

Consent Policy
Clinical Governance, Corporate

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1.0 Introduction

The aims of the policy are to ensure that:

- Processes are robust and fit for their intended purpose.
- Processes are clear and properly understood by staff.

The aims will be achieved through meeting the following core objectives:

- Ensuring Board level commitment to, and leadership of consent processes.
- Ensure robust processes are in place for obtaining and recording consent.
- Providing realistic resources to implement and support the policy and procedures.
- Development of clinical effectiveness and governance frameworks to demonstrate application of agreed processes.

2.0 Objective

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare. Seeking consent is also a matter of common courtesy between health professionals and patients. This document outlines the Trust's systematic approach to ensure that staff comply with best practice and are aware of their legal responsibilities to patients.

This policy and supporting procedures will help to ensure that the:

- Patients are assessed as being competent to consent to treatment.
- Patients have received sufficient information to give informed consent.
- Patients do not consent under duress.
- Staff taking consent are competent to do so.

3.0 Scope of Policy

This section should describe who needs to be aware of the document and implement the procedures described within the document.

4.0 Policy

The guidance processes to meet the policy's objectives can be sought in Appendix 1.

5.0 Roles and Responsibilities

- 5.1 Overall responsibility for the management of risk lies with the Chief Executive as Accountable Officer.
- 5.2 All Trust Directors are responsible, collectively, for the Trust's systems of internal control and management. The Board is responsible for adherence to the Care Quality Commission (CQC) Essential Standards for Quality and Safety and it needs to be satisfied that appropriate policies and procedures are in place and that systems are functioning effectively. The Board of Directors has delegated its accountability arrangements for consent processes to the Medical Director.

The responsibility for the management of consent necessarily involves the whole management chain of command, and all members of staff have a responsibility to ensure the effective implementation of the policy and procedures.

Within that system there are certain key officers whose specific functions are outlined below:

5.3 Medical Director

- Ensure that policy and procedures are agreed through consultation with relevant staff groups.
- Ensure that the overarching policy is updated regularly in line with national guidance and audit reports.
- Keep the Chief Executive and Board of Directors up to date with progress and highlight any areas of concern.

5.4 Clinical Directors/Deputy Chief Operating Officers/Heads of Departments

- Ensure that staff are aware of, understand and follow the policy and supporting procedures.
- Ensure that staff have access to appropriate training and assessment of competence.
- Ensure that patient information relevant to treatment and care provided within the Clinical Service Unit/Specialties/Departments is available to aid patients in their decision making regarding consent to treatment.
- Responsible for identifying the consultant and senior nursing staff who will provide procedure specific delegated consent training and assessment within the relevant speciality.
- Ensure that adequate resources are available within the work area to follow correct procedures.
- Ensure that regular audit of agreed processes and procedures takes place to monitor the effectiveness of practice and that remedial action is implemented where required.

5.5 Head of Quality & Governance

- Ensure that the policies and forms for consent are kept up to date with changing legislature.
- Ensure the continued availability of general consent training.
- Ensure that the organisation provides training updates to specialty leads when national guidance regarding consent is significantly changed.

5.6 Director of Post Graduate Medical Education

- Ensure that consent issues are included as part of junior doctors induction programmes.
- Ensure that on-going training takes place as part of the post graduate medical education curriculum.

5.7 Specialty Leads

- Responsible for identifying the procedures suitable for delegated consent.
- Responsible for developing or approving the procedure specific consent training for staff required to seek delegated consent within their speciality.

5.8 Consultants / Senior Nursing Staff

- Ensure that their junior staff are appropriately trained in general and procedure specific consent, before they are asked to seek consent from patients, and that this will only be for procedures approved for delegated consent.

5.9 Human Tissue Act (HTA) Designated Individual

- Responsible for providing training in consent for post mortems and for maintaining appropriate training records.

5.10 Staff Eligible to Obtain Consent

- Access appropriate training and information
- Work within agreed procedures and guidance
- Assist where required with audit processes

5.11 Staff Not Eligible to Obtain Consent

The taking of consent will be monitored through annual audit. Staff found to have obtained consent, that are not eligible to do so, will be followed up by the appropriate Clinical Director.

