Policy for Consent to Examination or Treatment

DOCUMENT CONTROL:	
Version:	6
Date ratified:	18/02/21
Approving body:	Quality Assurance and Patient Safety Committee
Name and job title of Lead Author:	Dr Joanne Thomas, AMD
Date published:	February 2021
Review date:	February 2024

Version Control Sheet

Document Title:

Policy for Consent to Examination or Treatment Version 5

Version	Date	Author	Status	Comment
2.0	May 2010		Final	Integrated Governance Group Approved
2.0	April 2011		Final	Transferred to Spectrum Community Health CIC Community Health
3.0	January 2013	Tracey Cooper, Head of Quality Therapies and Assurance	Draft	Changes made to include policy statement and to remove references to the PCT and make the policy relevant to Spectrum Community Health CIC Community Health. Discussed at Risk Management 19/2/13. It was agreed that in its current format it was very long and
4.0	February 2013	Janette Earnshaw, Quality and Assurance Manager	Draft	Revised following Risk Management feedback Original policy split to create a clear policy which directs staff on obtaining consent in most situations and guidelines document to provide additional information on consent issues. Guidance on consent for general anesthetics removed from the policy Flow chart created and included in policy document. Recording consent now references system one as most notes are electronic Consent form for obtaining consent for invasive procedures with children removed.
4.0	March 2013	Tracey Cooper	Draft	Recirculated to members of Risk management and Assurance meeting to confirm it now meets the requirements of the group. Taken to Senior Management meeting
4.0	March 2013	Tracey Cooper	Approved	Approved at Audit and Assurance Committee 19/03/13
4.0	August 2013	Tracey Cooper		Reviewed for transfer to HMP Styal with Interim Head of Service and Matrons at HMP Styal
4.1	January 2017	Julie Fleetwood	Review	Reviewed at Quality Group to include reference to Accessible information standard and updated references
4.2	February 2017	Julie Fleetwood	Approved	Quality checked. Included schedule of prosecution information NEDS evaluation Final approval given at QAPS

5	April 2017			ID number added. Converted to PDF for publishing Published 13/04/17
5.1	Dec 2020	Dr J Thomas	Draft	Peer review of policy by senior Spectrum clinicians resulting in following policy updates/amendments: 1. Introduction – defining principle of presumed patient consent 2. Obtaining consent – consent to access SCR in secure environments to support medications reconciliation: consent and care decision making in patients lacking mental capacity; use of telephone interpreting services. 3. In absence of mental capacity escalation to Spectrum senior clinical leaders for support to local MDT in complex cases. 4. Documentation – clarification of interventions proceeding with implied consent: need for written consent with Buvidal. 5. Legal Requirements/ Regulations and Relevant documentation – web links checked and updated where required. 6. General review of document to ensure grammatical correctness.
5.2	Feb 2021	Dr J Thomas	Draft	Peer review of policy by senior Spectrum clinicians resulting in following policy updates/amendments: 1. Obtaining Consent. Consent process for SCR access 2. Refusal of Treatment. Added direction re Advance Directive (Advance decision to refuse treatment). 3. General review of document to ensure grammatical correctness
5.3	Feb 2021	Lois Pape	Draft	Approved at QAPS 18/02/21. Document and version control amended.

6	Feb 2021	Lois Pape	Final	Request upload to Intranet.

Contents

1. Policy Statement

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Spectrum Community Health CIC (Spectrum) is committed to obtaining valid consent for treatment or investigations as this is absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking informed consent is also a matter of common courtesy between health professionals and patients. There are a range of guidance documents on consent and these must be consulted for details of the law and good practice requirements on consent. A health care professional who does not respect this principle is liable to legal action by the patient/client and action could be taken by their professional body.

The Health and Social Care Act 2008 (Regulated Activities) 2014 requires that*: "The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them".* CQC regulations allow for direct prosecution of any organisation that fails to provide those suitable arrangements. This policy directive requires professionals to work to the standards of their professional bodies and follow the requirements of this policy.

2. Introduction

Typically, primary care consultations proceed based on implied consent. Patients may indicate consent non-verbally (for example by presenting their arm for their blood pressure to be taken), orally, or in writing. For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below:

- **Voluntary** – the decision to either consent or not to consent to treatment must be made by the person themselves and must not be influenced by pressure from medical staff, friends or family.
- **Informed** – the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and what will happen if treatment doesn't go ahead.
- **Capacity** – the person must be capable of giving consent, which means they understand the information given to them, and they can use it to make an informed decision. Spectrum requires all Health Professionals to understand their obligations in relation to consent.
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3. Aims and Objectives of the Policy

This policy aims to set out the standards and procedures adopted by Spectrum to ensure that health professionals are able to comply with their professional requirements. The policy will ensure that Spectrum is adhering to the legal requirements of regulation 11 (CQC Fundamental Standards). Spectrum will assure compliance with the policy through an annual record keeping audit.

