

Older people, hospital discharge and duty of care

02| Risk, rights, patient choice and decision-making capacity

Information for health professionals

THE ISSUE

- Hospital staff sometimes refer to “duty of care” when making cautious discharge decisions, including decisions that may prevent older patients from returning home. However, duty of care has limits.
- A hospital must take reasonable care. It does not have to remove every risk or guarantee a patient’s safety after discharge. If an older person wants to go home and understands the risks, the hospital cannot rely on “duty of care” to press them into residential aged care.
- The hospital cannot detain a patient who has capacity, restrict their freedom, or override their informed decision about where and how they want to live. The concept of capacity for decision-making is defined by legislation, not by medical diagnosis alone.
- A person with capacity can choose to take reasonable risks to pursue their own goals and quality of life, including to return home accepting some risk around their health or level of functioning.
- The hospital must make sure the patient understands the risks, knows what support is available, and receives reasonable care and discharge planning, regardless of the decision they make.

A hospital meets its duty of care by informing, supporting and planning with the patient, not by overriding the patient’s choice simply to avoid risk.

PATIENT CHOICE

The law recognises that every adult with capacity has the right to decide what happens to their own body.

This means a patient with capacity can refuse treatment, leave hospital, and decide where and how they want to live. They can make this choice even if it involves risk, and even if hospital staff or family members would choose differently.

If hospital staff or family members disagree with the patient’s choice, that disagreement does not give the hospital legal authority to override the patient. Capacity assessments question a patient’s autonomy so should not be a default for discharge. All patients should be provided first with support and information they need to make and communicate their decision.

DUTY OF CARE AND DECISION-MAKING CAPACITY

Different rules apply if a patient does not have capacity to make a particular decision, such as whether to leave hospital or where to live.



Queensland law starts with a clear rule: every adult is presumed to have capacity. This means:

1. capacity depends on the specific decision and the specific time
2. a person may have capacity for some decisions but not others
3. staff must not assume a person lacks capacity because of their age, appearance, or diagnosis
4. staff must not assume a person lacks capacity because they make a decision others see as unwise.

[Queensland's Capacity Assessment Guidelines](#) explain how staff should assess capacity in practice.

Staff must assess capacity for the decision required at the time. For example, at the time they seek informed consent in relation to surgery. They must also support the person to understand the information, weigh the options and communicate their decision.

If an older person has capacity, the hospital must not override their wishes. Instead, the hospital must assess the patient's clinical needs, explain the risks of going home, discuss available options, and explore supports such as community services, home modifications and interim care.

The hospital must then respect and carry out the patient's decision, even if that decision involves risk.

A hospital that takes these steps will usually meet its duty of care, even if the patient later experiences harm.

A hospital may act unlawfully if it withholds important information or replaces the patient's informed choice with its own risk assessment.

If an older person has impaired or changing capacity, the hospital must balance duty of care with these principles:

- (a) start by presuming the person has capacity
- (b) recognise that adults have a right to make decisions, including decisions others disagree with
- (c) give the person proper support to make their own decision using a supported decision-making framework
- (d) do not treat the person as unable to decide unless staff have taken all practical steps to support them and give them the information they need
- (e) focus on the person's ability to make the decision, not on whether others think the decision is unwise.

If an older person has impaired or changing capacity, the hospital must first take all practical steps to help them make and communicate their own decision.

Staff or other such as family must not decide that a person lacks capacity just because the person is older, has a cognitive impairment, or makes a decision staff disagree with.

Informal supports v formal supports

Many people with impaired decision-making may not need to have a substitute decision-maker, as they have family or an informal support network who can help them with their decision making.

However, there may be times where family and informal networks are inadequate and a more formal process is required to ensure the protection of the person's interests. In these instances, a substitute decision-maker may be appointed or consulted.



If the person lacks capacity for the specific decision about discharge or accommodation and cannot be supported to make the decision, the hospital must involve the correct substitute decision-maker.

If a patient lacks capacity, Queensland law sets out who can make decisions for them.

Role of substitute decision-maker

The substitute decision-maker must firstly seek the views and preferences of the older person regarding the options. Their role is to help support the older person to make the decision if they can. The central question at this time is: ***what does the person want and how can their views, wishes and preferences be upheld?***

However, in cases where, even with this support, the patient cannot indicate a preference, the substitute-decisionmaker should choose the option that least restricts the person's rights, interests and opportunities and reflects the person's views, wishes and preferences that may have arisen in discussions with them or in other ways. The central question is: ***what would the person have wanted if they could decide for themselves?***

Health staff must also properly consider the person's human rights. Unless there is a Queensland Civil and Administrative Order currently in place, the usual order is:

- an attorney under an Advance health directive (health decisions only) or Enduring power of attorney
- a statutory health attorney, such as a spouse, carer, close friend or relation and then the Public Guardian as statutory health attorney of last resort.

