NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Consent to Assessment Examination and/or Treatment Policy (including Mental Capacity Act)

Policy Number	**CL/Pol/001**
Target Audience	**All Clinical Staff including Bank, Agency and Students**
Approving Committee	**Corporate Clinical Policy Group**
Date First Approved	**January 2012**
Last Full Review Date	**April 2020**
Next Full Review Date	**April 2023**
Extension agreed to	**June 2024**
Policy Author	**Deputy Medical Director**
Version Number	**5.2**

Applicable Statutory, Legal or National Best Practice Requirements	CQC Registration Regulations – Regulation 11 Children Act (1989) Data Protection Act (2018) Department of Health (2015) Mental Health Act Department of Health (2015) NHS Constitution for England Department of Constitutional Affairs (2007) Mental Capacity Act Department of Health (2009) Reference Guide to consent for examination Department of Health (2003) Confidentiality Equality Act (2010) European Convention on Human Rights (ECHR) 1950 Family Law Reform Act 1969 (Section 8) General Medical Council (2008) Consent General Medical Council (2018) 0-18 years Health and Social Care Act (2008) Regulations 2014 HM Government (2015) Working together to safeguard children Human Rights Act (1998) Human Tissue Act (2004) Mental Health Act (2005) Mental Capacity (Amendment) Act (2019) Mental Capacity Act Code of Practice (2008) NHS Constitution (DH, 2009) NHS Consent to Treatment (2019)

	NHS Dental Patient Charge Regulations (2005) NHS General Dental Services Regulations (2005) NHSLA Risk Management (2013/2014) NICE Medicines Adherence (2019) NICE Medicines Optimisation (2015) NMC The Code (2018) RCN Principles of Consent (2017) Royal College of Paediatrics and Child Health (2014) Safeguarding Children and Young People Royal College of Paediatrics and Child Health (2015) Making decisions to limit treatment in life-limiting and life-threatening conditions in children

The Trust is committed to an environment that promotes equality, embraces diversity and respects human rights both within our workforce and in service delivery. This document should be implemented with due regard to this commitment.

This document can only be considered valid when viewed via the Trust's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Version Control Sheet

Version	Date	Reviewed By	Comment
1.0	Jan 2012	SMT	Policy Approved
2.0	March 2013	Clinical Policy Sub-Group	Revised policy approved
3.0	July 2015	CDAG Andrea Melbourne	Approved subject to amendments Amendments completed, section 20, appendix I and consultation box updated
4.0	July 2017	Clinical Document Approval Group S. Arkwright	Approved subject to minor amendments Amendments approved by chair action
4.1	July 2018	J. Eatwell	Minor amendment to appendix A
4.2	July 2018	S. Arkwright	Approved by chair action
4.3	February 2020	S. Arkwright	Comments received from: Kristine Brayford-West, Rachel Hall, Jan McCartney, Anne Webb, Lisa Williams, Ruth Besford, Louise Evans
4.4	February 2020	Corporate Clinical Policy Group	Comments reviewed. Policy updated and sent for wider consultation. To be resubmitted to CCPG.
4.5	March 2020	J. Eatwell R. Besford A. Webb L. Williams	Amendments made to sections 5.3 and 11.8 Amendments to section 7.3 Comments made regarding references Immunisation consent forms added
4.6	March 2020	Corporate Clinical Policy Group	Reviewed virtually – references updated following comments from Anne Webb
5	April 2020	S. Arkwright	Approved by chair action
5.1	May 2020	Tracey Breary	Minor amendments to appendices F to U
5.2	May 2020	M. Corkery	Hyperlinks added to appendices F to U – approved by delegated authority.

Does this policy impact/potentially impact on: **Staff** **Patients** **Family Members** **Carers** **Communities**	**Yes**	**Please contact the Trust's Equality & Inclusion Manager at:** **Email: ruth.besford@nhs.net**
	No	**Please sign and date below:** **Name:** **Email Address:** **Date:**

Education & Professional Development Question

In order to ensure that any training requirements are discussed and resources planned and allocated to meet the needs of the service, you must consider whether this document has additional training requirements.

Please answer the following question by entering a cross in the box below:

	Yes	**No**
Does this document have any additional training requirements or implications?		x

If you have answered **YES** you must forward a copy of this document to Education & Professional Development **before** submitting to the Policy Officer.

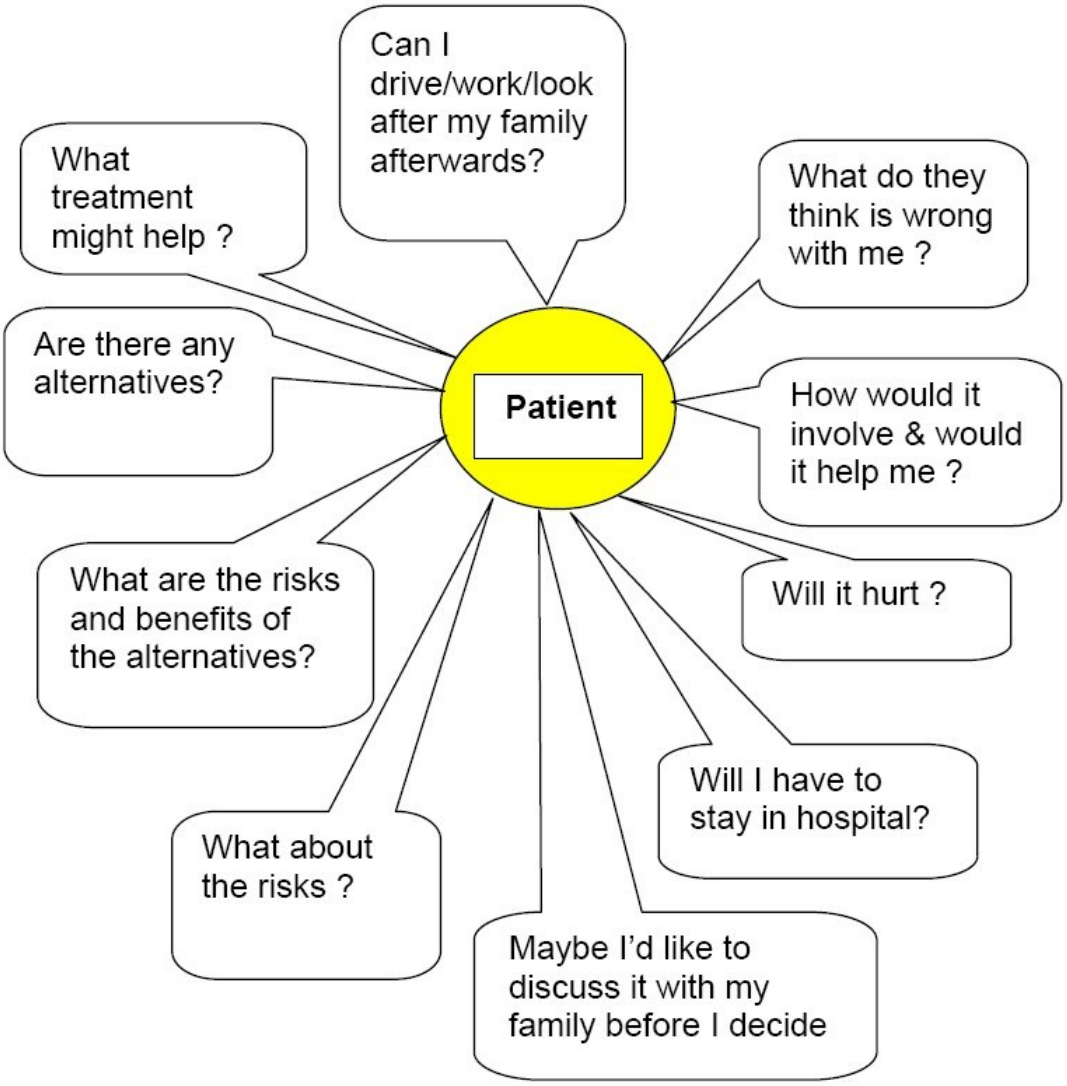
Date submitted to Educations & Professional Development: ……

No further action is required if you have answered NO.

