leaders. • If applicable, consider involving the community case manager in the Client's care.
Clinical Consultation	• When available, consider involving psychiatry or other appropriate Staff (e.g., psychologist, clinical counsellor, mental health clinician) for support in understanding mental health treatment. • When available, consider involving addiction medicine for support in understanding substance use treatment (e.g., VCH Complex Pain and Addiction Services or PHC Addiction Medicine Consult Team). • Inform the social worker or VCH ReAct Adult Protection Program for concerns of self-neglect, neglect, and abuse.

c. **Provide the Client with information about the Health Care, and invite questions:**

As per the *Health Care Consent Act,* Staff provide the Client with the **following information** about the proposed Health Care:

- The condition for which the Health Care is proposed;
- The *nature* of the proposed Health Care;
- The *risks and benefits* of the proposed Health Care that a reasonable person would expect to be told about;
- *Alternative courses* of Health Care (including the option and possible outcomes of no Health Care); and
- *Any other information* a person would reasonably require to understand the proposed Health Care and make an informed decision (e.g., removal of a facial mole may be a minor procedure but may be of great concern to a professional actor).

Staff must also offer the Client the opportunity to **ask questions**, providing answers and information within their scope of practice.

d. **Evaluate the Client's ability to understand the Health Care information:**

- Is the Client *oriented* to person and situation?
- Does the Client demonstrate *insight and judgment* about the decision?
- Does the Client appear to *understand the treatment being offered* and *appreciate the effect* the treatment may have on them?
- Does the Client understand the possible *outcomes of declining* treatment?

- Does the Client demonstrate the ability to *ask relevant questions* about the treatment?
- Is the Client able to *summarize* in their own words the benefits and risks?
- Is the client demonstrating difficulty with *simple recall or other memory loss* that specifically impacts their ability to understand the Health Care information?
- Is there evidence of *self-monitoring* for a change in their condition?

e. **Assess whether the Client is incapable to consent:** While Clients are presumed capable of making Health Care decisions, Staff may have reason to believe that a Client is *incapable*. In such cases, it is the responsibility of the **most responsible Staff member** – typically the Staff proposing the Health Care – to assess for incapability, supported through team-based collaboration as appropriate.

As per the *Health Care Consent Act*, when deciding whether a Client is incapable of giving, declining or revoking consent to Health Care, the Health Care Provider must base the decision on whether or not the Client demonstrates that they understand:

- **The information provided to them about the proposed Health Care, specifically:**
  - The condition for which the Health Care is proposed;
  - The *nature* of the proposed Health Care;
  - The *risks and benefits* of the proposed Health Care that a reasonable person would expect to be told about;
  - *Alternative courses* of Health Care; and
  - *Any other information* a person would reasonably require to understand the proposed Health Care and make an informed decision;
- **AND that the information applies to their own situation.**

Further Guidance on Assessing Incapability

- Use clinical judgment to evaluate the Client's ability to understand and apply the information.
- Follow your professional standards and scope of practice. Consult Professional Practice as needed.
- Consider the four elements of capability – understanding, appreciation, reasoning, and communicating a choice – to support assessments (Appendix D).
- While certain clinical tools may be used to support an assessment, they do not replace clinical judgment. **The determination of incapability should be based on the criteria established in the *Health Care Consent Act*.**
- **Note:** incapability is decision-specific. A Client may be incapable of making one Health Care decision but still capable of making others.
- If there continue to be concerns about the Client's ability to understand the information provided, seek input from the care team and site leadership.
- For more, refer to steps when a Client is determined to be incapable.

f. **For Clients capable of consenting, confirm that all elements of consent are met per the legislation:**

- The consent is about the proposed Health Care;
- The consent is given voluntarily;
- The consent is not obtained by fraud or misrepresentation (i.e., by providing misleading or untruthful information);
- The Client is capable of making a decision about whether to proceed with or decline (refuse) Health Care;
- Staff has given all the information a reasonable person (Client) would require to understand the proposed Health Care and to make a decision; and
- The Client has an opportunity to ask questions and receive answers about the Health Care.

g. **Ensure the Client's decision is clearly understood based on their unique form of communication:**
   - The Client may communicate the consent decision verbally or in writing.
   - They may use actions or symbol that communicate their consent (e.g., nodding, thumbprints, culturally significant marks).
   - **Note: Cooperating with Health Care may indicate consent *if* information about the specific Health Care was provided by Staff and understood by the Client.** If the Client does not have information about the Health Care being provided, consent cannot be inferred by behaviour; there must be a reasonable basis for believing that the Client's cooperation is the result of informed consent.

h. **Document the consent process:** Proper consent documentation must be included in the Client's health record. For more, refer to documentation steps.

i. **Communicate the Client's decision when applicable:** In certain situations, documentation itself may not be enough to ensure relevant teams involved in the Client's care are aware of the Client's decision. Timely communication and handover on a need-to-know basis between Staff (or care teams) helps to ensure more seamless care for the Client.

Note: Informed consent via video conferencing (or telephone) may be obtained when virtual care is offered and/or when the Client is unable to attend in person. The above steps continue to apply. Ensure that the Client is aware of all individuals present for the discussion.

Client is Incapable to Consent to a Health Care Decision

The following procedure relates to situations where Staff have determined the Client to be incapable of consenting to specific Health Care decisions.

Advance Directives

Clients may prepare an Advance Directive to give or decline consent to specific Health Care decisions if they become incapable in the future. When an Advance Directive has been prepared according to the requirements of the *Health Care Consent Act,* Staff must follow the Advance Directive. For support how to locate Advance Directives, please reach out to your area's social worker or site leadership.