4. Scope of the Policy

This policy must be followed by all Spectrum staff involved in service delivery, including locum staff, staff on secondment and bank staff.

5. Accountability

- Professional responsibility is determined by the clinician's Code of Professional Conduct/Standards and Job Description.
- CQC registered managers /Heads of Service are accountable for the implementation of this policy

6. Obtaining Consent

The following is a summary of what is required on a daily basis with regards to informed consent and joint decision making. The flow chart in appendix A provides an overview of the process. Further information is available in the Guidance on Informed Consent and Joint Decision Making.

When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent. When accessing a patient's summary care record (SCR) patient verbal consent must be obtained and documented (in the SystmOne record or equivalent). In the secure environment this should occur ideally at first reception screening to support medication reconciliation.

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?"

   The Mental Capacity Act code of practice provides the legal parameters required:

   https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected. This is still the case even if refusing treatment would result in their death, or the death of their unborn child.

   For adults who lack the mental capacity to decide about their treatment, healthcare professionals providing care may in this circumstance direct a care intervention that they believe is in the patient's best interests. These cases are often complex and close working with Spectrum's Safeguarding Team is advised. In complex cases it may be necessary to obtain a Best Interests court order. Lasting Power of Attorney is a process that allows a patient to nominate representatives in the event they lose mental capacity in the future – identification of the existence of such orders must be sought when planning care. Clinicians must take reasonable steps to seek advice from the patient's friends or relatives before making these decisions. When mental capacity is deemed absent the representation of an IMCA must be sought.

In a capacitous individual, who is making an extremely unwise decision as a result of coercion, undue influence or is otherwise disabled from making a free choice it may be possible to apply to the courts for an Inherent Jurisdiction ruling – this would then allow a decision to be taken on a patient's behalf which would otherwise be outside the remit of the MCA. Again, these cases are extremely complex and early support from Safeguarding must always be sought.

5. 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 must always check that the patient still consents to your caring for or treating them.

6. In terms of consent to intimate examinations staff must refer to guidance within the Chaperone policy which states that a Chaperone must be offered, and the health professional must record if there was a chaperone offered and accepted or declined

7. Obtaining Consent from Children - 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, someone 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.

Staff must follow the Fraser competence guidelines and record their decision making:

https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition- child-rights-law/gillick-competency-fraser-guidelines/

Responsibility of Health Professionals

It is a health professional's own responsibility:

- To ensure that when they require colleagues to seek consent on their behalf, they are confident that the colleague is competent to do so; and;
- To work within professional competence and not to agree to perform tasks which exceed that competence.

If you feel that you are being pressurised to seek consent when you do not feel competent to do so, you must in the first instance contact your line manager or Head of Service.

What information must be provided?

The Head of Service must ensure that there is enough information regarding treatment options available in clinical areas to support effective decision making. 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. It is good practice for staff to give specific information leaflets to patients prior to undertaking any course of treatment, even if that treatment does not necessitate signing of a consent form.

We must comply with the Accessible Information Standard 2016 and staff must ask about and record any communication requirements the patient/service user has both in receiving or giving of information (Braille, large print, audio versions). We must ensure all individuals who require an interpreter receive a service (all services have access to telephone interpreting services). This will ensure that all patients have a full understanding of all the options and potential risks or limitations of treatment prior to giving consent.

Recording of Consent

Consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid. The professional must record the patient's decision, and also the discussions that have taken place (or the visual cues that lead you to believe the patient is consenting). You must be assured that consent has been given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Open access clinics

Spectrum recognises that where patients access clinics directly, it must not be assumed that their presence at the clinic implies consent to treatment. Patients must be provided with the information they need before proceeding with an investigation or treatment, and informed consent must be obtained.