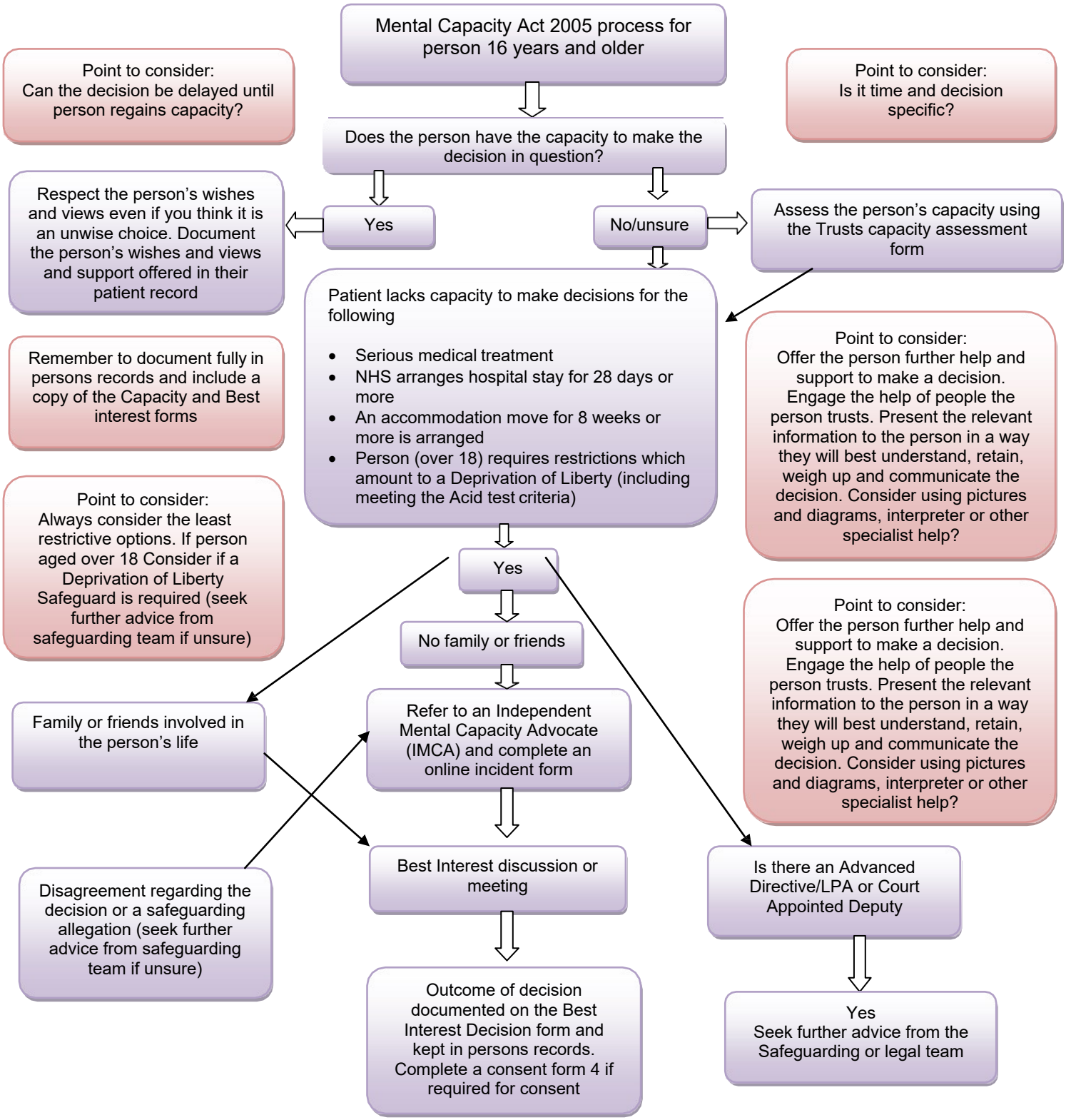
Contents

The following appendices can be accessed electronically by clicking on the links below:

Seeking Consent: Remembering the Patient's Perspective



Mental Capacity Act Assessment Decision making Process and Best Interest Process Chart



1 Introduction

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is absolutely central to healthcare, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between healthcare professionals (HCP'S) and patients – see appendix A.

Further information on helping patients to understand treatment options is available by clicking on the link below:

https://www.nice.org.uk/guidance/ng108

This policy relates to consent to assessment, examination or treatment – see the Confidentiality and Information Sharing Policy for advice regarding consent to share information.

1.1 Objective

It is the objective of Bridgewater Community Healthcare NHS Foundation Trust, hereafter referred to as the Trust, to:

- Encourage the active participation of individual patients in decisions relating to their treatment
- Promote patient education regarding the risks and benefits of clinical procedures
- Prevent misunderstandings and disagreements about consent leading to complaints and litigation.

1.2 Scope

This policy applies to all Trust employed clinical staff, registered and unregistered, bank and sessional staff, and learners in practice, who are required to work in clinical areas in the organisation. This includes but is not limited to doctors, nurses, health care assistants and allied HPC's.

2 Definitions

The definitions applicable to this policy are as follows:

Consent - a patient's agreement for a HCP 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:

- Have the mental capacity to take the particular decision

- Have received sufficient information to take it
- Not be acting under duress.

Parental Responsibility - all the rights, duties, powers, responsibilities and authority which by law a parent has in relation to the child and their property:

- Child's mother or father
- Child's legally appointed guardian
- Person with a residence order concerning the child
- Local authority designated to care for the child
- Local authority or person with an emergency protection order for the child.

NHS Children and Young People Consent to treatment:
https://www.nhs.uk/conditions/consent-to-treatment/children/

Treatment - is taken to include assessment, examination, investigation and treatment.

Risk - is used throughout to refer to any adverse outcome, including those which some HCP'S would describe as 'side-effects' or 'complications'.

Lasting Power of Attorney - a Lasting Power of Attorney (LPA) is a legal document that lets a person appoint someone to make decisions about their health and welfare and/or property and financial affairs. The health and welfare LPA is a different document to a property and financial affairs LPA; a person may have both. It can be used at any time when or if a person is not able to make their own decisions.

Advance Decision - a person may have made an advance decision to refuse particular treatment in anticipation of future incapacity (sometimes previously referred to as a 'living will' or 'advance directive'). A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment.

Best Interest principle - best interests' is a method for making decisions which aims to be more objective than that of substituted judgement. It requires the decision maker to think what the 'best course of action' is for the person. It should not be the personal views of the decision-maker. Instead it considers both the current and future interests of the person who lacks capacity, weighs them up and decides which course of action is, on balance, the best course of action for them.

3 Abbreviations

The abbreviations applicable to this policy are as follows:

LPA	Lasting Power of Attorney
MCA	Mental Capacity Act
HCP	Healthcare Professional
IMCA	Independent Mental Capacity Advocates
BMA	British Medical Association
PGD	Patient Group Direction
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
QIV	Quadrivalent Inactivated Vaccine
PGD	Patient Group Directions
GP	General Practitioner
MMR	Measles Mumps Rubella
Flu	Influenza
HPV	Human Papillomavirus
HCA	Health Care Assistant
L	Left
R	Right

4 Other Relevant Procedural Documents

This policy should be read in conjunction with the following documents:

Making Adjustments for Patients with Disabilities and Language Needs Policy

Medicines Policy

Procedure for the Management and Storage of Clinical Photographs and Digital Images

Confidentiality and Information Sharing Policy

Immunisations Policy

Safeguarding Adults Policy

Safeguarding Children Policy

Looked After Children Policy

Health Records Policy

Research & Development Policy

Advance Decisions to Refuse Treatment Policy

Clinical Audit Policy

Mental Capacity and Best Interests Decision Making Policy

Midwifery Planned Home Birth Policy and Procedures

Deprivation of Liberty Safeguards Policy

NICE Guidance and NCEPOD Management and Implementation Policy

Health Records Policy

Advance Care Planning Policy

Medicines Policy

Medication Incident Policy

Patient Group Directions (PGD) Policy

Incident Reporting Policy

Risk Management Framework

5 Roles and Responsibilities

5.1 Chief Executive

The Chief Executive has ultimate accountability for ensuring the provision of high quality, safe and effective services within the organisation and for ensuring that resources are available to ensure effective implementation.

5.2 Medical Director

The Medical Director is responsible as Accountable Officer and will work closely and coherently with the Chief Nurse/Chief Operating Officer.

5.3 Chief Nurse/Chief Operating Officer

The Chief Nurse/Chief Operating Officer, who is the Executive Lead for the Mental Capacity Act, is responsible for:

- Ensuring ratification, review and ongoing compliance with this policy through the clinical governance reporting structure
- Providing assurance to the Trust Board that training of all employees meets the required quality standards
- Ensuring the policy is reviewed in line with organisational requirements.

5.4 Director of Nursing Services (Borough Based)

Director of Nursing Services are responsible for:

- Ensuring Clinical Managers have the resources to implement this document and it is fully implemented within services
- Managing risks to implement this document or escalate significant risks to the Chief Nurse/Chief Operating Officer.

5.5 Clinical Managers/Line Managers

Clinical Managers/Line Managers are responsible for:

- Ensuring all relevant staff are aware of and adhere to this policy
- Ensuing staff who do not carry out specific procedures but could provide patient information, understand how to seek access to appropriate colleagues to answer any additional queries as part of local induction.

5.6 All Staff involved in the Clinical Care of Patients

Staff involved in the clinical care of patients are responsible for:

- Familiarising themselves with this policy
- Complying with this policy
- Ensuring the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

- Accessing the most up to date document on the intranet

- Ensuring that when they require colleagues to seek consent on their behalf they are confident the colleague is competent to do so

- Working within their own competence and not to agree to perform tasks which exceed that competence

- Contacting the Chief Nurse/Chief Operating Officer if they feel pressurised to seek consent when they do not feel competent to do so

- Identifying and making reasonable adjustments for patients (and where appropriate family members or carers) including in relation to disability, including communication and language formats, language, religion or culture – see section 13.

6 Equipment

Not applicable.

7 General Principles

In general, each patient has the right to accept or refuse treatment, and in this policy the term 'treatment' is taken to include assessment, examination, investigation and treatment. This is not only a right under common law, but is recognised as a basic tenet of ethical health care.