Steps:

1. Determine that the Client needs Health Care and is incapable of giving or declining consent.

2. Review the Advance Directive and determine if it is valid and relevant to the Health Care.
    a. Staff may provide Health Care to the Client if the Client has consented to it in their Advance Directive.
    b. Staff must not provide Health Care to the Client if the Client has declined consent to that Health Care in their Advance Directive.

When not to follow an Advance Directive

There are some situations where Staff are **not** required to follow an Advance Directive:

1. The instructions in the Advance Directive **do not address** the Health Care decision to be made;
2. The instructions in the Advance Directive are **so unclear** that it is not possible to determine whether the Client has given or declined consent to that Health Care decision;
3. Since the Advance Directive was made and while the Client was capable, their **known wishes, values or beliefs** in relation to a Health Care decision significantly changed;
    - **Note:** Before determining that an Advance Directive does not apply for an Indigenous Client, consider consulting an Indigenous Health/Wellness practitioner to explore whether shifts in the client's wishes reflect cultural reconnection, ceremony, or new teachings.
4. Since the Advance Directive was made, there have been **significant changes in medical knowledge, practice or technology** that might substantially benefit the Client in relation to Health Care for which the Client has given or declined consent in an Advance Directive.
    - **Note:** The Advance Directive applies if it *specifically states* that it applies despite any changes in medical knowledge, practice or technology.

If an incapable Client is receiving Health Care that has been declined in an Advance Directive, the Health Care must be discontinued, including Emergency or Urgent Health Care that is being provided.

If the proposed Health Care is not clearly addressed in the Advance Directive or the Advance Directive is not applicable based on the factors above, Staff must seek consent from the appropriate Substitute Decision Maker (SDM).

Substitute Decision Making

If the Client is determined to be incapable of making the specific Health Care decision, Staff must seek consent from the following **SDM** in **ranked order:**

1. **Committee of Person (Personal Guardian):** An SDM appointed by the Supreme Court of BC. Staff must ask to see a court order, check the date to ensure it remains valid, and place a copy in the Client's health record.
2. **Representative:** An SDM appointed by the Client through a Representation Agreement, which Staff must review for validity (e.g., date and signature) and place a copy in the Client's health record. Representatives fall under two categories, *section 7 and 9* (Appendix B). Consult site leadership and Risk Management for concerns about scope and validity of an agreement.
3. **Temporary Substitute Decision Maker (TSDM):** If a Client requires Health Care, is incapable of providing consent, **and** does not have a Committee, Representative or relevant and valid Advance Directive, then the Health Care Provider will need to undertake a TSDM selection

process to seek substitute consent. The *Health Care Consent Act* sets out a **ranked list of people that may act as TSDM,** in order of priority:

a. Spouse (including common-law spouses);
b. Client's child (all children are equally-ranked regardless of age);
c. Parent;
d. Sibling;
e. Grandparent;
f. Grandchild;
g. Another relative by birth or adoption;
h. Close friend;
i. Person immediately related by marriage;
j. A person appointed by the Public Guardian and Trustee.

Steps for appointing a TSDM

1. Consult with other Staff and care team members to navigate the TSDM selection process, including the physician, nurse practitioner, social worker as applicable.
2. Speak with the Client and any accompanying adults to assess who might be a suitable TSDM. If a qualified person does not accompany the Client, it may be necessary to contact any Support People that have been involved in the Client's care.
3. **Note:** In some cases, the Client's Support People may meet and decide amongst themselves who is the most appropriate person to be TSDM, which Staff can consider appointing. A person higher on the ranked list may (by informal agreement within the group) decline to act as TSDM in favour of a person lower on the list.
4. Ensure any potential TSDM meets the following criteria:
    a. A person 19+ years;
    b. Is capable of making the consent decision;
    c. Has been in contact with the Client within the last 12 months;
    d. Has no known dispute (i.e., legal, financial, or personal) with the Client; **and**
    e. Is willing to comply with the legal duties specified in the *Health Care Consent Act*.
5. Select a TSDM from the ranked list. Provide the TSDM with information needed to make an informed decision. Obtain substitute consent from the TSDM.
6. Inform the Client to the best extent possible about the TSDM and the decision.
7. Document steps taken in the Client's health record.

Note: In BC, a Power of Attorney does not provide authority to make Health Care or Personal Care decisions; a Power of Attorney relates only to legal and financial matters. A will also does not provide authority to make Health Care decisions. In other jurisdictions, like Ontario, a Power of Attorney may have the authority to make Health Care decisions. To help determine whether these extra-

jurisdictional documents apply to a Client in BC, reach out to your area's social worker, site leadership, and/or Risk Management as applicable.

Obtaining consent from the Public Guardian and Trustee (PGT) if a TSDM cannot be named

If no suitable TSDM is available from the ranked list, or if there is a dispute between two equally ranked and qualified potential TSDMs that is not resolved after reasonable efforts to resolve the conflict, Staff must contact the Public Guardian and Trustee (PGT), who can act as TSDM.

Prior to involving the PGT, consider the following:

- Involving the PGT as TSDM is a last resort. When disputes arise about who to name as TSDM, Staff should first make every reasonable effort to name a suitable TSDM. This may include facilitating conversations to reduce conflict and build consensus, and involving your area's social worker, site leadership, Ethics Services and Risk Management as appropriate.
- If equally ranked TSDMs cannot agree on who the TSDM is or cannot make a decision related to the proposed Health Care, Staff must contact the PGT.
- The PGT can make consent decisions for specific proposed Health Care. There are some limitations to what the PGT can consent to as TSDM. The PGT does not function as TSDM for an indefinite or unlimited period.