6.0 Associated documentation and references

- HSC2001/023 Good practice in consent implementation guide (2001) Reference Guide to Consent for Examination or Treatment 2nd Edition (2009) DOH
- Seeking consent: working with children DOH (2001) Mental Capacity Act (2005)
- Mental Capacity Act Code of Practice, Practice Guidance Version 1 (2007) Human Tissue Authority: Code of Practice – Consent (2006)
- Vulnerable Adults Policy (2008)
- 12 Points on Consent: The law in England DOH (2001) The Mental Health Act (1983)
- The Human fertilisation and Embryology Act (1990)
- Consent for Anaesthesia. Association of Anaesthetists of Great Britain and Ireland (2006)

7.0 Training & Resources

Knowledge and Skills

Clinical staff are expected to have an appropriate level of knowledge, skills and experience derived from their qualifications, professional training and experience to conduct informed consent with a patient, and in accordance with the law and policies and procedures available nationally and locally.

There is also a duty on clinical staff to maintain their professional standards and to participate in continuous professional development.

Training

The role of the Learning & Development Department in liaison with Clinical Service Units is to identify training needs via competency assessments and staff appraisal procedures and ensure relevant training programmes are established. The main learning and development programmes in place for consent are:

- Junior Medical Staff Local Induction
- Mental Capacity Act awareness training
- Generic Principles of Consent
- Procedure Specific Elements of Consent

Process for Obtaining and Recording Consent

The Trust has adopted the Department of Health’s Good Practice in consent document and has adapted the model policy and appendices for use locally. This document is attached at Appendix 1 and outlines in detail the Trust’s approach to obtaining and documenting consent.

The underlying principle within the Trust is that consent will be obtained by staff capable and competent to perform the procedure. In exceptional circumstances where there is a need to delegate the taking of consent to another member of the clinical team, strict systems and processes must be adhered to. In these circumstances and where the taking of consent is delegated to another health professional that is not capable and competent to perform the procedure, reference must be made to the Trusts Consent Training Policy.

8.0 Monitoring and Audit

Training figures will be monitored as specified in the Training Needs Analysis Policy.

Evidence of post-mortem consent training will be required from the HTA designated individual.

There are regular audits of the consent process, undertaken by Quality Assurance and Effectiveness team. These monitor compliance with the documentation of the consent process and compliance with the Consent Policy. The audits aim to confirm that consent is only taken by staff authorised to do so.

The Table below helps to focus the author on the monitoring requirements and must be used for all Policies. The table must be complete for all the minimum requirements of the relevant criteria within the Standards Manual. Assistance can be obtained from the Governance Lead.

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group/ committee for monitoring of action plan and Implementation
Compliance to consent to treatment	Audit	CEG	As required	CEG	Medical Director	CEG

9.0 Equality and Diversity

This section is mandatory and must include the statement below

Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy and procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

This section is mandatory and must include the statement below

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

**BARNSLEY HOSPITAL
NHS FOUNDATION TRUST**

**Good practice in consent to examination or
treatment
November 2013**

Good Practice in Consent To Examination or Treatment

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Guideline for consent to examination or treatment

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1. Introduction

1.1 Why consent is crucial

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients.

The underlying principle within the Trust is that consent will be obtained by staff having had the appropriate training and Knowledge that makes them capable and competent to perform the procedure.

1.2 This guideline

The Department of Health has issued a range of guidance documents on consent (see overleaf), and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures for Barnsley Hospital NHS Foundation Trust [the Trust] which aims to ensure that health professionals are able to comply with the guidance. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

1.3 What consent is – and isn't

1.3.1 ---- "Consent" - General principle is that no medical treatment can be given without Consent of the patient. There must be a proposal to treat, communication of that proposal, understanding of what is proposed and agreement (consent) to this proposal by the patient possessing the relevant mental capacity.

In the light of recent a court case (Montgomery v Lanarkshire Health Board) the requirements of a valid consent go beyond previously accepted practice

The law now requires a doctor to take “reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.”

So doctors must now ask themselves three questions:

- Does the patient know about the material risks of the treatment I am proposing?
- Does the patient know about reasonable alternatives to this treatment?
- Have I taken reasonable care to ensure that the patient actually knows this?

Only when the doctor has satisfied his/herself that the above questions has been satisfactorily answered can the consent be deemed "Fully Informed"

For the consent to be valid, the patient consenting must have the relevant mental capacity to do so :

- be able to receive and retain treatment information
- to believe it
- to weigh the information in order to reach a decision
- to communicate his/her decision.

Consent is not valid if it is obtained:

- by Fraud
- by Duress
- by patient lacking mental capacity.

It is the duty of the person taking the consent to be satisfied that none of these factors apply.

