

Title	INFORMED CONSENT			Number	CL54
Effective From:	02.10.14	Duration:	No end date	Review:	July 2022
Author:	Tahir Moghal			Version:	1.3
Other Ref:	IG-F-007 - Patient Agreement to Proposed Procedure or Treatment (For patients aged 16 or over) IG-F-008 - Parental Agreement to Proposed Procedure or Treatment for a Child or Young Person IG-F-009 - Adults who are unable to Consent to Proposed Procedure or Treatment CG15 Informed Consent Policy & Procedure				
Contacts:	Steve McDonnell – Clinical Lead				

Version Control

(Only last 3 versions, earlier versions can be found in the appropriate Archive directory for the document)

DATE	CHANGE	CHANGED BY
02.06.16	Reviewed, no change	TM
16.11.18	Change to Government website link	SB
22.05.19	Reviewed, no change	SMcD
05.04.22	Reviewed with minor changes	SMcD/FW

1. INTRODUCTION

The purpose of this policy is to provide guidance for staff within BADGER about the requirements and processes for obtaining informed consent.

1.1 Why consent is important

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare; seeking consent is also a matter of common courtesy between health professionals and patients.

1.2 This procedure

The Department of Health has issued a range of guidance documents on consent (see section 1.4), and these should be consulted for details of the law and good practice requirements on consent. This paper sets out the standards and procedures in BADGER which aim to ensure that health professionals are able to comply with the guidance.

1.3 What consent is – and isn't

“Consent” is a patient’s agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision;
- have received sufficient information to take it; and
- not be acting under duress.

Consent is not valid if obtained by fraudulent means.

The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional’s advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them.

Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, ‘seeking consent’ is better described as ‘joint decision-making’: the patient and health professional need to come to an agreement on the best way forward, based on the patient’s values and preferences and the health professional’s clinical knowledge.

Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, **in general, no-one else can give consent on someone else’s behalf**. However treatment may be given if it is in their best interests, as long as the requirements of the Mental Capacity Act 2005 are adhered to and it has not been refused in advance in a valid and applicable advance directive or advance decision.

1.4 Guidance on consent

The Department of Health has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent; they are available from

<https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition>

Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies, e.g. GMC, NMC.

2. STATEMENT

The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done. It is health professional carrying out the procedure who will be held responsible in law if this is challenged later.

3. RESPONSIBILITIES

All staff have a responsibility for ensuring that the principles outlined within this document are universally applied. This procedure applies to all members of staff who are involved in taking consent.

4. WHEN SHOULD CONSENT BE SOUGHT?

When a patient formally gives their consent to a particular intervention, this is only the endpoint of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking consent'.

a. Single stage process

In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. If the patient is willing for the procedure to go ahead, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

b. Treatment of young children

Where a child is involved, you should discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. Parental responsibility is defined in the Children Act (1989) as:

"All the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to a child and his property" (Children Act 1989, section 3 (1)).

You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers will have such responsibility if jointly registered with the mother on the birth certificate, but not otherwise). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

c. Documentation

For clinical intervention procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done through documenting in the patient's notes that they have given oral consent.

Attending for a procedure and proffering an arm or removing clothing implies consent for the majority of the population. However, there are times when people may be directed or instructed what to do, without fully understanding why, or what is happening.

In the case of people with a learning disability, who present at the primary care treatment centres, they may not always arrive fully understanding why or what they are there for. In these cases it is important to establish a person's preference regarding treatment and their capacity to consent. This should include their level of understanding, their ability to retain the information and their ability to express their choice. This is important even in the most common procedures, (such as the taking of blood pressure, temperature, an injection, etc.)

5. PROVISION FOR PATIENTS WHOSE FIRST LANGUAGE IS NOT ENGLISH

BADGER is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use children to interpret for family members who do not speak English.

Interpreter service arrangements at BADGER are available on Adastra Operational Procedure P01. BADGER has a contractual arrangement with 'Language line' and the use of an interpreter must be recorded in the patient notes.

6. Treatment Centres

Where patients access a treatment centre directly, it should not be assumed that their presence at the treatment centre implies consent to particular treatment. You should ensure that they have the information they need before proceeding with an investigation or treatment.