Refusal of treatment

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

If a patient who is judged to have capacity is refusing life-saving interventions an Advance Directive (Advance decision to refuse treatment) must be discussed. This would record the patient's wishes in the event of loss of capacity e.g. through loss of consciousness or confusion. If the patient does not wish to make an Advance Directive their capacity must be regularly assessed. In the event of loss of mental capacity, a Best Interests decision regarding further treatment must then be taken. "

Decision Making for Adults who *may* lack capacity

1. A patient's capacity to make decisions must, throughout be assumed to be present (do not make assumptions that the patient is incapable based on diagnosis, appearance or behaviour etc.).
2. The patient's ability to make decisions must be optimised before concluding they are incapable. Ensure they have adequate time, repeat information as necessary, and use any appropriate communication aids available – e.g. interpreters, sign language, etc.
3. Patients are allowed to make unwise decisions; clinicians must demonstrate the patient is incapable of processing the information and making the decision before acting against their wishes.
4. Decisions subsequently made on behalf of patients 'without capacity' must always be in the patient's best interest and be the least restrictive on their basic rights and freedoms.
5. 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 (under emergency circumstances).
6. 'Best interests' go wider than best medical interests and 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.
7. 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.

How to seek a court declaration

Occasionally there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interest. Where the consequences of having or not having the treatment are potentially serious, a court declaration may be sought.

In such circumstances the case must be referred to appropriate representatives of Spectrum's Senior Clinical, Nursing, and/or Operations teams who will support and advise.

7. Documentation

For significant procedures i.e. IUD insertion and Mole removal, health professionals must document clearly both a patient's agreement to the intervention, and the discussions which led to that agreement. This may be done either through the use of a consent form (with further detail in the patient's record if necessary), or through documenting in the patient's record that they have given oral consent.

Routine immunisations, joint injections, and contraception injections can proceed on the premise of implied consent.

Buvidal depot is a new treatment for opioid dependence – it's administration will require written consent.

Written consent

Completed forms must be kept with the patient's notes. Any changes to a form, made after the form has been signed by the patient, must be initialed and dated by both patient and health professional for paper records and documented on SystmOne for all others. Consent must always be recorded in the SystmOne electronic patient record if that system is being used.

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.

Availability of forms

Standard consent forms and forms for adults who are unable to consent for themselves are used within Spectrum.

There are three versions of the standard consent form, see Appendix B.

Recording of Consent

Staff must document in a patient's record that the patient has given informed consent to the procedure which they are about to undertake. When a patient has given written consent, a copy must be securely attached within the patient's record or scanned onto the SystmOne record.

If a new episode of care is commenced or a change of treatment is indicated, the patient's informed consent must be obtained.

Completing consent forms

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

If the patient signs the form in advance of the procedure, a health professional involved in their care on the day must sign the form to confirm that 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 to provide the second signature, as long as they have access to appropriate colleagues to answer questions, they cannot handle themselves.

The Director of Nursing and Quality Assurance has responsibility to ensure that health professionals employed by Spectrum are appropriately trained in the consent process as appropriate. Health professionals who do not themselves carry out a procedure but provide information must have the appropriate level of knowledge and have developed the necessary competence to seek consent.

8. Implementation and Dissemination

This policy will be ratified by the Quality Assurance and Patient Safety Committee following staff consultation and approval at the Quality Group. Staff have access to this policy on the Spectrum intranet.

9. Monitoring and Training

Spectrum must ensure that any health professional employed by them who is involved in the process of 'Joint Decision Making' – seeking/obtaining consent to examination or treatment from patients or clients has the appropriate experience and receives local training on this policy.

Following initial training it is the responsibility of each staff member to ensure that they remain competent in the seeking/obtaining consent to examination or treatment and as such undertake relevant training as identified through joint development review and personal development planning.

The Director of Nursing and Quality Assurance must undertake an annual audit of the implementation and compliance with the Policy for Consent to Examination or Treatment.

10. Legal Requirements/Regulations and Relevant Documentation

Legal and Regulatory

Health & Social Care Act 2008 (Regulated Activities) Regulations 2014
https://www.legislation.gov.uk/uksi/2010/781/contents/made

CQC Regulation 11 Consent
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-11-need-consent

CQC Schedule of Offences (can be prosecuted directly for not following the legal requirements for obtaining consent)

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/offences

Professional

GMC Consent Patient and Doctors Making Decisions together

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent

Guidance on Consent General Pharmaceutical Council 2018

https://www.pharmacyregulation.org/sites/default/files/document/in_practice_guidance_on_consent_june_2018.pdf

Nursing & Midwifery Council (2015) Code of Professional Conduct, Nursing & Midwifery Council

https://www.nmc.org.uk/standards/code/

Children

NSPCC Gillick competency and Fraser guidelines
https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines

0-18 year's guidance for doctors

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years

CQC brief guide to capacity in under 18s including Gillick competence 2019

https://www.cqc.org.uk/sites/default/files/Brief_guide_Capacity_and_consent_in_under_18s%20v3.pdf

Mental Capacity (Amendment) Act 2019

https://www.legislation.gov.uk/ukpga/2019/18/contens

Mental Capacity Act Code of Practice

https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

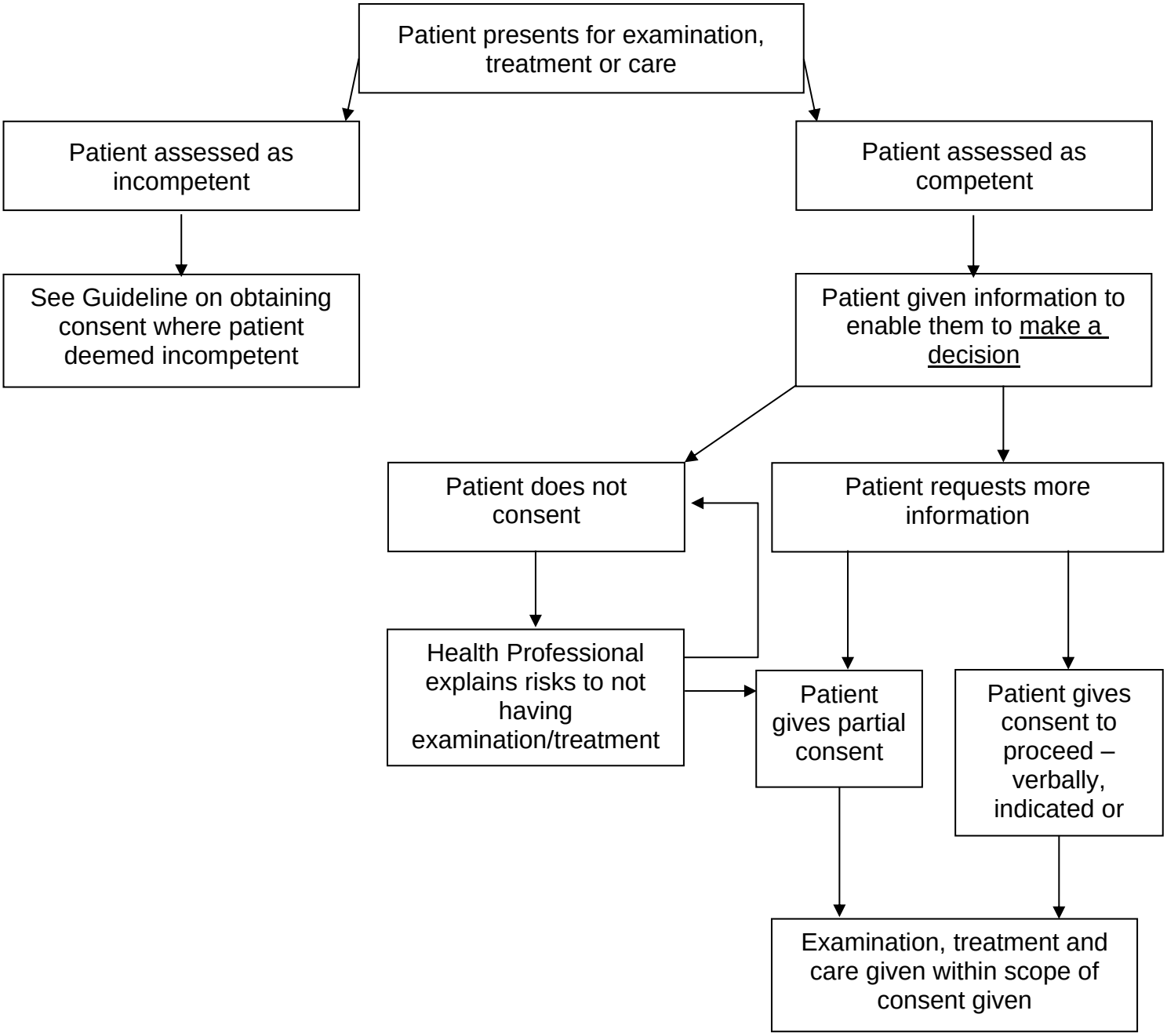
Prison

Seeking consent-working in prison
https://bulger.co.uk/prison/seekingconsentinprison.pdf

Other

Reference Guide Consent for Examination or Treatment (2009)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf

Appendix A – Obtaining Informed Consent



Appendix B – Consent Forms

The following consent forms are currently in use

Form 1	Patient agreement to treatment or investigation
Form 2	Patient/parental agreements to investigation or treatment (Procedures where consciousness not impaired)
Form 3	Form for adults who are unable to consent to investigation or treatment

Spectrum Community Health CIC Consent form 1

Patient agreement to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name..……..……..…….