The Trust seeks to ensure that relevant information is provided to all patients, in ways that each patient can understand, about proposed treatments, including non-medical interventions such as personal care and therapy and including any alternatives. This information should contain an estimate of the relative risks and benefits of proposed treatments, and should be sufficiently detailed to enable patients to arrive at a balanced judgment, having had the opportunity to put their own value on the relative risks and benefits described.

The Trust recognises that patients may withdraw consent after it has been given, and may refuse treatment at any time.

7.1 What is consent – and is not

"Consent" is a patient's agreement for a HCP 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:

- Have the mental capacity to take the particular decision
- Have received sufficient information to take it
- Not be acting under duress.

Specific attention should be given to the requirements of the Mental Capacity Act when dealing with situations where patients do not have the capacity to make decisions about their treatment. For further information see section 8 of this policy.

7.2 The Necessity for Consent

Consent is necessary for two reasons:

- Obtaining of informed consent, with discussion of risks, benefits and side effects associated with any treatment, is part of the process of developing trust and cooperation between patient and HCP

- It provides practitioners with a defence to subsequent charges under criminal law, or of trespass to the person under the law of tort.

It is relevant also to the law of negligence, which requires all HCP's to counsel their patients in a way recognised by their peers as appropriate. It is necessary to answer patients' questions truthfully and fully.

7.3 The Nature of Consent

For consent to be valid, three elements must be satisfied:

- The act of consenting must be wholly voluntary

- The person consenting must be capable of understanding the nature of the treatment

- The person consenting must be provided with sufficient information about the treatment to know what they are accepting.

It is the responsibility of the practitioner to ensure communication with the patient is effective. Any issues in understanding caused by language, understanding, and/or special requirements must be addressed.

Extra time will be needed; explanations should be in plain language, without the use of jargon. A communication assessment including the use of communication aids may be needed.

Assistance may be necessary in the form of an accompanying family member, friend or advocate. However, this should only be arranged with the consent of the individual and consideration of the likely impartiality of the family member.

Where English is a second language an interpreting or translation service should be used rather than a family member. Children should not be used for seeking consent of their parents, carers/guardians or others who they may be accompanying.

It is critical to check understanding by asking the patient to describe what they understand the information means. Only then is it possible to ensure that informed consent to any assessment, care or treatment is being given. Refer to the Making Adjustments for Patients with Disabilities and Language Needs Policy for further information.

7.4 Guidance on Consent

- Reference guide to consent for examination or treatment provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. It can be accessed on the internet at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653 1_.pdf

- General Medical Council (2008) guidance re consent: patients and doctors making decisions together (currently under review):

- 12 key points on consent: the law in England has been distributed widely to HCP working in England. This one-page document summarises those aspects of the law on consent which arise on a daily basis and is attached at Appendix B.

- HCP's must also be aware of any guidance on consent issued by their own regulatory bodies.

8 Mental Capacity

8.1 Mental Capacity Act 2005

The legal requirements in the Mental Capacity Act (MCA) (2005) are supported by five statutory principles:

Principle 1: Assume a person has capacity unless proved otherwise

Principle 2: Do not treat people as incapable of making a decision unless all practicable steps have been tried to help them

Principle 3: A person should not be treated as incapable of making a decision because their decision may seem unwise

Principle 4: Always do things or take decision for people without capacity in their best interests.

Principle 5: Before doing something to someone or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way.

Detailed guidance on the Act is provided in the Mental Capacity Act (2005) Code of Practice and Deprivation of Liberty Safeguards Code of Practice that act as a supplement to the primary Code of Practice. For further detail see:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

8.2 Assessing Capacity

A person lacks capacity if they are unable to make a decision for themselves in relation to a matter because they have an impairment, or disturbance, of the mind or brain. This can be either permanent or temporary.

The HCP should not make a judgement of the patient's capacity on the basis of the patient's behaviour or other aspects of their behaviour. Where there is any doubt with regard to the patient's capacity, a formal assessment must be made.

A person is unable to make a decision if they are unable:

- To understand the information relevant to the decision
- To retain that information
- To use or weigh that information as part of the process of making the decision
- To communicate their decision, whether by talking, using sign language or any other means.

If they fail to meet one or more of the above, they will be deemed to lack capacity to make a decision.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity.

HPC'S must involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example, by providing information in non- verbal ways where appropriate.

If the incapacitated patient has a valid advance refusal to treatment that relates to an intended intervention then this has the same authority as a patient with capacity making their own decisions.

On occasion, a patient may have a court appointed person with Lasting Power of Attorney (LPA) for Health and Welfare or the Court of Protection may have appointed a deputy to make decisions on behalf of the patient. If the terms of the LPA or the Deputy extend to decisions relating to personal welfare, such a person may have the authority to consent to or withhold medical treatment on behalf of a patient. This does not extend to making decisions about carrying out or continuation of life-sustaining treatment unless this is clearly stated.

Where a serious medical intervention is proposed for a patient who lacks capacity and there are no persons close to the patient who can be consulted other than paid carers, then there is a duty to instruct an Independent Mental Capacity Advocate (IMCA). This person will help establish the best interests of the patient. In an emergency where there is no time to refer to an IMCA then the HCP can and should act in the patient's best interest.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having, or not having, the treatment is potentially serious, an application to the Court of Protection may be appropriate. To make an application contact the Trust Legal Services Department who will act as the Trust's link with appropriate solicitors. In urgent situations outside of normal office hours contact the on-call hospital manager via the Royal Cornwall Hospital switchboard.

8.3 Best Interests

Where a person lacks capacity to make decisions for themselves, any decision must be made in that person's best interests.

The Mental Capacity Act provides HCP with protection from civil and criminal liability for acts or decisions made in the best interests of the person who lacks capacity.

The Act emphasises that when determining what is in an individual's best interests a HCP must not make assumptions about someone's best interests solely on the basis of the person's age or appearance, condition, disability, or any other aspect of their behaviour. The Act requires that the professional must consider all the appropriate circumstances relating to the decision in question. These are expressed as factors that the professional is aware of and which are reasonable to take into account.

When considering the relevant circumstances, the Act deems that the professional must consider whether the person is likely to regain capacity and, if so, whether the decision can wait. In addition, the professional should involve the individual as much as possible in the decision that is being made on their behalf.

As much as possible, the professional must consider the persons past and present wishes and feelings (especially if they are recorded in writing), any particular beliefs or values the person may have that could influence the decision in question, and any other factors that the individual may consider if they were able to do so.

HCP's must demonstrate in their record-keeping that the decision has been based on all available evidence and has taken in any conflicting views. As far as possible, and if it is appropriate to do so, the HCP must take into account the views of any of the following individuals:

- A person previously named by the person lacking capacity as someone who should be consulted
- The patient's carers or anyone who is interested in his or her welfare
- Any attorney appointed under a Lasting Power of Attorney
- Any deputy appointed by the Court of Protection to make decisions for the person who lacks capacity

8.4 Procedure to Follow when Patients Lack Capacity to Give or Withhold Consent

Where an adult patient may not have the capacity to give or withhold consent to an intervention that normally requires written consent, a capacity and best interest assessment must be documented on Consent Form 4 (form for adults who are unable to consent to investigation or treatment), along with details of the consultation and involvement of people close to the patient.

The standard consent forms must never be used for adult patients unable to consent for themselves. For complex interventions, a formal best interest decision meeting may need to be held.

For intervention that would not normally require written consent, Form 4 must NOT be used; the Trust mental capacity assessment and best interest forms should be used in these circumstances.

Any HCP involved in the care of a person who lacks capacity must make sure a record is kept of the process of working out the best interests of that person for each relevant decision, setting out:

- How the decision about the persons best interests was reached
- What the reasons for reaching the decision were
- Who was consulted to help work out the best interests
- What particular factors were taken into account.

If the incapacitated patient has a valid advance refusal to treatment that relates to an intended intervention then this has the same authority as a patient with capacity making their own decisions.

On occasion, a patient may have a court appointed person with Lasting Power of Attorney (LPA) for Health and Welfare or the Court of Protection may have appointed a deputy to make decisions on behalf of the patient. If the terms of the LPA or the Deputy extend to decisions relating to personal welfare, such a person may have the authority to consent to or withhold medical treatment on behalf of a patient. This does not extend to making decisions about carrying out or continuation of life-sustaining treatment unless this is clearly stated.

Where a serious medical intervention is proposed for a patient who lacks capacity and there are no persons close to the patient who can be consulted other than paid carers, then there is a duty to instruct an Independent Mental Capacity Advocate (IMCA). This person will help establish the best interests of the patient. In an emergency where there is no time to refer to an IMCA then the HCP can and should act in the patient's best interest. For additional information about the IMCA service please see the Trust's Mental Capacity and Best Interest Decision Making Policy.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having or not having the treatment are potentially serious, an application to the Court of Protection may be appropriate. To make an application contact the Trust Secretary who will act as the Trust's link with appropriate solicitors. In urgent situations outside of normal office hours contact the on-call Senior Manager.

8.5 Advance Decisions to Refuse Treatment

A person with capacity may have made an advance decision to refuse treatment in anticipation of any future incapacity (previously referred to as a 'living will' or 'advance directive').

A valid and applicable advance decision to refuse treatment has the same effect as if that person has capacity and is refusing consent to treatment. This is a well-recognised rule of common law, and the Mental Capacity Act 2005 now puts advance decisions on a statutory basis.