To involve the PGT:

- Submit a formal request to the PGT outlining the proposed Health Care, the Client's health condition(s), and efforts made to identify an appropriate TSDM:
  - **Phone:** 1-877-511-4111; **Fax:** 604-660-9479; **Email:** AIS-PDS@trustee.bc.ca
- The PGT may consult with Staff, the Client (if possible), and other relevant individuals.
- Provide the PGT with any information that the Client or their TSDM would require to make a decision.
- The PGT makes a decision based on the best interests of the Client, considering their known wishes, values, and beliefs.

The PGT is on-call weekends and statutory holidays from 0800 to 1200 (as of July 2025).

For support with contacting the PGT, consult your area's social worker or site leadership. Visit trustee.bc.ca for more information.

Legal duties of Temporary Substitute Decision Makers (TSDMs)

When a TSDM considers a Health Care decision for the Client:

a. The first duty of the TSDM is to consult with the Client as much as possible.
   - It is important to understand that a Client can still express a wish or desire even if they are incapable to make the Health Care decision.

b. The TSDM must follow the Client's wishes as expressed when they were capable; or

c. If no wishes have been expressed, the TSDM must make a decision based on the best interests of the Client. When determining what is in the best interests of the Client, the TSDM must consider:

- the Client's current wishes, and known beliefs and values;
- whether the Client's condition or well-being is likely to be improved by the proposed health care;
- whether the Client's condition or well-being is likely to improve without the proposed health care;
- whether the benefit the Client is expected to obtain from the proposed health care is greater than the risk of harm; and
- whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care.

Note: Clients may make **expressed wishes** about future Health Care. There is no legal requirement for how wishes must be expressed; any verbal or written expression of their values, wishes, and beliefs is acceptable. When the Client is incapable, expressed wishes and advance care plans made by the Client while capable are used by decision-makers as the basis for Health Care decisions.

Limits of TSDM decision-making

A TSDM may only decline Health Care necessary to preserve life if there is substantial agreement among Staff caring for the Client that:

a. The decision to decline the Health Care is medically appropriate; and

b. The TSDM has made the decision in accordance with their duties as a decision-maker.

A TSDM cannot give consent to Health Care more than 21 days before the Health Care occurs. If there is a delay of more than 21 days between the TSDM's consent and the Health Care, Staff should confirm in writing that the Client remains incapable and the TSDM still consents to the Health Care. This can occur in elective surgery situations where the Client is on a waiting list.

A TSDM may not make decisions pertaining to *specific* Major Health Care. Refer to page 19 of the VCH/PHC Consent for Health Care Policy for more information.

Removing a Temporary Substitute Decision Maker (TSDM)

If the TSDM is not following their duties as a TSDM, Staff may remove a person as TSDM after consultation with the care team, social worker and site leadership. Consult with Ethics Services and Risk Management as appropriate. Staff should inform the Client and former TSDM of this decision. Staff will select a new TSDM from the ranked list. Document the details of the situation and rationale for removing the TSDM in the Client's health record. Reports of suspected abuse and neglect by a TSDM must be made to a Designated Responder or the VCH ReAct Adult Protection Program.

Emergency or Urgent Care (Section 12 of the *Health Care Consent Act*)

To provide Emergency or Urgent Health Care without consent, the following criteria must be met. The Client:

- ❑ Requires the Health Care without delay to preserve their life, prevent serious mental or physical harm, or to alleviate severe pain;
- ❑ Is apparently impaired by drugs or alcohol, is unconscious or semi-conscious, or for any other reason is determined to be incapable of consenting to the Health Care required to address the urgent or emergency health need;
- ❑ Does not have a relevant and valid Advance Directive;

- ❑ Does not have a known and available Substitute Decision Maker (SDM) that Health Care Providers can contact for consent within a reasonable time in the given circumstances (or a parent or Legal Guardian if the Client is a Minor); and
- ❑ Has not declined the specific Health Care required via a previously capable expression of instruction.

If Emergency or Urgent Health Care is required for a Client who is incapable, and the SDM declines to consent, the Health Care Provider may proceed without the SDM's consent **if** they believe the SDM is not fulfilling their legal duties under the *Health Care Consent Act*.

Additional steps when Emergency or Urgent Care is initiated

1. **Document the Decision:** The authorizing physician or nurse practitioner must complete the **VCH/PHC Consent for Health Care Form** as soon as possible (within a reasonable timeframe).
2. **If the Client remains incapable:**
   - Obtain SDM consent for continued treatment within a reasonable timeframe.
   - If there is no SDM, identify and name a TSDM.
   - If no TSDM is available, contact the Public Guardian and Trustee.
3. **If the Client remains incapable but the emergency has resolved:** Follow standard procedures for obtaining substitute consent.
4. **If the Client regains capability:** Their consent must be obtained to continue treatment.

Role and responsibilities for Emergency or Urgent Care

- Nurses, allied health, and health care assistants provide emergency intervention(s) based on their scope of practice and clinical judgment (e.g., CPR, naloxone), and document intervention(s) in the Client's health record as per practice standards.
- Physician, nurse practitioner, midwife, or dentist (Medical Staff) initiates any additionally required Emergency or Urgent Care interventions (i.e., a treatment plan). At this time, the Medical Staff completes the **VCH/PHC Consent for Health Care Form**.

Obtaining Consent for Minors

The ability of a Minor to give or decline consent to Health Care is **based on the Minor's understanding of the decision, rather than their age**. A Minor who is able to make a Health Care decision is called a Mature Minor in relation to that decision and may give consent regardless of whether they are accompanied by a parent or Legal Guardian. Staff providing Health Care should assess whether a Minor is capable of providing consent based on the criteria set out in the *Infants Act*.

Steps:

1. **Assess the Minor's understanding:** Evaluate whether the Minor understands the nature and consequences and the reasonably foreseeable benefits and risks of the Health Care; **and**
2. **Assess the Health Care at issue:** Based on clinical judgment, determine whether the Health Care is in the best interests of the Minor.
3. **If both criteria are met:** Seek consent from the Minor based on standard processes.