The hospital or staff does not become a substitute decision-maker.

Hospital staff cannot make personal health or accommodation decisions for a patient unless they have legal authority to do so.

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The hospital or staff does not become a substitute decision-maker. Hospital staff cannot make personal health or accommodation decisions for a patient unless they have legal authority to do so.

CAN DUTY OF CARE JUSTIFY OVERRIDING A PATIENT'S WISHES?

No. If a patient has capacity, a hospital cannot override their wishes just because staff believe the risk is too high.

An adult with capacity can refuse treatment or leave hospital. The hospital's role is to make sure the decision is informed and voluntary.

Queensland law allows involuntary detention only in limited mental health situations. It does not give hospitals a general power to detain an older person because of cognitive impairment or physical frailty.

If a patient wants to leave and the hospital has no legal power to detain them, detention may amount to false imprisonment.



CASE EXAMPLES

Example 1: Patient with capacity wants to go home

An older patient lives alone and wants to return home after treatment. Staff are worried about falls and recommend residential aged care. The patient understands the risk of falling, understands the supports available at home, and still chooses to go home.

In this situation, the hospital should not direct the patient into residential aged care. It should explain the risks clearly, arrange appropriate referrals and supports, document the discussion, and respect the patient's decision.

Example 2: Patient makes a risky decision

A patient with capacity refuses a recommended home care package because they value privacy and do not want support workers visiting their home. Staff believe the decision is unwise.

The hospital should not treat the refusal as proof that the patient lacks capacity. Instead, staff should check that the patient understands the likely consequences, explore alternatives, and document the patient's informed choice.

Example 3: Capacity is unclear or changes over time

A patient has delirium after surgery. In the morning, they cannot explain the risks of going home or describe the support they would need. By the afternoon, the delirium improves and they can understand the information and make a clear decision.

In this situation, staff should not make a permanent decision based on one negative capacity assessment. They should reassess capacity at the right time, give the patient support to decide, and involve a substitute decision-maker only if the patient lacks capacity for the specific decision when the decision must be made.

Example 4: Patient lacks capacity and needs a substitute decisionmaker

A patient with advanced dementia may not understand the discharge options or the risks of returning home alone or be able to contribute any preferences. The patient has an Enduring power of attorney appointing their daughter for health and personal decisions.

In this situation, the hospital should involve the daughter as the substitute decision-maker. The decision should focus on the option that least restricts the patient's rights and best reflects their known or previously expressed wishes, values and preferences.

Example 5: Hospital has no general power to detain

A patient with capacity decides to leave hospital against medical advice. Staff are concerned that the patient may fall at home, but the patient understands the risk and still wants to leave.

In this situation, staff should not lock the ward, remove the patient's belongings, or otherwise prevent the patient from leaving unless there is a specific legal power to do so. Staff should explain the risks, offer supports, document the discussion, and arrange follow-up where possible.



FLOW-CHART: KEY CONSIDERATIONS BEFORE RESTRICTING A PATIENT'S CHOICE

Step	Key question	What staff should do
1	What decision needs to be made?	Identify the specific decision, such as discharge, accommodation, treatment, services or leaving hospital.
2	If patient seems confused or unwell or overwhelmed, can the decision wait?	Reassess at a better time if possible. Treat temporary confusion, pain, medication effects, fatigue or communication barriers where relevant. Remember the acronym: PINCHME (is pain, infection, nutritional deficits, constipation, decreased hydration, medication or environment making them appear confused?) Also consider whether social 'differential diagnoses' e.g. grief, trauma may be impacting their ability to make the decision.
3	Has the patient been properly supported to make the decision?	Give clear information, explain risks and options, use communication supports, allow time, and involve trusted people if the patient wants that support.
4	Is the decision informed and voluntary?	Check that the patient understands the main risks, benefits and alternatives and are not being pressured by anyone to make a particular decision. If they do decide freely and voluntarily, respect the decision, even if staff disagree with it.
5	If the patient cannot make the decision at all, despite staff following the process above, capacity may be an issue.	Start by presuming capacity. Assess capacity for this decision at this time. Do not rely on age, diagnosis, appearance or an unwise choice.
6	Formal capacity assessment should be undertaken in relation to the decision.	Refer to the Capacity Assessment Guidelines for how to do this. The Guidelines have a framework around capacity assessments as well as questions you may ask in relation to health, personal and/or financial to assist with this.
7	If the patient lacks capacity, who has legal authority to decide?	Choose the option that best reflects the person's wishes, values and preferences while limiting their rights and freedoms as little as possible.
8	Is the proposed option the least restrictive option?	Choose the option that best reflects the person's wishes, values and preferences while limiting their rights and freedoms as little as possible.