Patient's first names..……..……

Date of birth …….

Responsible health professional..……..……

Job title …….

NHS number (or another identifier) ……...

Male Female

Special requirements ……..……
(e.g. other language/other communication method)

To be retained in patient's notes

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

……

……

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits

……

……

Serious or frequently occurring risks

……

…..……..

Any extra procedures which may become necessary during the procedure

Blood transfusion……

other procedure (please specify)

……

……

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided…….

This procedure will involve:

general and/or regional anesthesia / local anesthesia sedation

Signed……Date ……..…..

Name (PRINT) ……..... Job title ……
Contact details (if patient wishes to discuss options later)

…..…….

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed …….…… Date…….……

Name (PRINT)…….

Top copy accepted by patient: yes/no (please ring)

Statement of patient
Patient identifier/label

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask– we are here to help you. You have the right to change your mind at any time, including after you have signed this form to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anesthesia with an anesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

…….

Patient's signature ……. Date…….

Name (PRINT)…….……

A witness must sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature ……Date…….…..

Name (PRINT)…….……

Confirmation of consent (to be completed by a health professional when the patient is

admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that he/she has no further questions and wishes the procedure to go ahead.

Signed……Date ……...…….

Name (PRINT) ……. ……Job title ……...…….

Important notes: (tick if applicable)

See also advance directive/living will (e.g. Jehovah's Witness form) Patient has withdrawn consent (ask patient to sign /date here)

……..……

Guidance to health professionals
(To be read in conjunction with consent policy)

What a consent form is for:

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form acts as an *aide-memoire* to health professionals and patients, by providing a check list of the kind of information patients must be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

Please use in conjunction with the Spectrum Policy for Consent to Examination or Treatment 2017

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you must use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- They are unable to comprehend and retain information material to the decision and/or
- They are unable to weigh and use this information in coming to a decision.

You must take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients must be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition, if patients make it clear that they have particular concerns about certain kinds of risk, you must make sure they are informed about these risks, even if they are very small or rare. You must always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options but want you to decide on their behalf. In such circumstances, you must do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you must document this on page 2 of the form or in the patient's notes.

Consent Form 2 – Patient / parental agreement to investigation or treatment which does not require a general anesthetic (procedures where consciousness is not impaired)

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names.....

Date of birth .....

Age .....

Responsible health professional.....

Job title .....

NHS number (or another identifier) .....

Male F e m a l e

Special requirements.....
(e.g. Other language/other communication method)

To be retained in patient's notes
Name of procedure (include brief explanation if medical term not clear)

.....
.....

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient/parent. In particular, I have explained: the intended benefits
……..

……..

Serious or frequently occurring risks:
……..……..……

……..

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

The following leaflet/ tape has been provided …….

Signed.…… Date ……..……

Name (PRINT) ……..… Job title ……..……

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

Signed.…… Date ……..……

Name (PRINT) ……. ……..

Statement of patient/person with parental responsibility for patient:

- **I agree** to the procedure described above.
- **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- **I understand** that the procedure will/will not involve local anesthesia.

Signature …… Date ……..…. …..

Name (PRINT) ……..……

Relationship to patient ……..……

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance).

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signed…… Date ……...……

Name (PRINT) ……. ……. Job title ……

Guidance to health professionals (to be read in conjunction with consent policy)

This form documents the patient's agreement (or that of a person with parental responsibility for the patient) to go ahead with the investigation or treatment you have proposed**. It is only designed for procedures where the patient is expected to remain alert throughout and where an anesthetist is not involved in their care: for example: for drug therapy where written consent is deemed appropriate.** In other circumstances you must either use form 1 (for adults/competent children) or form 2 (parental consent for children/young people) as appropriate.

Consent forms are not legal waivers – if patients, for example; do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients also have every right to change their mind after signing the form.

Who can give consent?