For more complex situations, consider the following steps:

Situation	Steps
A Minor is not capable of consenting because they do not meet the criteria set out in the *Infants Act.*	Consent must be obtained from the Minor's parent/guardian. **Note:** Staff are only required to obtain consent to Health Care from the parent/guardian who is initiating services. As per Section 40(2) of the *Family Law Act* (FLA), each Minor's parent/guardian may exercise all parental responsibilities for the Minor unless a separation agreement or court order says otherwise.
There is a known disagreement between the Minor's parents/guardians about consent to the Health Care.	Contact your site leadership and involve Ethics Services and Risk Management for support.
A Mature Minor consents to Health Care and the parent/guardian declines and subsequently requests access to the Minor's health records.	Contact the Privacy Office (VCH | PHC) for support.
The parent/guardian declines to consent to Health Care that is in the Minor's best interests or is Necessary Care to preserve the Minor's life or to prevent permanent impairment.	Refer to VCH/PHC Consent for Health Care Policy (page 4) and involve your area's social worker. Contact Risk Management as applicable.

A Minor may not make a request for MAiD unless they are 18 years old. For MAiD issues involving Minors, contact the VCH Assisted Dying Program.

Documentation

As a general principle, it is beneficial to document any form of consent and the process to obtain the consent in the Client's health record. Ensure you review relevant VCH/PHC discipline-specific documentation guidelines, as well as your college standards related to consent documentation.

When is consent documentation required? How detailed should it be?

Clinical judgment is key when considering when to document and what to include. The amount of detail should be proportional to the risks associated with the Health Care provided in the Client's situation.

- **For Minor Health Care or routine Health Care the Client previously consented to:** Any consent documentation may be brief as per clinical judgment and direction from program leadership.
- **For Major Health Care or complex situations:** Detailed documentation is indicated. When in doubt, err on the side of more detailed documentation. Situations include:
    - The proposed Health Care is assessed to be high-risk, invasive, or non-standard;
    - The Client's capability is fluctuating or unclear;
    - The involvement of an SDM;
    - There is disagreement, hesitation, or uncertainty expressed by the Client or SDM;

- There is disagreement or a dispute between the SDM and other family members.

If support is needed for complex situations, refer to Appendix C.

Steps:

a. **Record the consent discussions and decision** in the Client's health record (e.g., progress note). The following elements should be included as applicable to the situation:

- Information given to the Client regarding the proposed Health Care (e.g., condition, nature of the health Care, risks and benefits, alternative options);
- The Client's level of understanding about the information;
- Any methods used to enhance the Client's understanding of the information;
- When applicable, determination of incapability to make specific Health Care decision(s), and supporting evidence/observations;
- When applicable, involvement of an SDM and information provided to the SDM about the proposed Health Care; and
- The Client or SDM's decision and expressed wishes.
  - **Note:** Because the Client's expressed wishes, values, and beliefs play an integral role in consent and decision-making, best practice is to document from the lens of what matters to the Client and include any wishes they have expressed.

b. **Complete the VCH/PHC Consent for Health Care Form in the following mandatory situations (printed from FormFast in Cerner, PARIS, Profile EMR or print shop):**

- Administration of blood or blood products within hospital;
- Emergency or Urgent Care (section completed by physician or nurse practitioner);
- As directed by program leadership.

The **VCH/PHC Consent for Health Care Form** is a tool that is beneficial in the following situations:

- When obtaining Client's consent for Major Health Care;
- When a TSDM is providing substitute consent;
- For any complex scenarios where using the form promotes the Client's understanding of the treatment and their rights, and obtaining written consent reduces risks.

c. **Document involvement of SDM:**

- When applicable, document the identification and involvement of the SDM in the Client's health record. If you are at a CST Cerner site, complete SDM/TSDM PowerForm.
- If a Committee of Person is involved, place a copy of the court order in the Client's health record as verification of the appointment.
- If a Representative is involved, place a copy of the Representation Agreement in the Client's health record as verification of the appointment.
- If a TSDM is involved, document in the health record discussions, details, and steps that took place to select the TSDM. Further, as per the legislation, Staff who propose Major Health Care and determine a Client is incapable to consent to the Health Care must

inform the Client of who has been appointed as their TSDM and what Health Care has been consented to by the TSDM. This notification can be done verbally (and documented in the chart). However, based on need and clinical judgment, consider providing the Client with a written summary of the same information.

d. **Program-specific consent forms:** Confirm with site leadership regarding which program-specific consent forms are required. Best practice is to include or append the **VCH/PHC Consent for Health Care Form** to program-specific informational documents.

e. **Clients who cannot read and/or write:** In place of a signature, the person may make a mark on the consent form that will be recognized as their identifier. Staff should document to this effect on the form.

f. **Clients with physical impairments:** A Client unable to make a mark on the consent form should indicate verbal consent to the Health Care. Staff should document to this effect on the form.

Intersecting Legislation

BC's *Health Care Consent Act, Mental Health Act (MH Act),* and *Adult Guardianship Act (AGA)* can intersect in several ways, depending on the Client's circumstances. A brief summary:

Health Care Consent Act	• Governs consent for most Health Care (specifically medical treatments or voluntary psychiatric treatment). • Gives the authority to provide emergency care without consent for incapable Clients if the criteria are met.
Mental Health Act (refer to VCH/PHC Involuntary Admissions Policy)	• Authorizes Designated Facilities to provide *involuntary* psychiatric treatment if the Client meets certification criteria. This authority overrides the *Health Care Consent Act* specifically for involuntary psychiatric treatment. • **Note:** The MH Act must not be used to authorize Health Care for medical conditions. A Client receiving involuntary psychiatric treatment under the *MH Act* still has the right to decline medical (non-psychiatric) Health Care, unless Staff have also determined the Client to be incapable to make these medical decisions. If this is the case, then standard procedures for engaging an SDM or providing Emergency or Urgent Care per the *Health Care Consent Act* apply for the medical decisions.
Adult Guardianship Act (refer to VCH Adult Protection Policy | PHC Adult Protection Guideline)	• Authorizes assessment and intervention in situations where an adult is experiencing abuse, neglect, or self-neglect and cannot seek support and assistance.