Withdrawal of Consent ---- Consent can be withdrawn at any time by a patient possessing mental capacity. Withdrawal of consent must be communicated to those staff providing treatment. If consent is withdrawn after the treatment has started, then the medical staff must

stop but cannot be required to leave the patient in an unacceptable state.

- 1.3.2 The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.
- 1.3.3 Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, **no-one else can give consent on their behalf**. However, treatment may be given if it is considered to be in the patient's best interests and is necessary in relation to the preservation or improvement of health. (Re F (mental patient sterilisation) 1990) 2 AC 1. It is important to check if there is an advance directive in place. Should there be an advance directive then for it to be effective the staff treating the patient must be aware of its existence and all efforts made to establish whether the patient has left any such directive. Ignorance is no defence and it is up to the TRUST to have in place systems that minimise the chance of an advance statement being missed. Advance directive is of indefinite duration and patients making these should be advised of the need to review them regularly along with their medical advisor especially with emergence of new forms of treatments. For further details on advance directives see the Department of Health's *Reference guide to consent for examination or treatment* (chapter 1, paragraph 19 supplement to this policy). For a person to have capacity they must be able to:
- Comprehend and retain information material to the decision, especially as to the consequence of having or not having the intervention and;
 - Must be able to use and weigh this information in the decision making process
- 1.3.4 Any patient who triggers abnormalities on AMT or who has a history of significant, mental illness, learning difficulties or previously impaired capacity should undergo documented formal Mental Capacity Assessment prior to consent to demonstrate, as far as possible, that the patient has appropriate capacity
- 1.3.5 The Mental Capacity Act also provides for additional rights to the patient and their relatives and additional criteria that may be applied in circumstances where the mental capacity of the patient is in question.

The Trust provides further guidance and training on the Mental Capacity Act as a separate document.

- 1.3.6 The Trust's Mental Capacity Act 2005 policy (see Policy Warehouse, under "C") sets out in section 4, guidance regarding staff responsibilities for: (a) the assessment of a patient's mental capacity to decide a particular decision; (b) who is responsible for undertaking assessments of mental capacity under the Act; (c) how assessments under the Act need to be recorded with reference to the 'diagnostic threshold' and the 'functional test'; (d) how to determine and record a 'best interests decision' regarding a patient who lacks the mental capacity to decide; (e) when to refer to the Independent Mental Capacity Advocacy (IMCA) service; and (f) when to refer to formal Safeguarding Adults processes. The policy also makes clear as to which decisions can be made under the provisions of the Act and which decisions are excluded. The policy also gives guidance on Mental Capacity Act compliant record keeping and how staff can be protected from liability for acts performed under the Act, the use of restraint, advance decision making, the decision making authority of attorneys and deputies, and the resolution of disputes through the Court of Protection. The policy includes a summary of Deprivation of Liberty Safeguards scheme though for a comprehensive guide to the scheme, please refer to the Trust's Deprivation of Liberty Safeguards policy.
- 1.3.7 If an individual is illiterate, the individual may be able to make their mark on the form to indicate consent. It is good practice for the mark to be witnessed by a person other than the clinician/practitioner seeking consent, and for the fact that the individual has chosen to make their

mark in this way to be recorded in the medical case notes. Similarly, if the individual has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes, or on the consent form.

1.4 Guidance on consent

- 1.4.1 The Department of Health has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies.
- 1.4.2 *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. Paper copies are available direct from the Risk Manager on extension 2209, or the individual ward or department's policy folders, and may also be accessed on the internet at www.doh.gov.uk/consent.
- 1.4.3 *12 key points on consent: the law in England* has been distributed widely to health professionals 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 A. Further copies are available from www.doh.gov.uk/consent.
- 1.4.4 *DoH Guidance on seeking consent 2009*: Available on the hospital intranet site under Risk Management
- 1.4.5 Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available from the Trust's intranet, the Risk Manager on extension 2209, and on the internet at www.doh.gov.uk/consent.

2. Documentation

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

2.2 Written consent

2.2.1 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.

2.2.2 It is rarely a legal requirement to seek written consent¹ but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant 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')
- 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

2.2.3 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 health professional.

2.2.4 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.

2.2.5 All professionals taking consent should formally offer the patient the white copy of

the consent form. The patient acceptance or non acceptance of their copy should be recorded on the front page of the consent form, by circling the appropriate response This is consistent with the GMC Guidance

¹ The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances.