The Act clearly sets out the requirements that such a decision must meet to be valid and applicable. These are summarised below:

- The person must be over 18 years of age or over
- The person must have the capacity to make such a decision
- The person must make clear which specific treatments they are refusing
- If the advance decision includes the refusal of life-sustaining treatment, it must be in writing (it can be written by somebody else or recorded in the healthcare notes), it must be signed and witnessed and it must state that the decision applies even if life is at risk

- A person with capacity has the right to withdraw their advance decision at any time.

HCP's must follow an advance decision if it is indeed valid and applicable, even if it may result in the person's death. If they do not comply with this, they could ultimately face criminal prosecution or civil liability. The Mental Capacity Act does, however, protect a HCP from liability for treating or continuing to treat a person in the person's best interests if they are not satisfied that an advance decision exists which is valid and applicable.

Likewise, the Act also protects HCP from liability for the results of withholding or withdrawing a treatment if at the time they reasonably believe that there is a valid and applicable advance decision. If however there is genuine doubt or disagreement regarding whether an advance decision exists, or is valid and applicable, the case should be referred to the Court of Protection.

Although the Court does not have the power to override an advance decision, HCP can provide life sustaining treatment or treatment to prevent the patient's condition deteriorating further, whilst awaiting a decision from the court. If an advance decision is not valid or applicable to current circumstances, the HCP involved must consider the advance decision as part of their assessment of the person's best interests.

Some HCP's may disagree with a person's right to refuse life sustaining treatments, however the Mental Capacity Act does not change the current legal position. Although HCP's do not have to act in such a way that goes against their beliefs, they must not abandon patients or cause their care to suffer. If this is the case, patients should have the option of transferring their care to another HCP or, if they lack capacity, arrangements should be made for the management of the patients care to be transferred to another HCP.

Patients should always be offered measures that are essential to keeping them comfortable. This is sometimes referred to as 'basic' or 'essential' care, and includes warmth, shelter, actions to keep a person clean and free from distress and the offer of food and water by mouth.

The BMA's guidance advises that basic care should always be provided unless it is actively resisted by a patient, and that 'refusals of basic care by patients with capacity should be respected, although it should be continued to be offered'. Advance decisions made under the Mental Capacity Act cannot refuse actions that are needed to keep a person comfortable.

The Act allows HCP's to carry out these actions in the best interests of a person who lacks capacity. An advance decision can refuse artificial nutrition and hydration. However, although basic/essential care would include the offer of oral nutrition and hydration, it would not cover force feeding an individual or the use of artificial nutrition and hydration.

The courts have recognised that an individual with capacity has the right to choose to refuse food and drink, although this may be qualified if the person has a mental disorder. Towards the end of such a period, an individual is likely to lose capacity, and the courts have stated that if the individual has, while they have capacity, expressed the desire to refuse food until death supervenes, the person cannot be force fed or fed artificially when they lack capacity.

If the person is refusing food as a result of mental disorder, then detention and treatment without consent may be a possibility under the Mental Health Act 1983, different considerations may apply and more specialist guidance should be consulted.

8.6 Limited Consent

In certain circumstances a patient may provide only limited consent. Practitioners agreeing to proceed under such restrictions must respect the patient's wishes. Practitioners should not take any action without obtaining the patient's consent beforehand except for measures that are both unforeseen and necessary to save life or prevent irreversible damage.

It is incumbent upon practitioners to discuss fully with patient's the consequences of limited consent, preferably in the presence of a medical, nursing or AHP colleague. It is particularly important that such discussions are fully and contemporaneously documented in the clinical records.

If HCP's feel unable to proceed without unlimited consent, attempts should be made to identify a colleague who would be prepared to continue treatment within the limits specified by the patient.

The most frequent example of limited consent is found when patients who are Jehovah's Witness refuse transfusion of blood and blood products on religious grounds - see appendix D for further information regarding Jehovah's Witnesses.

9 Documentation

For significant procedures, it is essential for HCP to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's health records if necessary), or through documenting in the patient's health records that they have given oral consent.

Consent Forms:

- Form 1 for adults or competent children
- Form 2 for parental consent for a child or young person
- Form 3 for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetic will be involved in their care

- Form 4 must be completed for adults who are unable to consent where Form 1 would otherwise be used. Unless it is a life threatening emergency, HCP's must complete a formal Mental Capacity assessment and best interest documentation prior to completing Consent Form 4

- Immunisation Consent Forms – Appendix F to U

The Business Services Authority forms (FP17, FP17DC, and FP17PR) are to be used where appropriate within the Dental services as required by the General Dental Service and Personal Dental Service Regulations.

For dental patients undergoing a general anaesthetic, oral surgery, sedation, complex or other high risk procedures or for patients where capacity is an issue then both a Business Services Authority and a Department of Health consent form should be completed. Completed consent forms must be kept with the patients notes for retention in accordance with the Health Records Policy.

10 Type of Consent

Consent may be written, oral or implied. Implied consent occurs for example when a patient proffers an arm for the taking of a blood sample. In order to defend an allegation of assault or negligence at a later date, it is helpful to have fully documented consent to treatment by the patient. For procedures with significant, unavoidable or frequently occurring risk, it is essential for practitioners to document clearly both a patient's agreement to the intervention and the discussion, which led up to that agreement.

In all circumstances, patients have a right to receive sufficient information to reach a balanced judgment and come to an informed decision. This is known as 'valid consent'. They can expect to have an explanation, presented in a sensitive and understandable way, of the benefits, significant, unavoidable or frequently occurring risks, alternatives, known complications and side effects.

Written advice (i.e. information leaflets) should be prepared whenever possible and given to patients to back up verbal explanations.

10.1 Expressed Consent

Expressed consent is given when a patient confirms their agreement to a procedure or treatment in clear and explicit forms whether orally or in writing.

10.2 Written Consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is evidence that the patient has given consent, but is not proof of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment.

Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

It is rarely a legal requirement to seek written consent but it is good practice to do so if any of the following circumstances apply:

- The treatment or procedure is complex, or involves significant, unavoidable or frequently occurring risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some HCP would describe as 'side-effects' or 'complications')
- The procedure involves general/regional anaesthesia or sedation
- Providing clinical care is not the primary purpose of the procedure
- There may be significant consequences for the patient's employment, social or personal life
- The treatment is part of a project or programme of research approved by the Trust.

Completed forms should be kept with the patient's notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and HCP.

It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past); it would be helpful to do so. See appendix E for service areas where formal consent for treatments is required.

10.3 Verbal Consent

Verbal consent should be limited to those procedures where there is minimal risk, and the agreement for the procedure to take place must always be recorded in the patient's health records by the professional administering the procedure.

10.4 Implied Consent

Implied consent applies where it is reasonable to assume the patient's consent by their actions, e.g. undressing and lying on a couch for a physical examination. Although such circumstances normally present no problems, consideration must always be given to the need to explain and obtain written consent for any procedure where an adverse consequence could arise about which the patient might not be aware or where particular difficulties in explaining the procedure or doubts as to the patient's understanding occur. In those circumstances, a full entry should be made in the health records, which the patient must be asked to counter-sign.

In a circumstance where a patient declines to sign and has the capacity to do so, the procedure must not proceed. However, if a patient lacks capacity refer to section 8.

There is no legal requirement that consent for treatment should be given in a particular way. Consent in writing is by far the best form of evidence and is the preferred method if any risk is contemplated.

10.5 Voluntary Consent

Consent must be obtained in the absence of coercion or duress. A patient's apparent consent to, or refusal of, treatment may be rendered invalid by undue influence of a third party, if it can be shown that the patient's will has been overridden. In this respect practitioners have an obligation to satisfy themselves that the decision reached is really that of the patient.

Important points to consider are the effect of the patient's condition on their ability to withstand third party influence, and the proximity of this relationship to the third party in question. This point is particularly important in situations where the patient is refusing consent. Where the patient is agreeing to clinically justified treatment recommended by clinical practitioner, there is a presumption in favour of an adult patient's competence.

A mentally capacitated patient may refuse treatment for any reason, rational or otherwise, even if such a decision is fatal for the patient. In principle this remains the case where the consequences are fatal for a patient's unborn child. However, when faced with a case where an apparently irrational decision has fatal consequences, the possibility of temporary incapacity must be considered - refer to section 8).

11 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'. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient's condition.

11.1 Single Stage Process (Verbal)

In many cases it will be appropriate for a HCP to initiate a procedure immediately after discussing it with the patient. For example, during an on-going episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant, unavoidable or frequently occurring risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

Discussions related to the consent process e.g. provision of patient information leaflets, any questions asked etc. must be annotated in the patients' health records.

If a proposed procedure carries significant, unavoidable or frequently occurring risk risks, it will be appropriate to seek written consent. HCP's must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear the patient understands and consents, the HCP may proceed.

11.2 Two or More Stage Process (Written)

In most cases where written consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out.

This may be on just one occasion or it might be over a whole series of consultations with a number of different HCP's. The consent process will therefore have at least two stages:

- The first being the provision of information, discussion of options and initial (verbal) decision

- The second being confirmation the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process.

The patient may be invited to sign the form, confirming they wish treatment to go ahead, at any appropriate point before the procedure. If a form is signed before patients arrive for treatment, a member of the healthcare team must check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure.