Everyone aged 16 or over is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, if they wish. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf. Even where a child is able to give consent for himself or herself, you must always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you must complete this form as usual, and ask an independent witness to confirm that the patient has given consent verbally or non-verbally.

When NOT to use this form (see also 'This form' above)

If the patient is 18 or over and is not legally competent to give consent, you must use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- they are unable to comprehend and retain information material to the decision and/or
- They are unable to weigh and use this information in coming to a decision. You must always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds about treatment. The courts have stated that patients must be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition, if patients make clear that they have particular concerns about certain kinds of risk, you must make sure they are informed about these risks, even if they are very small or rare. You must always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options but want you to decide on their behalf. In such circumstances, you must do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you must document this overleaf or in the patient's notes

Spectrum Community Health CIC

Consent Form 3 – Form for adults who are unable to consent to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names..... Date of birth.....

Responsible health professional.....

Job title .....

NHS number (or another identifier) .....

Male Female

Special requirements .....
(e.g. other language/other communication method)

To be retained in patient's notes

Patient identifier/label

All sections to be completed by health professional proposing the procedure

A. Details of procedure or course of treatment proposed

……

……

……

……

(NB see guidance to health professionals overleaf for details of situations where court approval must first be sought)

B. Assessment of patient's capacity

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because:

- **the patient is unable to comprehend and retain information material to the decision; and/or**
- **the patient is unable to use and weigh this information in the decision-making process; or**
- **the patient is unconscious**

Further details (excluding where patient unconscious): for example; how above judgements reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful.

……

……

……

……

C. Assessment of patient's best interests

To the best of my knowledge, the patient has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the procedure to be in the patient's best interests because:

……

……

……

(Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)

The treatment cannot wait until the patient recovers capacity because:

……

……

……

D. Involvement of the patient's family and others close to the patient

The final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (e.g. spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical interests" and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

(to be signed by a person or persons close to the patient, if they wish)

I/We have been involved in a discussion with the relevant health professionals over the treatment of …… (Patient's name). I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form. I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision) …….

……..

……

Name ……

Relationship to patient……...

Address (if not the same as patient). ……..……

……..

……..

Signature …… Date…….……

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?)
Yes No

Details **……**

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature…… Date ……

Name (PRINT) ……... Job title …….

Where second opinion sought, s/he must sign below to confirm agreement:

Signature ..... Date ..... Name

(PRINT) ……... Job title ……

Guidance to health professionals (to be read in conjunction with consent policy)

This form must only be used where it would be usual to seek written consent but an adult patient (18 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you must use the standard consent form and respect any refusal.

Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you must document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the *Mental Health Act 1983*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or 'living will'), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health's *Reference guide to consent for examination or treatment*.

When treatment can be given to a patient who is unable to consent

For treatment to be given to a patient who is unable to consent, the following **Must** apply:

- the patient must lack the capacity ('competence') to give or withhold consent to this procedure AND the procedure must be in the patient's best interests.

Capacity

A patient will lack capacity to consent to a particular intervention if he or she is:

- Unable to comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question; and/or

- Unable to use and weigh this information in the decision-making process. Before making a judgement that a patient lacks capacity you must take all steps reasonable in the circumstances to assist the patient in making their own decisions (this will clearly not apply if the patient is unconscious). This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates or supporters

Capacity is ‘decision-specific’: a patient may lack capacity to make a particular complex decision but be quite able to take other more straight-forward decisions or parts of decisions.

Best interests

A patient’s best interests are not limited to their best medical interests. Other factors which form part of the best interest’s decision include: the wishes and beliefs of the patient when competent;

- their current wishes
- their general well-being
- their spiritual and religious welfare

Two incapacitated patients, whose physical condition is identical, may therefore, have different best interests.

Unless the patient has clearly indicated that particular individuals are not to be involved in their care, or unless the urgency of their situation prevents it, you must attempt to involve people close to the patient (spouse/partner, family and friends, carer, supporter or advocate) in the decision-making process. Those close to the patient cannot require you to provide particular treatment which you do not believe to be clinically appropriate. However, they will know the patient much better than you do, and therefore are likely to be able to provide valuable information about the patient’s wishes and values.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion must be sought, unless the urgency of the patient’s condition prevents this. Donation of regenerative tissue such as bone marrow, sterilisation for contraceptive purposes and withdrawal of artificial nutrition or hydration from a patient in Persistent Vegetative State must never be undertaken without prior High Court approval. High Court approval can also be sought where there are doubts about the patient’s capacity or best interest.