7. WHO IS RESPONSIBLE FOR SEEKING CONSENT?

The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done. It is the health professional carrying out the procedure who will be held responsible in law if this is challenged later. Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional responsible.

8. REFUSAL OF TREATMENT

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983*. The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* for more

detail. For the young patient who is not deemed to be Fraser competent, refer to the parent/carer.

If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their case notes.

9. MENTAL CAPACITY

A capable (or competent) person may not be given medical treatment to which s/he does not consent. The treating of an incapable person is governed by the Mental Capacity Act 2005. In some cases the Act permits medical treatment to be given without the patient's consent, as long as it is in their best interests and has not been refused in a valid and applicable advance directive (living will) or advance decision. Different rules apply in the case of children and in the case of patients detained under the Mental Health Act 1983, which take precedent.

Every adult is assumed to be capable. The default position, therefore, is that all adults have capacity until they are proven otherwise. This assumption will be displaced where:

The patient is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

It does not matter if the impairment or disturbance is permanent or temporary. A person is unable to make a decision for himself if he is unable:

- to understand the information relevant to the decision
- to retain that information
- to use or weigh the information as part of the process of making the decision
- to communicate the decision

The assessment of capacity should be made by the healthcare practitioner in charge of the patient's medical treatment.

Restraint will only be lawful to compel an incapable patient to receive treatment when the person using it reasonably believes that it is necessary in order to prevent harm to the patient and the restraint is proportionate to the likelihood and potential severity of that harm.

a. Procedures to follow when patients lack capacity to give or withhold consent

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in the patient's case notes, along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity.

10. SEEKING CONSENT FROM PEOPLE IN PRISON

You need to make sure you have the prisoners' consent to do what you are doing, if they are able to give it. This respect for people's rights to determine what happens to their own bodies is a fundamental part of good practice. It is also a legal requirement. The fact that a patient is also a prisoner does not affect their right to determine whether or not to accept treatment where they have the mental capacity to make such a decision.

At times, where a prisoner is highly disturbed or violent, it may simply not be possible to make a reasoned assessment of their capacity. In such cases, where you have some reason to believe that they may lack capacity, you may have no choice but to assume incapacity until such time as the patient is calm enough for you to make a more in-depth judgement. It is important to remember, however, that you are professionally accountable for such decisions and should be able to justify at a later date on what evidence you based both your assumption of incapacity and any subsequent treatment.

The Department of Health guidance document 'Seeking Consent: Working with People in Prison' (DOH, July 2002, Gateway Reference: 2002) focuses on the particular issues which may arise when seeking consent from people in prison. The issues covered include the right of a competent adult patient to refuse treatment, assessment of 'competence', circumstances in which patients who lack capacity can receive treatment, the position of young people, dealing with violent or threatening behaviour, where patients may also have associated health problems, self-harm and food refusal.

APPENDIX 1: 12 KEY POINTS ON CONSENT: THE LAW (SUMMARY)

When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.
2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: “can this patient understand and weigh up the information needed to make this decision?” Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.
3. Patients may be competent to make some health care decisions, even if they are not competent to make others.
4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children give consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, some-one with parental responsibility must give consent on the child’s behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.
8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal.