When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

11.3 Seeking Consent for Anaesthesia

Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks with the patient. However, in elective treatment it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia.

Patients should therefore either receive a general leaflet about anaesthesia in out-patients or have the opportunity to discuss anaesthesia in a pre-assessment clinic.

The anaesthetist must ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient's health records or on the consent form.

Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then they will also be responsible for ensuring the patient has given consent to that form of anaesthesia.

In addition, where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring the patient has all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

11.4 Emergencies

Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's health records to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that can be given, but should not affect its quality.

11.5 Treatment of Children and Young People

The legal position concerning consent and refusal of treatment by those under the age of 18 is different from that of adults. The consent of a young person with capacity is sufficient even in the face of a refusal from a person with parental responsibility.

Parental consent is always required in cases where a child does not have sufficient understanding of the entire purpose and risks of the proposed treatment. The HCP should satisfy themselves that the person offering consent on behalf of a child has parental responsibility for that child.

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. This must be recorded in the child's health records.

HCP's must be aware that not all parents have parental responsibility for their children. For example, unmarried fathers do not automatically have such responsibility although they can acquire it.

The HCP must carry check if they are in any doubt about whether the person attending with the child has parental responsibility for the child. If the HCP is unable to establish parental responsibility, professional judgement should be used as to whether to proceed with the appointment or to rearrange the appointment. This decision must be documented in the child's health record.

Where it is not a scheduled appointment, or it is the first appointment, and a child is brought by someone who does not have parental responsibility, the clinician must check directly with the person who has parental responsibility to establish whether they consent to the treatment/have authorised this other person to give consent

The only exception to this would be where a child is brought for urgent/emergency treatment e.g. dental and podiatry by someone who has "care of" the child at that particular time.

11.6 Unmarried Fathers

Unmarried fathers only have PR if they:

- Are named as the child's father on the birth certificate
- Have a legally binding Parental Responsibility Agreement
- Have a Parental Responsibility Order.

Fathers who are not married to his child's mother may acquire parental responsibility via three routes:

- For children born after 1st December 2003, by jointly registering the birth of the baby with the mother
- By a parental responsibility agreement with the mother
- By parental responsibility order, made by a court.

Further government information regarding parental rights and responsibilities can be obtained via the following link:

https://www.gov.uk/parental-rights-responsibilities

In some cases, where a child has sufficient understanding of the proposed treatment, it may be appropriate for the child to give valid consent. In these cases, the practitioner must ensure:

- The child has a sufficiently broad understanding of the hazards involved in any proposed treatment, and of any available alternatives

- That there is full documentation in the clinical records of those factors considered in deciding that the child is competent to give valid consent

- That the child is positively encouraged to inform his/her parent of any proposed treatment unless it is not in his/her interests to do so.

Where children are not considered competent to be fully responsible for consent HCP's may involve them in the process (see section 11.7). Children, even of a young age, should be encouraged to take part in the giving of consent, for example, by adding their signature to the parental consent - see appendix C for Assessing Fraser Competence Checklist.

Where children or young people who have not yet reached their 18th Birthday purport to refuse treatment, whether they have been assessed as competent or not, under the Fraser Guidelines their refusal may be countermanded by parents or, if necessary, by the Courts. HCP's should take into consideration the importance of the proposed treatment and the degree of comprehension of the child. In difficult cases, further advice should be sought via the line manager or the Safeguarding Children Team.

For National Screening Programmes (e.g. childhood measurement programme) the organisation operates in accordance with National Guidance relating to letters requesting consent from parents).
Also, specific measures under the Children Act 1989 allow teachers to give consent under specific circumstances to safeguard children's welfare in schools (e.g. for immunisation in absence of parents in boarding schools).

11.7 Fraser Guidelines/Gillick Competence

Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. By confusing them, we lose crucial details necessary for obtaining consent.

11.8 Age of consent

In UK law, a person's 18th birthday draws the line between childhood and adulthood (Children Act 1989 s105) - so in health care matters, an 18 year old enjoys as much autonomy as any other adult. To a more limited extent, 16 and 17 year-olds can also take medical decisions independently of their parents. The right of younger children to provide independent consent is proportionate to their competence - a child's age alone is clearly an unreliable predictor of his or her competence to make decisions.

Victoria Gillick challenged the Department of Health guidance which enabled doctors to provide contraceptive advice and treatment to girls under 16 without their parents knowing. In 1983, the judgement from the case laid out criteria for establishing whether a child under 16 has the capacity to provide consent to treatment; the so-called 'Gillick test'. It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options.

If a child passes the Gillick test, he or she is considered 'Gillick competent' to consent to that medical treatment or intervention. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity to consent to some treatments but not others. The understanding required for different interventions will vary, and capacity can also fluctuate such as in certain mental health conditions. Therefore, each individual decision requires assessment of Gillick competence.

If a child does not pass the Gillick test, then the consent of a person with parental responsibility (or sometimes the courts) is needed in order to proceed with treatment. Parental responsibility cannot be used for consent if the care and treatment will result in a deprivation of liberty

The 'Fraser guidelines' specifically relate only to contraception and sexual health. They are named after one of the Lords responsible for the Gillick judgement but who went on to address the specific issue of giving contraceptive advice and treatment to those under 16 without parental consent.

The House of Lords concluded that advice can be given in this situation as long as:

1. They have sufficient maturity and intelligence to understand the nature and implications of the proposed treatment

2. They cannot be persuaded to tell her parents or to allow the doctor to tell them

3. They are very likely to begin or continue having sexual intercourse with or without contraceptive treatment

4. Their physical or mental health is likely to suffer unless he/she received the advice or treatment

5. The advice or treatment is in the young person's best interests.

HCP's should still encourage the young person to inform his or her parent(s) or get permission to do so on their behalf, but if this permission is not given they can still give the child advice and treatment. If the conditions are not all met, however, or there is reason to believe that the child is under pressure to give consent or is being exploited, there would be grounds to break confidentiality.

Fraser guidelines originally just related to contraceptive advice and treatment but, following a case in 2006, they now apply to decisions about treatment for sexually transmitted infections and termination of pregnancy.

Although this ruling was around sexual health advice it has now been accepted that it can be applied to any situation requiring consent.

The HCP must be able to justify that the young person has sufficient maturity to understand the nature, purpose, hazards and benefits of the treatment in order to give a valid consent. A young person may have the capacity to consent to an uncomplicated procedure but not to a more complex one, e.g. request for emergency hormonal contraception as opposed to termination of pregnancy.

A child's request for confidentiality must be respected even when this includes refusing permission to discuss the treatment with their parents, unless this puts the child or others at risk. However, the HCP should seek to persuade such a young person to tell their parents or allow the HCP to do so. If the HCP is to proceed with the treatment without parental involvement they must be able to justify that the best interest of the child are being served. When such situations arise, it may be helpful to obtain advice from senior colleagues or the Safeguarding Children Team.

In the majority of cases where there are no issues between child and parent, it is advisable to obtain both the child's and the parental consent.

Problems may arise if assessment of competence is disputed by parents/guardians. Some parents believe that children under the age of 16 should not have the right to consent to any treatment on their own behalf. This is not a correct statement of law. The test is not one a parent can make.

Where such a disagreement arises, the HCP must explain the legal position to the parent.

11.9 Young Person (16-17 years)

Young people aged 16 or 17 are presumed in UK law, like adults, to have the capacity to consent to medical treatment.

However, unlike adults, their refusal of treatment can in some circumstances be overridden by a parent, someone with parental responsibility or a court.
This is because there is an overriding duty to act in the best interests of a child. This would include circumstances where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm.

Where young persons aged between 16 and 17 years give consent to treatment, this consent is as effective as that of an adult. In these cases any additional consent from a parent or legal guardian with parental responsibilities is unnecessary.

However, it is good practice to ask the permission of such patients to discuss any major or potentially hazardous procedure with parents or guardians. In this age group, such discussion with parents or legal guardian with parental responsibilities in the absence of the patient's permission is likely to constitute a breach of confidentiality. However, if there is a safeguarding concern this confidentiality may be breached. In such circumstances the HCP must seek advice from the Safeguarding Children Team.

If the young person with capacity is refusing treatment but the HCP still believes that it is their interests to have the treatment, then they should discuss with their line manager or the Safeguarding Children Team. It is not considered good practice, in line with the human rights legislation, to rely upon the consent of a person with parental responsibility to overrule the refusal of a young person with capacity in all the circumstances.

For further guidance on the Mental Capacity Act and 16 and 17 year olds - refer to Trust policies:

Safeguarding Children Guideline 9 - Mental Capacity and the Mental Capacity Act (2005) application to Children and Young People.

12 Provision of Information

The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue.

Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on.

Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask HCP's to make decisions for them.

A capacitated adult is entitled to decide which, if any, of the available forms of treatment to undergo, and their consent must be obtained before treatment interfering with their bodily integrity is undertaken. The HCP is therefore under a duty to take reasonable care to ensure the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.

12.1 Test of Materiality

The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk or the HCP is, or should be, reasonably aware that the particular patient would be likely to attach significance to it.

The HCP is, however, entitled to withhold from the patient information as to a risk if they reasonably consider its disclosure would be seriously detrimental to the patient's health. The HCP is also excused from conferring with the patient in circumstances of necessity, as for example where the patient requires treatment urgently but is unconscious or otherwise unable to make a decision. It is unnecessary for the purposes of this case to consider in detail the scope of those exceptions.