The *Health Care Consent Act* does not provide the authority to restrain, seclude, or hold an incapable person in hospital against their will unless the Emergency or Urgent Care criteria (Section 12) applies or substitute consent has been obtained. Provision of Health Care (which may include a plan or course of treatment) is a necessary condition for holding a person in a facility or the use of seclusion or restraints. Further, these interventions are to be provided as a last resort intervention for the shortest possible

duration needed for the safety of the Client or others (refer to your organization's least restraint protocols). For situations where *prolonged* seclusion, restraints, or holding a person in a facility may be justified, consult with care team members, site leadership, as well as Risk Management and Ethics Services as applicable for further support.

Further, if a Client poses a risk to themselves or others, the MH Act or AGA may be applicable. For more information, refer to Appendix E: Intersections of Health Care Consent Act, MH Act, and AGA and the Capability and Consent Tool, BC Edition (ReAct Adult Protection Program).

Definitions

"Adult" means any individual nineteen years of age or older who is receiving care from any VCH or PHC facility, program, or service.

"Advance Directive" refers to a legal document created pursuant to the *Health Care (Consent) and Care Facility (Admission Act)* where an Adult sets out their decisions regarding Health Care.

"Client" refers to any Adult who is receiving Health Care in VCH or PHC on an inpatient or outpatient basis, and includes any Clients of community based programs and residents in care facilities.

"Committee of Person" refers to an individual appointed by a court to manage the personal and health affairs of an incapable Adult, pursuant to the *Patients Property Act*.

A "**Culturally Safe"** environment is physically, socially, emotionally, and spiritually safe, and is an outcome of cultural competency, defined and experienced by Indigenous Clients who receive the service. Cultural safety is based on understanding the power differentials and potential discriminations inherent in the health service delivery system.

"Designated Facility" means a provincial mental health facility, psychiatric unit, or observation unit; refers to specific hospitals or other facilities where a person may be admitted under authority of the *Mental Health Act*.

"Designated Responder" refers to a person within VCH who has been assigned by their program area and undergone established adult protection training. This person is responsible to investigate, and if necessary, intervene in concerning reports of vulnerable adults suspected of being abused, neglected or self-neglected, utilizing the broader legal framework.

"Emergency or Urgent Care" means Health Care that is necessary and must be provided without delay in order to preserve the Client's life, to prevent serious mental or physical harm, or to alleviate severe pain (as per Section 12 of the *Health Care Consent Act*).

"Health Care" means anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other purpose related to health, and includes:

- A series or sequence of similar treatments or care administered to a Client over a period of time for a particular health problem;
- A plan for care that:
  - Is developed by one or more Staff;
  - Deals with one or more of the health problems that a Client has and may deal with one or more of the health problems that a Client is likely to have in the future given the Client's current health condition; and
  - Expires no later than 12 months from the date of consent; and

- Participation in a medical research program approved by an ethics committee designated by regulation.

"Health Care Provider" means a person, or a person in a prescribed class of persons, who, under a prescribed Act, is licensed, certified or registered in BC to provide Health Care.

"Legal Guardian" means a person who has been appointed as a Minor's guardian pursuant to the *Family Law Act*, or a Director or caregiver appointed under the *Child, Family, and Community Services Act*, who has the authority to consent to Health Care decisions on behalf of a Minor.

"Major Health Care" means major surgery, any treatment involving a general anesthesia, major diagnostic or investigative procedures, or any Health Care designated by law as Major Health Care, including radiation therapy, intravenous chemotherapy, kidney dialysis, electroconvulsive therapy, and laser surgery.

"Mature Minor" means any Minor who has been assessed as meeting the requirements of section 17 of the *Infants Act*. That is, they understand the nature and consequences and any foreseeable benefits or risks associated with proposed Health Care that the Health Care Provider has determined is in the Minor's best interest.

"Medical Staff" means privileged, employed, or contracted medical providers and medical leaders working at VCH or PHC or providing health care services through VCH or PHC, including Physicians, Midwives, Nurse Practitioners, Dentists, and Fellows. For clarity, this includes medical providers working both in hospital and community sites.

"Minor" means a person under nineteen (19) years of age.

"Minor Health Care" means any Health Care that is not Major Health Care and includes routine tests to determine if Health Care is necessary, and routine dental treatment that prevents or treats a condition or injury.

"Necessary Care" is care which, in the opinion of two physicians/nurse practitioners, is necessary to preserve the Minor's life or to prevent permanent impairment of the Minor's health.

"Personal Care" refers to assistance with daily activities, such as bathing, dressing, eating, toileting, and mobility. In *Bentley v. Maplewood*, the court identified a legislative gap for making Personal Care decisions when a person is incapable and does not have a Representative or Committee. It held that in such cases, service providers must consult the person's family, friends, and any written wishes regarding Personal Care decisions.

"Representative" is an individual appointed via a Representation Agreement to make Health Care and/or personal care decisions on behalf of another Adult if that Adult becomes incapable, or to help the Adult make decisions. Please see Appendix B for more on Representatives.

"**Restraint**" means any chemical, electronic, mechanical, physical, environmental, or other means of controlling or restricting a Client's freedom of movement, including placement in a secure room.

"Representation Agreement" is a legal document that appoints a SDM or a decision-making supporter chosen voluntarily by an Adult.