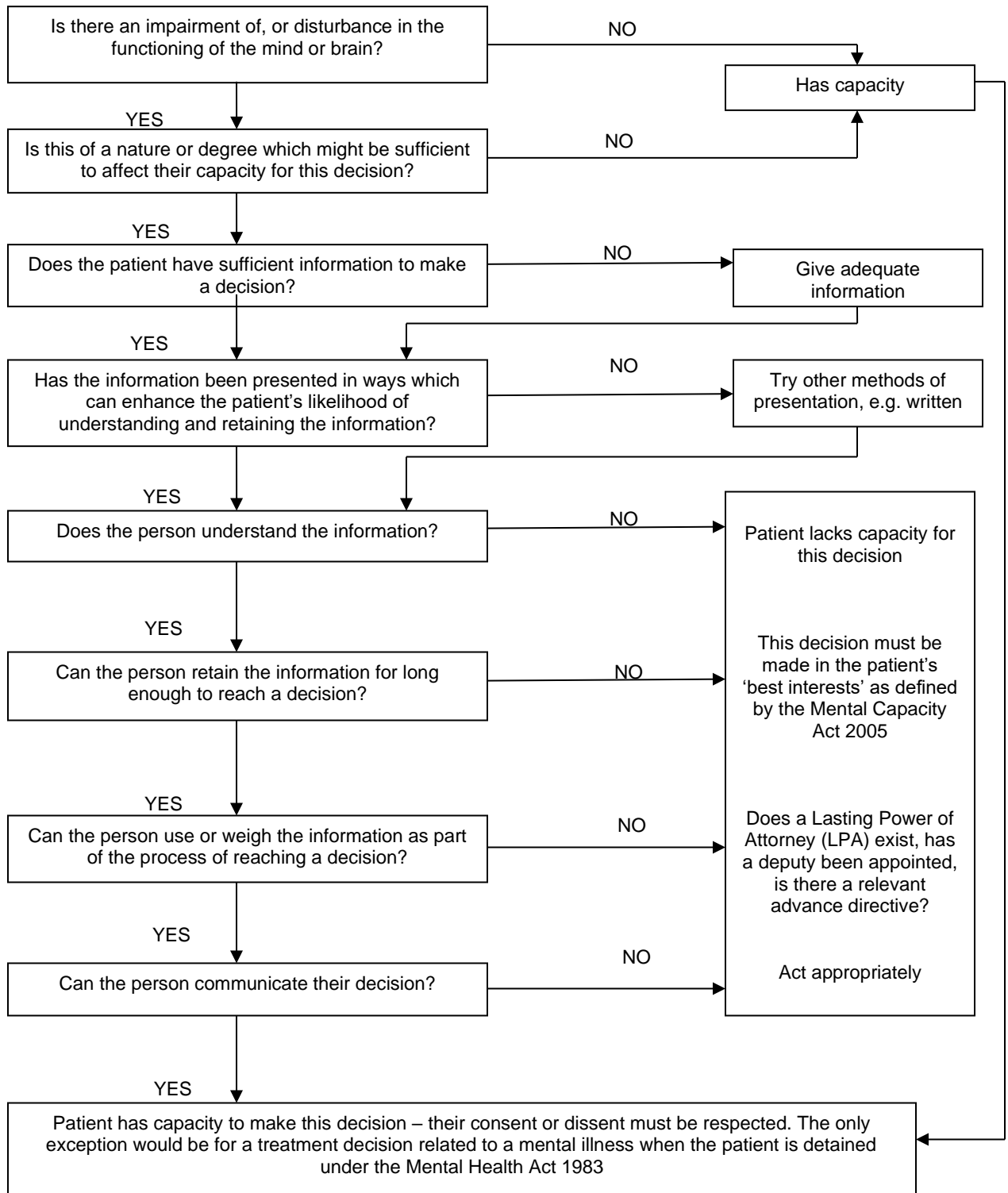
Refusal of treatment

10. Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the fetus.

Adults who are not competent to give consent

11. A capable (or competent) person may not be given medical treatment to which he does not consent. The treating of an incapable person is governed by the Mental Capacity Act 2005. In some cases the Act permits medical treatment to be given without the patient's consent, as long as it is in their best interests and has not been refused in a valid and applicable advance directive (living will) or advance decision. In some cases appointed advocates can make a decision on the patient's behalf.
12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and those circumstances arise, you must abide by that refusal.

APPENDIX 2: ALGORITHM TO DETERMINE CAPACITY



APPENDIX 3: CONSENT FORM TEMPLATES

Signed Consent:

Getting signed consent is good practice, as is making a record of consent in the notes (written or electronic). Informed consent requires full information on the proposed treatment, alternatives and possible complications including, for example, a measured opinion about the cosmetic result. The following

The following consent forms contain standardised 'Consent Form' templates for use in different presenting situations, together with their respective 'guidance to health professionals' notes. The can be found on the Pool Drive – Badger QMS – Forms – Information Governance or in Aastra Communications tab – Badger Standard Forms – Information Governance.

IG-F-007 - Patient Agreement to Proposed Procedure or Treatment (For patients aged 16 or over)

IG-F-008 - Parental Agreement to Proposed Procedure or Treatment for a Child or Young Person

IG-F-009 - Adults who are unable to Consent to Proposed Procedure or Treatment