Step	Key question	What staff should do
9	Is anyone proposing to stop the patient leaving? Consider impact on human rights and assess accordingly.	Check whether there is a specific legal power to detain or restrict the patient. Duty of care alone is not enough. • Before restricting movement, staff should identify which human rights are affected, such as liberty, freedom of movement, privacy, equality, dignity and access to health services. • Staff should ask whether the restriction is lawful, necessary, proportionate and the least restrictive option available under the <i>Human Rights Act 2019</i> (Qld)? • Consider practical alternatives, such as extra supports, risk controls, family or carer involvement, community services, closer follow-up or a time-limited plan. • Staff should record the legal basis, human rights considered, alternatives explored, reasons for the decision, and how the restriction will be reviewed.
10	What needs to be recorded?	Document the process: the decision needed, how you supported the patient to make the decision. e.g. information provided, risks discussed, supports offered, the patient's decision, capacity assessment and how this was completed, substitute decision-maker involvement, and discharge plan.

EXAMPLES: ASSESSING WHETHER A RESPONSE IS PROPORTIONATE UNDER THE HUMAN RIGHTS FRAMEWORK

A response is more likely to be proportionate if staff can show that it addresses a real and serious risk, has a clear lawful purpose, limits the patient's rights as little as reasonably possible, and will be reviewed regularly. The examples below show how staff can apply that reasoning in practice.

Example 1: Proportionate response — extra supports rather than detention

A patient with capacity wants to leave hospital and return home. Staff are concerned about falls. Instead of stopping the patient from leaving, staff arrange equipment, a community nursing referral, family contact, medication review, transport, and follow-up.

This is likely to be proportionate because it manages the risk without unnecessarily limiting the patient's liberty, movement, privacy or autonomy.

Example 2: Disproportionate response — refusing discharge because risk remains

A patient with capacity understands the risk of falling at home and still wants to leave. Staff refuse discharge because they cannot remove all risk. They argue that the patient has no insight into the risks involved and therefore lacks capacity to make the decision to discharge.

This is unlikely to be proportionate. The purpose of reducing harm is important, but refusing discharge may go further than reasonably necessary if less restrictive options are available.



Example 3: Proportionate short-term response — temporary supervision while capacity is reassessed

A patient appears confused after medication and tries to leave at night. Staff believe the confusion may be temporary and that the patient cannot currently understand the immediate risks.

A short, time-limited response may be proportionate if staff use the least restrictive option available, reassess capacity promptly, treat reversible causes, involve the appropriate decision-maker if needed, and document why the temporary response was necessary.

Example 4: Disproportionate response — using a blanket rule

A ward decides that any patient over a certain age who lives alone must wait for residential aged care placement before discharge.

This is unlikely to be proportionate because it does not assess the individual patient's circumstances, capacity, wishes, risks, supports or less restrictive options. The decision to refuse discharge is not based upon evidence or reasoning. It is ageist.

Example 5: Proportionate decision-making — documenting the balance

Staff propose a restriction for a patient who lacks capacity and is at immediate risk of serious harm. Before acting, they record the affected rights, the purpose of the restriction, why it is likely to reduce the risk, what alternatives were considered, why those alternatives were not enough, why the proposed response is the least restrictive available option, and when the decision will be reviewed.

This approach helps show that the decision is reasoned, individualised and balanced, rather than based only on general concern about risk.

KEY PRACTICE PRINCIPLES

1. Duty of care means taking reasonable care. It does not mean removing every risk.
2. If a patient with capacity refuses a recommended option, such as residential aged care, that refusal does not mean the hospital has breached its duty.
3. Duty of care does not let a hospital restrict a patient's freedom or autonomy.
4. At discharge, the hospital must give clear information, support decision-making, plan the discharge properly, and make appropriate referrals. It must not force a particular outcome.
5. Staff must presume capacity. They must assess capacity for the specific decision and must not rely on age, diagnosis or an unwise choice to deny capacity
6. Public hospitals must act compatibly with human rights and consider less restrictive options. They are public entities under the *Human Rights Act 2019* (Qld).
7. Staff should not use a broad idea of "duty of care" to justify restrictive decisions. That approach is likely inconsistent with the law.



REFERENCES

- *Rogers v Whitaker* (1992) 175 CLR 479.
- *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, also known as Marion's Case.
- *Hunter and New England Area Health Service v A* [2009] NSWSC 761.
- *Re MB* [1997] 2 FLR 426.
- *Airedale NHS Trust v Bland* [1993] AC 789.
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- *Guardianship and Administration Act 2000 (Qld)*.
- *Powers of Attorney Act 1998 (Qld)*.
- *Human Rights Act 2019 (Qld)*.
- *Mental Health Act 2016 (Qld)*.
- *Queensland Capacity Assessment Guidelines*.

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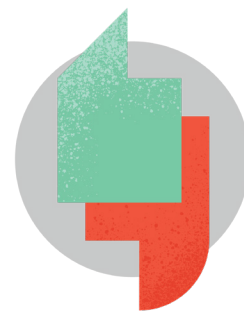
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