"Staff" means all employees (including management and leadership), Medical Staff, resident doctors, fellows, trainees, students, contractors, and other services providers engaged by VCH or PHC.

"Substitute Decision Maker (SDM)" refers to an individual authorized to make Health Care, personal care, or other type of decisions on behalf of an Adult. The hierarchy of Health Care SDMs is, in descending order:

1. A Committee of Person appointed by the court pursuant to the *Patients Property Act;*
2. An individual appointed as a Representative by an Adult via a Representation Agreement;
3. A Temporary Substitute Decision Maker (TSDM) chosen in accordance with section 16 of the *Health Care (Consent) and Care Facility (Admissions) Act*.

"Support People" are individuals identified by Clients as needing to be involved in their Health Care and other matters. Support People can be family members, friends, or others.

"Temporary Substitute Decision Maker (TSDM)" refers to the decision-maker chosen by Staff to make a Health Care decision for a Client if they are not capable, do not have a relevant and valid Advance Directive, and do not have a Representative or Committee of Person with relevant authority.

"Trauma and equity-informed practice" is a strengths-based framework grounded in an understanding of responsiveness to the impact of trauma. It emphasizes physical, psychological, and emotional safety for everyone, and creates opportunities for survivors to rebuild a sense of control and empowerment.

Related Documents

- Consent for Health Care Policy
- Consent for Care Facility Admission Policy
- Consent to Health Care in British Columbia: A Course for Health Care Providers
- Capability and Consent Tool, BC Edition
- *Health Care (Consent) and Care Facility (Admission) Act (HCCCFAA)*
- *Infants Act*
- Involuntary Admissions Decision Support Tool (Protecting People's Rights under BC's Mental Health Act)
- Ministry of Health: Consent to Health Care in BC: A Course for Health Care Providers
- Ministry of Health: Health Care Providers' Guide to Consent to Health Care
- Risk Assessment and Consent of Procedures in Medical Imaging
- VCH/PHC Health Care Consent Learning Tools (one.VCH.ca)

Discipline-specific documentation guidelines

- PHC Physiotherapy
- PHC Social Work
- VCH Clinical Counsellor
- VCH Community Mental Health and Substance Use
- VCH and PHC Dietitians
- VCH Long-Term Care Nursing and Health Care Assistants

- VCH Nursing Handover
- VCH Occupational Therapy
- VCH Physiotherapist
- VCH Procedural Sedation (Registered Nurses and Respiratory Therapists)
- VCH Social Work
- VCH Speech Language Pathology
- VCH/PHC/PHSA/FHA Medical Imaging