12.2 Provision for Patients whose First Language is Not English

The Trust is committed to ensuring 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. Refer to the Making Adjustments for Patients with Disabilities and Language Needs Policy.

12.3 Access to more Detailed or Specialist Information

Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets.

The following arrangements are available to assist patients to obtain such information:

- Patient Services Team - telephone: 0800 587 0562
- NHS web page: http://www.nhs.uk/Pages/HomePage.aspx

12.4 Access to HCP's between Formal Appointments

After an appointment with a HCP, patients will often think of further questions which they would like answered before they make their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or to wait until the date of an elective procedure, by which time it is too late for the information genuinely to affect the patient's choice.

Following a consultation, it is the responsibility of the HCP seeing the patient to give specific contact details should the patient have further queries between consultations. This information should be clearly outlined to the patient and shown in the space on the Consent Form for contact details.

12.5 Open Access Clinics

Where patients access clinics directly, it should not be assumed their presence at the clinic implies consent to a particular treatment. The HCP must ensure they have the required consent before proceeding with an investigation or treatment.

12.6 Failure to Warn

If patients convince a Court they were not warned of known complications and/or side effects, and that if they had been warned they would not have gone ahead with the treatment, this will be considered as negligence on behalf of the Trust. It is not enough to be simply ready to answer a patient's questions.

Risks should be openly explained as far as is reasonable for the particular patient, indicating the probability of each arising and the likely seriousness. All discussions must be documented in the patients' health records.

A risk is material if, in the circumstances of a particular case where a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it: or, where the practitioner is aware, or should reasonably be aware to attach significance to it. There may be particular characteristics about a patient, e.g. age, occupation or lifestyle, which may make certain medical information more relevant to them than it would be to other patients. If so, they must be informed of this.

12.7 Written Patient Information

Where appropriate, patients should be provided with written patient information to supplement and reinforce verbal discussions.

13 Responsibilities of Staff Seeking Consent

The HCP carrying out the procedure is ultimately responsible for ensuring the patient is genuinely consenting to what is being done: it is they 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 is being be carried out, this will naturally be done by the HCP responsible. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought, it may be appropriate for other members of the team to participate in the process of seeking consent.

An important part of this is the identification and provision of communication support or differing information formats for patients who need addition or specific support to understand and make informed consent due to a disability or impairment, or where English is not first language. It is the staff member's responsibility to ensure this support is provided, generally from professional services, but in the case of some patients, for example those with moderate or severe learning disabilities it may be the family member or carer who is best able to provide this support.

13.1 Completing Consent Forms

The standard consent form provides space for a HCP to provide information to patients and to sign confirming that they have done so.

The HCP providing the information must be competent to do so: either because they themselves carry out the procedure or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

It is a requirement that staff taking consent are trained in the risks relating to specific procedures where they do not themselves carry out the specific procedure, but could potentially provide the information patients need in coming to a decision. When staff are trained and competent it is a requirement they access clinical supervision.

- HCP'S confirming the patient's consent must have access to appropriate colleagues where they are not able to answer any remaining questions

- Should access to appropriate colleagues not be available, consent cannot be obtained

- Procedure specific training and general consent training is available in each service. This will form part of the induction to service training and as new procedures are developed further training will be provided.

If the patient signs the consent form in advance of the procedure, for example in out-patients or at a pre-assessment clinic, a HCP involved in their care on the day should sign the form to confirm the patient still wishes to go ahead and has had any further questions answered.

It will be appropriate for any member of the healthcare team, for example a nurse admitting the patient for an elective procedure, to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

13.2 Who Gains Consent?

Consent should be gained by a HCP who is both capable of performing the procedure and is able to explain the risks and benefits. Where this is not practicable, the task may be delegated (although responsibility remains with this practitioner). Where the process is delegated the following must be clearly demonstrated:

- The person giving the information is conversant with the procedure, understands the benefits and risks involved, and has been trained and assessed and is aware of his or her own knowledge limitations

- The patient is made aware of the implications of the treatment including pre, peri and post-procedure effects and consequences

- The person explaining the procedure is subject to an audit process

- Adequate literature describing the procedure, its benefits and risks and any alternative is always given to the patient

- The patient has proper access to the delegating practitioner so that any problems or queries, which cannot be answered by the person explaining the treatment, can be easily and speedily addressed.

There must be a clear centrally held record of who can take delegated consent for specific procedures that normally require written consent.

13.3 Assessing the Patient's Understanding

In assessing the patient's understanding, note should be taken of the possible limiting factors, e.g.:

- Sensory impairments, including vision, hearing and speech

- Language barriers (if necessary an interpreter should be used)

- Patient's level of literacy

- Mental disabilities, e.g. memory, neurological disability/learning disabilities

These restrictions to communication should be acted upon and use of communication aids, advocacy (formal or informal) translation, interpreting and/or British Sign Language interpreters should be used. To increase the potential for a full level of understanding, patients may wish to have relative or friend or nurse with them so that they can discuss what is said, then and later, more effectively. There must always be a reasonable opportunity to ask questions.

13.4 Blanket Consent

Blanket consent must not be used and the Consent Form must always state specific assessment, examinations and/or treatments. These must be described in words that patients will understand and abbreviations should not be used. More than one procedure may be recorded on the form as long as it is linked and undertaken within an appropriate time-scale. It is important always to record the date of consent and the site of an operation must always be adequately specified, e.g. left hand.

13.5 Prior to Treatment

Before any procedure takes place, checks should be made to ensure that it matches what has been written on the Consent Form.

13.6 Influence of Medication and Alcohol

Occasionally some substances such as medication and alcohol may affect the patient's ability to give consent.

It is important to remember that consent must not be obtained from a patient after pre-medication. Patients who are sufficiently affected may not have the capacity to consent, which means that any consent obtained in these circumstances will not be valid and should not be relied upon. Treatment should not be commenced until the patient is deemed to have regained sufficient capacity to make an informed decision and give consent, unless the patient's life is endangered or their health would be significantly compromised without immediate treatment.

14 Refusal of Treatment

The organisation recognises the rights of patients to vary or withdraw consent after it has been given, without prejudice to their care. Advice on significant risks and further discussion concerning difficult and exceptional cases may be found in section 15 and appendix D (Jehovah's Witness Patients).

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A mentally capacitated adult is entitled to refuse any treatment, except in circumstances governed by the Mental Health Act 2005.

The situation for children is more complex: see the General Medical Councils Website for further information, in particular sections 30-33 of 0–18 years: guidance for all doctors, by clicking on the link below:

GMC (2018) 0–18 years: guidance for all doctors

The following paragraphs apply primarily to adults:

If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in patients' health record. If the patient has already signed a consent form, but then changes their mind, you (and where possible the patient) should note this on the form.

Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care.

Where another HCP believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient's care to that HCP.

14.1 Treating without Consent

Patients have an absolute right to give or to withhold consent to any intervention as long as they have the mental capacity to do so. Patients are deemed competent unless otherwise proven. It is the responsibility of the practitioner to prove lack of capacity. In the event of a patient refusing to consent the practitioner should make every effort to obtain a signature declining treatment. In these instances taking the opinion of a Psychiatrist is necessary, and therefore they cannot be coerced, however necessary the treatment may be.

The circumstances where treatment can be given without consent are limited to:

- Life threatening situations where the patient is unconscious and cannot express a wish. In such cases it would be appropriate for the practitioners to speak to the patient's relatives (if available) outlining the treatment to be given and the reasons for its necessity

- The treatment of a mental disorder, if sufficiently connected to the mental disorder for which the patient has been sectioned, may be treated under the Mental Health Act

- Where a minor is a ward of Court and the Court rules that the treatment is in the child's best interests

- In accordance with statutory powers, e.g. Public Health (Control of Diseases) Act 1984.

In cases, where additional treatment is considered necessary during a procedure under general anaesthetic it must not take place without the patient's consent. The need must be discussed after the patient has recovered and a further intervention scheduled if the patient gives the appropriate consent.

In the circumstances where treatment can be given without the consent of the patient the Consent Form must not be signed by another party on behalf of the patient. No person, however closely related, can give consent for the treatment of another adult, regardless of whether or not that person is deemed competent or not. Instead, contemporaneous notes must be made in the health record explaining the situation and the decision to proceed without patient consent.

15 Consent to Treatment with Medicines

15.1 Information on Medicine(s)

Informed consent must be obtained and documented for all medicine use, having discussed the benefits and risks of that treatment.

In order to obtain consent, HCP must ensure that all decisions around medicines are properly informed. It is important that patients have access to reliable, factual and balanced information over choices of healthcare involving medicines.

HCP should have ready access to accurate up to date information on any medicine they prescribe, dispense or administer. HCP's must give patients and/or their representatives' sufficient information about the proposed medicine(s) and satisfy themselves that the patient has understood what is proposed according to the relevant NICE guidelines on medicines adherence and medicines optimisation, so that the patient is able to give informed consent to the treatment, for example:

- What the medicine is
- How the medicine is likely to affect their condition (that is, its benefits)
- Likely or significant adverse effects and what to do if they think they are experiencing them
- How to use the medicine
- What to do if they miss a dose
- Whether further courses of the medicine will be needed after the first prescription
- How to get further supplies.