Appendices

Appendix A: Health Care Consent Process Map

Appendix B: Representation Agreements

Appendix C: Support with Navigating Complex Consent Situations

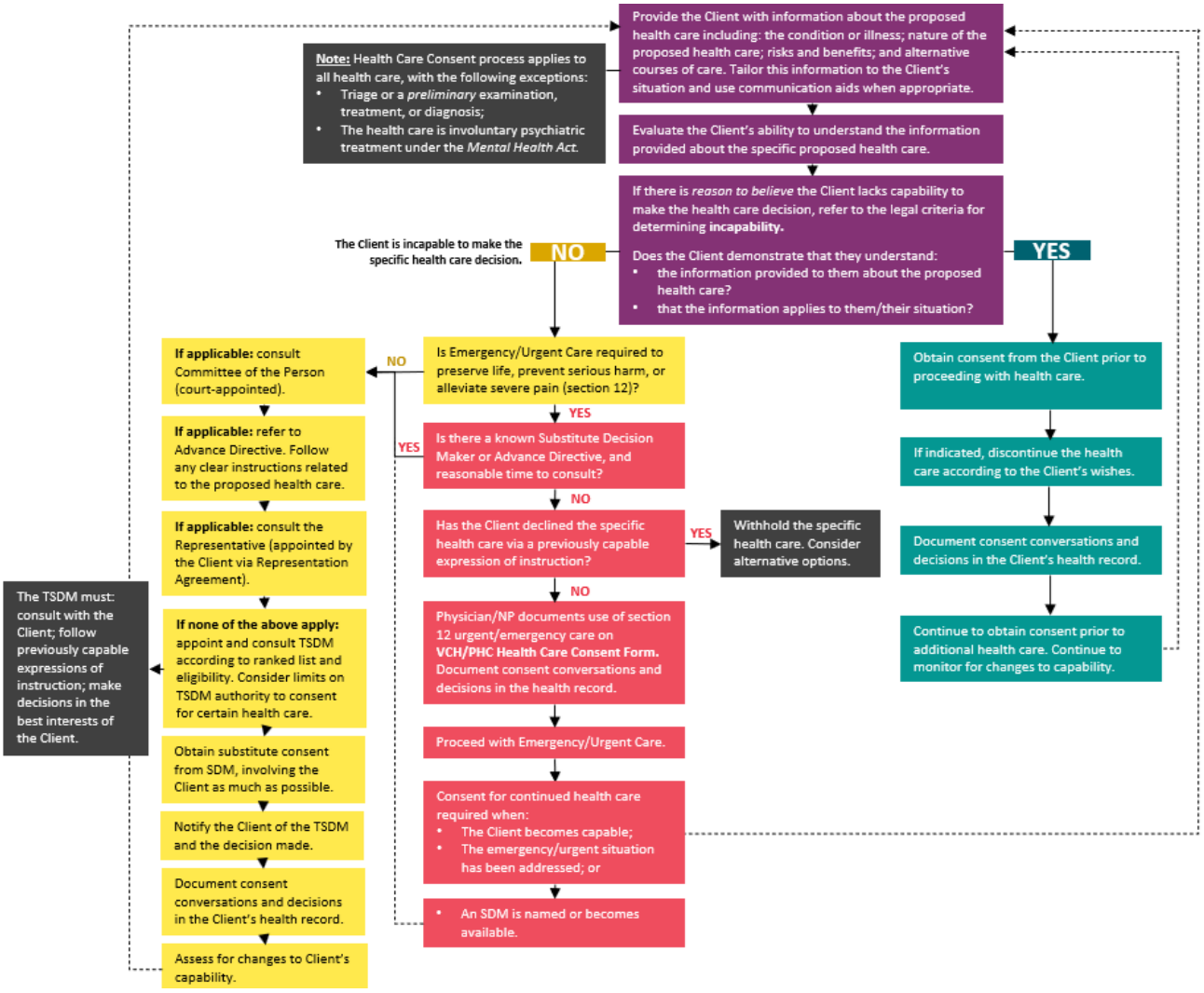
Appendix D: Four Elements of Capability

Appendix E: Intersections of *Health Care Consent Act,* MH Act, and AGA

Appendix F: Special Consent Situation – Adoption

Appendix A: Consent for Health Care Process Map

For larger version: click here (one.vch.ca).



Appendix B: Representation Agreements

Representative

A Client may have planned for future incapability by appointing a person to serve as their Representative via a Representation Agreement made under the *Representation Agreement Act*.

Staff must obtain copies of the Representation Agreement and review it to ensure the proposed Health Care is within scope of the Representation Agreement. A copy of the Representation Agreement must be added to the Client's health record.

The *Representation Agreement Act* allows for two types of Representatives:

Section 7 Representative

Section 7 Representation Agreements, or Standard Representation Agreements, permit a Representative to make decisions about:

- Personal Care;
- Routine management of financial affairs;
- Health Care; and
- Obtaining legal services and instructing counsel in relation to certain legal matters.

Section 7 Representatives are not permitted to make decisions about:

- Sterilization for non-therapeutic purposes;
- Refusal of Health Care that is necessary to preserve life;
- The use of physical Restraints; or
- Admission to a licensed Care Facility. For more on care facility admission see the Consent to Care Facility Admission Policy.

Section 9 Representative

Section 9, or Enhanced or Non-Standard Representation Agreements, have a wider scope than Section 7 Representation Agreements. Section 9 Representatives can give or decline consent to Health Care necessary to preserve life. Section 9 Representatives can also give or decline consent for care facility admission.

Representatives must carry out their duties under Section 16 of the *Representation Agreement Act*. For concerns about whether a Representative is acting according to their duties, contact Risk Management or Ethics Services.

Appendix C: Support with Navigating Complex Consent Situations

First steps: team-based approach

The Staff proposing the Health Care is typically responsible for obtaining consent. At times, Staff may encounter complex consent issues that diverge from standard procedures, such as uncertainty about a client's fluctuating capability, disputes over who qualifies as a Substitute Decision Maker (SDM), or conflicting instructions from multiple decision-makers.

Staff should reach out to other care team members for support (including site leaders, educators, and clinical mentors) and strive to navigate the situation in good faith and with reasonable care.

Identification of a TSDM should not be delayed while waiting for social work involvement. If a social worker is not available – such as after-hours – the care team (e.g., medical staff such as physician, NP, midwife) should proceed with the most appropriate TSDM available, with follow-up if/as the situation evolves.

Next steps: addressing unresolved concerns

If the issue remains unresolved after attempts by the care team, consider involving the following services as applicable to the situation. *If there are significant legal or liability concerns, involve Risk Management promptly.*

Ethics Services → VCH | PHC
Provides consultation for ethically challenging situations, including issues related to beginning- or end-of-life care, capability, privacy/confidentiality, autonomy, and substitute decision-making.

Professional Practice (most appropriate practice leader or educator) → VCH | PHC
Offers clinical guidance, education, and policy interpretation to support best practices in care delivery, including guidance related to professional roles and scope.

Risk Management → VCH | PHC

Supports Staff with navigating complex clinical concerns with the goal of promoting patient safety and preventing harm, liability, and organizational risk. May involve legal counsel when required.

Additional considerations

Advance Care Planning (ACP) → VCH | PHC

ACP enables adults to document their health care values, wishes, and Substitute Decision Makers (SDMs) via tools like "My Voice," Representation Agreements, or Advance Directives. These preferences guide future care when patients are unable to speak for themselves.

- At VCH: Visit the VCH link above or contact your area's social worker.
- At PHC: The ACP Lead provides expertise on ACP tools, processes, and legislation, supporting staff in applying ACP best practices across clinical settings. Visit the PHC link above.

Situations of Abuse, Neglect, or Self-Neglect → VCH | PHC

Under the *Adult Guardianship Act*, Staff must report any suspected cases of abuse, neglect, or self-neglect of adults who are confirmed or suspected to be unable to seek support and assistance.

- At VCH: Report concerns to the ReAct Adult Protection Program.
- At PHC: Report concerns to your area's social worker (Designated Responder).

Appendix D: Four Elements of Capability

These four elements of capability can support Sstaff in thinking about the potential incapability of a Client to make a consent decision.

1. **Understanding** refers to the Client's ability to comprehend basic facts about the proposed Health Care.
2. **Appreciation** involves recognizing how the Health Care applies to one's own situation.
3. **Reasoning** refers to the ability to compare options, and weigh risks and benefits.
4. **Communicating a Choice** refers to the ability to express a clear decision.

Note: The absence of one or more elements does not automatically indicate that a Client is incapable. Staff must apply clinical judgment, taking into account the Client's situation and context. Ultimately, determinations of incapability should be grounded in the legal criteria outlined on page 8.

Appendix E: Intersections of the *Health Care Consent Act*, MH Act, and AGA

1. ***Mental Health Act* (MH Act) & *Health Care Consent Act***

   - The **MH Act** allows for the involuntary admission and treatment of individuals with mental health condition(s) in or through a Designated Facility if they meet specific criteria outlined on the Form 4.1: First Medical Certificate (Involuntary Admission).
   - When admitted involuntarily, **the consent requirements under the *Health Care Consent Act* do not apply** to psychiatric treatment. The facility Director or their Delegate can authorize treatment.
   - However, for any non-psychiatric Health Care (e.g., surgery, cancer treatment, wound care, etc.), the ***Health Care Consent Act* applies**, meaning consent must be obtained from the Client or an SDM (unless the Emergency or Urgent Care criteria applies).

2. ***Adult Guardianship Act* (AGA) & *Health Care Consent Act***

   - The **AGA** is applicable when an adult who is apparently incapable of seeking support and assistance is experiencing **abuse, neglect, or self-neglect** and may need protective intervention.
   - In emergencies, Section 59 of the AGA allows VCH/PHC to: Remove an adult from their home or other location and convey them to a safe place (like a hospital), provide emergency health care, and take any other emergency measure that is necessary to protect the adult from harm (including preventing the adult from leaving a safe place).
   - The legal test for providing emergency Health Care under section 59 of the AGA is the same as providing emergency Health Care under Section 12 of the *Health Care Consent Act*. If an adult only requires emergency Health Care and no other additional supports or emergency interventions are needed, the *Health Care Consent Act* may be more appropriate.
   - In non-emergency situations, the AGA may be used to obtain a court-ordered Support and Assistance Plan that authorizes actions necessary for non-emergent Health Care (for example: to attend pre-operative and the post-operative appointment, receive home care services, medication administration and monitoring). **The *Health Care Consent Act* still applies to Health Care decisions when an adult is subject to an AGA investigation**. If the adult has no suitable TSDMs available, the PGT must be contacted.
   - If there is any indication that a suspected abuser is also acting as the SDM/TSDM, notify the VCH ReAct Adult Guardian Program and/or your area's social worker (PHC).

3. ***Mental Health Act* (MH Act) & Adult *Guardianship Act* (AGA)**

   - The MH Act and the AGA have separate purposes but can work together to support the care of an adult who meets the criteria for both.
   - If an adult who is certified under the MH Act is also experiencing neglect, self-neglect or abuse, it may be appropriate to start an Adult Guardianship Investigation and develop a Support and Assistance Plan under the AGA.

Health Care Consent Act	*Mental Health Act*	*Adult Guardianship Act*
These Acts are not always used in isolation; they can be used in any combination necessary and in accordance with their legal criteria.		
USAGE		
• Applies to most Health Care. Requires Staff to provide information about the Health Care to the Client and obtain informed consent. • When the Client is determined incapable to consent to a Health Care decision, identify SDM or TSDM (Section 16). • When the Client is determined to be incapable and a SDM is not available, Emergency or Urgent Care may be provided without consent to preserve the Client's life, prevent serious mental/physical harm, or alleviate severe pain (Section 12).	• Specifically for providing involuntary psychiatric care when Client meets the criteria (Section 22): I. Suffering from a disorder of the mind that requires psychiatric treatment and seriously impairs their ability to react appropriately to their environment or to associate with others; II. Requires treatment in or through a designated facility; III. Requires care, supervision, and control in or through a Designated Facility to prevent their substantial mental or physical deterioration or for their own protection or the protection of others; and IV. Not suitable for voluntary admission.	• Under Section 59 of the A*ct:* I. Enter any premises where the Client may be located and use reasonable force as needed; II. Remove the Client from the premises and convey them to a safe place; III. Provide emergency Health Care; IV. Alert the PGT that the Client's finances may require protection; and V. Protect the client from harm with emergency measures. • Apply to the court to establish a longer-term plan of Health Care and other measures (section 51).
AREA OF APPLICATION		
• Any Health Care, subject to limitations in the legislation. • Emergency or Urgent Care. • Care Facility Admission.	• Involuntary psychiatric treatment.	• Emergency Health Care and court-ordered support and assistance.
LIMITATIONS		
• Health Care provided without consent must meet criteria of Emergency or Urgent Care (Section 12).	• Involuntary psychiatric care does not include treatment related to medical issues (such as labs or diagnostic imaging) unless the goal is to rule out a medical cause for a psychiatric condition.	• Section 59 applies only in emergencies. • Designated Responders investigate and determine if the adult meets the criteria for the AGA.

Appendix F: Special Consent Situation – Adoption

In accordance with the *Adoption Act*, the authority to give consent for adoption remains with the biological birthing parent until they have:

- In writing transferred 'care and custody' of the child to the Director (Ministry of Children and Family Development), or the administrator of an adoption agency; or
- Consented to adoption, at which time the Director or the administrator of an adoption agency becomes the guardian of the child and authorized to make consent decisions. However, if the adopting parents wish to delay adoption procedures while health care is provided, the authority for consent remains with the biological mother unless 'care and custody' of the child has been transferred to someone else.

Refer to the *Adoption Act* for more information.

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Last Reviewed:	31-OCT-2025	
Review due by:	31-OCT-2028	
Approved By: *(committee or position)*	PHC	VCH
	PHC Professional Practice Standards Committee	VCH: (Regional DST Endorsement - 2nd Reading) Health Authority & Area Specific Interprofessional Advisory Council Chairs (HA/AIAC) Operations Directors Professional Practice Directors Health Authority Medical Advisory Committee (HAMAC) Final Sign Off: Vice President, Professional Practice & Chief Clinical Information Officer, VCH
Owners: *(optional)*	PHC	VCH
		Manager – PHC/VCH Legislative Initiatives Director – PHC/VCH Legislative Initiatives