It is important to discuss treatment options carefully with the patient to ensure that the patient is content to take the medicine as prescribed, (also termed adherence) In particular the patient should be helped to distinguish the side-effects of prescribed medicines from the effects of the medical disorder. Where the beneficial effects of the medicine are likely to be delayed the patient should be advised of this.

The information given to patients, carers, children and other HCP's must be given in a way they can understand, and be accurate and consistent - refer to the relevant NICE Clinical Guidelines:

- Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence
- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes for further information.

When administering medicines, the HCP must ensure appropriate consent has been obtained and that the patient is still content to take the medicine as prescribed.

In addition, refer to the Medicines Policy and Standard Operating Procedure for Administration of Medicines.

It is the responsibility of the person administering to ensure that a medicine supplied for a particular patient is only administered to that patient. If supplied as a stock item, the person administering should ensure that, where possible, the batch number and expiry date are recorded on the patient's health record, that the medicine is of a suitable quality, and the integrity of the product has been maintained.

15.2 Unlicensed Medicines or Medicines used Off-Licence / 'off label'

Informed consent must be obtained and documented for all medicine use, having discussed the benefits and risks of that medicine treatment. This is equally true when using unlicensed medicines or for medicines used off-licence/off label.

The prescriber must take account of the safety of the medicine, how well established it is in practice, the treatment options of not giving the medicine etc.

Prescribers must be fully aware of the current information about the use and contraindications of the medicine that they propose to prescribe. In particular, unlicensed or off-licence/off label medicines are less likely to be approved formulary choices and every alternative formulary choice must be explored prior to consideration of the use of an unlicensed or off licence/off label medicine.

For unlicensed or off-licence/off label use, the manufacturers information may be of limited help and the necessary information where available must be sought from elsewhere.

Many medicines are not licensed for use in children. The use of some unlicensed medicines or licensed medicines for off-licence/off label use is often necessary in paediatric practice - see the Trust Medicines Policy available on the intranet.

If there is no alternative other than to prescribe an unlicensed or off-licence/off label medicine, the prescriber must inform the patient (or the patient's carer where appropriate) of the medicines licence status, what this means and where appropriate explain that its effects will be less understood than those of a licensed product. The results of the discussion must be documented in the patient's notes.

15.3 Patient Group Directions (PGDs)

PGDs provide a legal framework that allows some registered HCP's to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a prescriber. A PGD is a specific written instruction for the supply or administration of named medicines, in an identified clinical situation, by a named HCP.

HCP's working under a PGD must obtain consent from the patient to be treated, and follow the same processes as above in section 14.1, and refer to the Trust Medicines policy.

15.4 Covert Administration of Medicines - see also Medicines Policy

The Nursing and Midwifery Council (NMC) recognises that this is a complex issue that has provoked widespread concern. It involves the fundamental principles of patient and client autonomy and consent to treatment, which are set out in common law and statute and underpinned by the Human Rights Act 1998.

Disguising medicine(s) in the absence of informed consent may be regarded as deception. However, a clear distinction should always be made between those patients/clients who have the capacity to refuse medicine(s) and whose refusal should be respected, and those who lack capacity.

Among those who lack this capacity, a further distinction should be made between those for whom no disguising is necessary because they are unaware that they are receiving medicine(s) and others who would be aware if they were not deceived into thinking otherwise.

The covert administration of medicines is only likely to be necessary or appropriate in the case of patients or clients who actively refuse medicine(s) but who are assessed not to have capacity to understand the consequences of their refusal.

The NMC recognises that there may be certain exceptional circumstances in which covert administration may be considered to prevent a patient or client from missing out on essential treatment. In such circumstances and in the absence of informed consent, the following considerations may apply:

- The best interests of the patient or client must be considered at all times
- The medicine(s) must be considered essential for the patient's or client's health and wellbeing, or for the safety of others
- The decision to administer medicine(s) covertly should not be considered routine, and should be a contingency measure. Any decision to do so must be reached after assessing the care needs of the patient or client individually. It must be patient, or client specific, in order to avoid the ritualised administration of medicine in this way
- There should be broad and open discussion among the multi-professional clinical team and the supporters of the patient or client, and agreement that this approach is required in the circumstances. Those involved should include carers, relatives, advocates, and the multi-disciplinary team (especially the Pharmacist). Family involvement in the care process should be positively encouraged
- The method of administration of the medicines should be agreed with the General Practitioner and Pharmacist

- The decision and action taken, including the names of all parties concerned, should be documented in the care plan and reviewed at appropriate intervals

- Regular attempts should be made to encourage the patient or client to take their medicine(s). This might best be achieved by giving regular information, explanation and encouragement, preferably by the team member who has the best rapport with the individual.

16 Special Situations

Withholding or Withdrawing Life Sustaining Treatment

16.1 General

A HCP's professional's legal duty is to care for a patient and to take reasonable steps to prolong their life. Although there is a strong presumption in favour of providing life-sustaining treatment, there are circumstances when continuing or providing life-sustaining treatment stops providing a benefit to a patient and is not clinically indicated.

There is no legal distinction between withdrawing and withholding life-sustaining treatment. A person with capacity may decide either contemporaneously or by a valid and applicable advance decision that they have reached a stage where they no longer wish treatment to continue. If a person lacks capacity, this decision must be taken in their best interests and in a way that reflects their wishes (if these are known).

16.2 The Dying Patient

The aim of medical and nursing practitioners in this situation is to ease suffering without attempting to prolong life artificially. In those rare situations where disagreement arises between patients or their parents/relatives a Court may authorise the withholding or withdrawing of such treatment as is appropriate to the individual case.

In the case of children, staff are referred to detailed advice issued by the Royal College of Paediatrics and Child Health. In these cases HCP's should seek advice from the Safeguarding Children Team.

16.3 HIV Testing

For consent to be real and valid, it is not sufficient for a patient to consent to blood testing in general terms without being told the nature and purpose of the proposed test. Consent for HIV testing should be expressly sought and the possible consequences of the testing explained.

These should include the fact that by testing a baby for HIV, the mother is also being tested. Practitioners are advised to consult the Local Sexual Health Clinic regarding the protocol on testing for HIV.

16.4 Tissue

The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing) raises some difficult issues. Such tissue can be very valuable in education and research, and its use may lead to developments in medical knowledge and hence improvements in healthcare for all.

At present, this Trust requires that patients should be given the opportunity to refuse permission for tissue taken from them during surgery or other procedure to be used for education or research purposes.

Blood samples are obtained during investigation of a disorder or to monitor treatment. Patients are able to consent verbally to the procedure as the blood samples are not obtained under anaesthetic.

Explicit consent is not necessary for public health surveillance using the unlinked anonymous method, but a well-publicised opt-out policy must apply.

The right to opt out will be documented on consent information and in the patient record. Any enhanced health surveillance undertaken in the organisation is at the direction of the Health Protection Agency and in accordance with national guidance. Notifiable diseases are reported in line with statutory requirements and are exempt from the Data Protection Act.

Pending the outcome of the review of the law governing the use of human organs and tissue, the Department of Health believes that tissue samples may be used for quality assurance purposes without requiring specific patient consent provided there is an active policy of informing patients of such use. This is essential to ensure the high quality of service which all patients have the right to expect. Wherever possible, samples of tissue used in this way should be anonymised or pseudonymised.

The organisation does not undertake any research on tissue samples and only takes tissue samples for testing purposes. The organisation would expect that those institutions used for testing of tissue samples to abide by the governing laws of England at the time.

In specific situations where clinical governance considerations require it, staff will ensure that as part of obtaining consent, they will advise patients that samples may be kept for quality control and future diagnostic reasons;

For example: When consent is obtained from patients for cervical smears to be taken, it will be explained that slides will be kept for an adequate period of time, for future reference if any future slide shows a developing abnormality, or the slides are required to be re-checked within the parameters of a Quality Assured service.

16.5 Human Tissue

The Human Tissue Act 2004 makes consent a fundamental principle in the lawful retention and use of body parts, organs and tissue from living or the deceased.

17 Clinical Photography and Conventional or Digital Video Recordings

Photographic and video recordings made for clinical purposes form part of a patient's health record.

Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, HCP's should always ensure they make clear in advance if any photographic or video recording will result from that procedure. This is especially pertinent if photographic and video recordings are made for research purposes - see the Management and Storage of Clinical Photographs and Digital Images Procedure for further information and associated consent form.

18 Childhood Immunisation

It is good practice to gain written consent for childhood immunisations. However, there is no requirement for the national model consent forms to be used for a school routine immunisation programme if a simpler form is more appropriate.

The main concern is that:

- The consent given is valid, i.e. is given voluntarily by an appropriately informed person (either the patient or someone with parental responsibility for a patient under the age of 18)

- The process of consent is recorded, with this record accessible to both the patient and the medical professionals concerned.

When vaccinations are offered within the school setting without parents in attendance, written information about the vaccination must be provided along with a consent form for completion and return before the vaccination session. The parent or guardian must be given the opportunity to contact the team delivering the vaccination session if they have any queries.

If a parent fails to return a vaccination consent form, the service should attempt to get verbal consent and/or consent from the young person if the young person is Gillick Competent.

To aid the recording of consent for school-aged childhood vaccination programmes there are various consent forms for each vaccination programme, these include:

- Parent consent form

- Verbal consent form (for use when telephone contact is made to get verbal consent)

- Self-consent (for use in high school vaccination programmes, when young people give their own consent to vaccination)

See appendices F to U.

19 Consultation

Key individuals/groups involved in the development of the document to ensure it is fit for purpose once approved.

Name	Designation
Jeanette Hogan	Deputy Chief Nurse
Sharan Arkwright	Deputy Chief Nurse
Kristine Brayford-West	Director for Safeguarding Services
Jim Eatwell	Named Nurse / Safeguarding Adult Lead
Louise Evans	Safeguarding Children Specialist Nurse
Sarah Wilson	Head of Safeguarding
Aruna Hodgson	Medical Deputy Director
Jan McCartney	Trust Secretary
Mary Corkery	Policy Officer
Rachel Hall	Head of Research|
Ruth Besford	
Anne Webb	Head of Knowledge and Library Services
Sharon Ramsdale	Information Governance and Records Manager
Sandra Rutter	Clinical Manager
Christine Whittaker	Associate Director - Organisational Development
Jo Lister	Safeguarding Midwife/Deputy Team Leader
Corporate Clinical Policy Group	

Name	Designation
Lisa Williams	0-19 Clinical Public Health Nurse Specialist
Patricia Reid	Business Manager

20 Dissemination and Implementation

20.1 Dissemination

The Medical Deputy Director is responsible for disseminating this policy to Borough Directors for disseminating to relevant staff.

This policy will be made available on the intranet and published in the Team Brief and staff bulletin.

20.2 Implementation

Training on consent issues relating to treatments or procedures carried out in specific service areas will be carried out by the line manager as part of clinical supervision or when a member of staff starts work.

The Local induction programmes will cover issues relating to consent issues and processes specific to each service area. The service manage will ensure local induction includes discussion and familiarisation of staff with consent issues pertinent to the activities of their service.

Training on Consent and the Mental Capacity Act can be accessed via e-Learning. Staff must attend the e-Learning introductory session prior to undertaking any of the e-learning courses. Relevant courses should be identified as part of individual development plans.

HCP's should be aware of any guidance on consent issued by their own regulatory bodies.

Further Information and all the approved consent forms are available on the organisations intranet via the following link:

http://nww.bridgewater.nhs.uk/corporate/Pages/Consent.aspx

21 Process for Monitoring Compliance and Effectiveness

Compliance with this policy will be monitored through the assessment of incidents, complaints and claims that are related to this policy. Any identified trends that relate to a failure to comply with this policy will be addressed appropriately.

Compliance with the policy will also be monitored through the record keeping audit within service areas and action plans developed where appropriate.

22 Standards/Key Performance Indicators

None applicable.

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Appendix A Key Points of this Policy

1 Everyone has a fundamental legal and ethical right to determine what happens to their own body.

2 Valid consent underpins healthcare delivery whether basic care or major surgery.

3 For the consent to be valid, the patient must:

- Have capacity to make the particular decision
- Have received sufficient information to make it
- Not be acting under duress.

4 Where an adult patient lacks capacity no-one else can give consent on their behalf unless they are a personal welfare lasting power of attorney or a deputy appointed by the Court of Protection.

5 Only people who have parental responsibility for the child can give consent on their behalf and it is important to check this with the adult who accompanies the child.

6 A young person aged 16 or 17 has an explicit right to provide consent to surgical, medical or dental treatment.

7 An adult patient with capacity is entitled to refuse any treatment, except in circumstances governed by the Mental Health Act.

8 Identifiable photographic and video recordings made for treating or assessing a patient must not be used for any purpose other than the patient's care without the consent of the patient or a person with parental responsibility.

9 There are four forms available on the intranet via the following link:

http://nww.bridgewater.nhs.uk/corporate/Pages/Consent.aspx

- Form 1 for adults or competent children
- Form 2 for parental consent for a child or young person
- Form 3 for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care
- Form 4 must be completed for adults who lack the capacity to consent to investigation or treatment

Immunisation Consent Forms can be found in appendices F through to U.

Appendix B 12 Key Points on Consent: The Law in England

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. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

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 foetus.

Adults who are Not Competent to Give Consent

11. No-one can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

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 C Assessing Fraser Competence Checklist

This form is to be used by Health Professionals assessing young persons (ages 11-16) consent to treatment or refusal to consent in the absence of a person with responsibility.

Name of Child/Young Person…… Venue/ School ……

Date of Birth ……..

	Yes	No
• Parent/Guardian has provided consent	☐	☐
• Parent/Guardian has refused consent to this treatment/procedure	☐	☐
• Has the young person refused to tell the Parent/Guardian or to allow the health professional to discuss it with their parents?	☐	☐

If answered "yes" to any of the above points, what actions have been taken and what evidence do you have to support this? *(Please write all relevant evidence in the space provided).*

……

……

The Young Person:

• Understands the benefits of proposed treatment	☐	☐
• Understands the risks of proposed treatment	☐	☐
• Understands what the treatment involves	☐	☐
• Understands the implications of not having the treatment	☐	☐
• Understands the alternatives available	☐	☐
• Understands what effects on their lives of having or not having the treatment will be	☐	☐
• Understands the language and clinical terms	☐	☐
• Understands the procedure to be carried out	☐	☐
• Demonstrates the ability to communicate a choice	☐	☐

Name of Professional Completing this form ……

Signature…….. …… Designation…….

Date……

Appendix D Jehovah's Witness Patients: Consent and Treatment Background

Some patients referred for treatment are Jehovah's Witness. Their religious convictions prevent them from accepting blood or blood products, even when these are necessary to sustain life. In common with all patients the wishes of Jehovah's Witness patients should be respected throughout any care and treatment.

It is the responsibility of the practitioner in charge of the patient's care to ensure that the position regarding the administration of blood or blood products is clarified before the patient is admitted for the procedure in question. The responsible practitioner should discuss with every Jehovah's Witness patient the implications of any refusal to accept blood or blood products. This should be at the earliest opportunity, and always before a decision is taken to recommend a procedure, which might, in normal circumstances, require the use of blood products.

If a patient on a waiting list or scheduled treatment is discovered to be a Jehovah's Witness, then he/she should be contacted at the earliest opportunity to discuss the administration of blood and blood products.

Procedures

If the patient's refusal of blood and blood products is absolute, the practitioner must decide whether he is able to treat the patient while fully complying with the patient's wishes. If he feels unable to comply with the wishes of the patient, then he should refer him/her to a colleague who does feel able to.

If the practitioner is willing to proceed with treatment in accordance with the patient's wishes, he should use the standard Consent Form produced for this situation. Occasionally, it will emerge during discussions, that the patient is willing to subordinate religious conviction to survival and allow the practitioner to use blood or blood products if this is necessary to save the patient's life. In these situations, the amended Consent Form should be used.

If a patient is unconscious and found to be carrying a card stating that as a Jehovah's Witness a transfusion must not be given in any circumstances, even if necessary to save life, the practitioner must respect the patient's wishes. Decisions should always be documented.

Children of Jehovah's Witness Patients

Parents who are Jehovah's Witness may not prohibit practitioners from administering blood or blood products to their children, but consent should be obtained for procedure, usually from the Court.

Where a parent or parents are Jehovah's Witness and purport to refuse transfusion of blood or blood products in the course of treatment of their child, practitioners must always seek legal advice. In emergency situations, practitioners may rely on the support of Courts to endorse decisions that are taken in good faith and in the best interests of the child concerned.

If the patient is the child of a Jehovah's Witness and the child is under the age of 16 the practitioner must assess whether the child is 'Fraser Guidelines' competent. If he/she is and consents to treatment, the procedure should go ahead even if the parents object. Where time allows, legal advice should be sought.

Appendix E Service Areas where Formal Written Consent for Treatment is required

All Services	Photography
Physiotherapy	Acupuncture Steroid Injections
Dental Services	Extractions Surgical Procedures All treatment performed in sedation All treatments performed under general anaesthetic
Podiatry	Nail surgery
Children's Services	Newborn Screening, National Childhood Measurement Programme, School-aged immunisation programmes
Dermatology	Excisions

Guidance for procedures which need a written consent form

It would not be practicable to identify all procedures which require a written consent, nor anticipate all new areas of service development. Therefore, each clinical service must refer to guidance from their professional bodies and keep updated on best practice.

The following statement is key to the decision making:

The treatment or procedure is complex, or involves significant, unavoidable or frequently occurring risks. The term 'risk' is used throughout to refer to any adverse outcome, including those, which some health professionals would describe as 'side-effects' or 'complications'

Evidence in the patient's notes and consent forms will demonstrate how the health professional obtained consent which needs to be both informed and understood by the patient.

Types of Forms to be used:

DoH Form One - only if anaesthesia is to be used

DoH Form Two - for parental agreement to investigation or treatment for a child or young person. Only people with parental responsibility are entitled to give consent on behalf of their treatment

DoH Form Three - for patient / parental agreement to investigation or treatment where consciousness is not impaired. *This would be the most commonly used in Community Services and General Practice*

DoH Form Four is for adults who are unable to consent to investigation or treatment - **if written consent for the procedure would normally be sought.**

Immunisation Consent Forms – see appendices F to U.