2.3 Providing patients with Information to support their decision making

2.3.1 Patients should be provided with information, either written or verbal, to support their decision making.

2.3.2 The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensive information about their condition and about all possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing and any reasonable alternative or variant treatments). 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.

2.3.3 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 health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the *presumption* must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

2.3.4 Where information is provided to a patient regarding their procedure, either verbally or in the form of an information leaflet (or other format) it must be documented on the patient consent form in the relevant sections for benefits/risks and confirming where verbal or written information has been provided.

2.4 Provision for patients whose first language is not English

2.4.1 Barnsley Hospital NHS Foundation Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff.

2.4.2 It is not appropriate to use children or other family members to interpret for people who do not speak English, however it is recognised that this may be the only option available.

2.4.3 There will be emergencies, or urgent cases where clinicians' will be required to act in the patients best interest.

2.4.4 Staff should use 'The Big Word' which is a telephone interpreting service that is accessed directly by the Ward or Department on 0800 862 0653; each area has the procedure for using this service. If a face to face interpreter is required this is accessed via the PALS office ext. 2430 during office hours and the 219 duty manager out of

hours. (See procedure for Patient Interpreting Services on the Hospital Intranet Website under useful documents). For patients who require a signing

interpreter, contact PALS. 48 hours notice is required to arrange this service

2.5 Access to more detailed or specialist information

2.5.1 Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. This Trust has made the following arrangements to assist patients to obtain such information:

- PALS Manager may facilitate additional information, assist with requirements for patients with special needs, or arrange clinical appointments
- Individual clinicians may provide 'agreed' information via the internet

2.6 Procedures to follow when patients lack capacity to give or withhold consent

2.6.1 Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in form 4 (form for Adults who are unable to Consent to Investigation or Treatment), along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient. The standard consent forms should never be used for adult patients unable to consent for themselves. For more minor interventions, this information should be entered in the patient's notes.

2.6.2 An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. You should involve appropriate colleagues in making 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.

2.6.3 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, a court declaration may be sought. See Appendix D for details of how to do this.

2.7 Availability of forms

2.7.1 Standard consent forms are supplied to all wards, and are available from Supplies (ext. 2029) on a standard stock requisition form. There are four versions of the standard consent form:

- **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. (The use of form 3 is optional but may be thought more

appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary)

- **form 4** for adults who are unable to consent for themselves

2.8 Medical Student and observers

2.8.8 There is a variety of students within the Trust who may, as apart of their knowledge and skills development, attend patient consultations to observe. This situation requires the consent of the patient in the normal way and to ensure their privacy, dignity and confidentiality. This consent should not be assumed and it is best practice for the clinician leading the consultation to verify consent.

3. When should consent be sought?

3.1 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.

3.2 Single stage process

3.2.1 In many cases, it will be appropriate for a health professional 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 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.

3.2.2 If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals 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 that the patient understands and consents, the health professional may then proceed. Patients should be given written information leaflets regarding their procedure that should include possible risks or complications.

3.2.3 Day case surgery may occur in circumstances where consent is formally recorded on the day of surgery. This is acceptable provided the consent does not take place 'at the door' of the operating room and the patient has received information in advance (e.g. by letter) and has had time for reflection. Processes are in place to identify higher risk patients and such patients are redirected through the pre-assessment process. The risk of inappropriate same day consent is minimised through this process.

3.3 Two or more stage process

3.3.1 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 (either within primary care or in a hospital out-patient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that 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.

3.3.2 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. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, however, 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?" Whilst a time scale is not specified, in practice, consent of over 12 months standing should be considered invalid. The Trust considers a period of 3 months to be a reasonable working standard for most elective procedures.

- 3.3.3 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.

3.4 Seeking consent for anaesthesia

- 3.4.1 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. 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 should ensure that the discussion with the patient and their consent is documented in the anaesthetic record (blue form), pre-operative assessment form or in the patient's notes if a more detailed record is required 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 he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.
- 3.4.2 Information about anaesthesia, preferably in the form of a patient leaflet, should be provided to patients undergoing elective surgery. Anaesthetists should record details of the elements of a discussion in the patient's records, or anaesthetic record, noting what risks, benefits and alternatives were explained. A separate formal consent form signed by the patient is not required for anaesthetic

procedures that are done to facilitate another treatment or as part as an inter-related process.

3.5 Information and the Process of Consent

3.5.1 The anaesthetist caring for the patient must take responsibility for the adequacy of information provided for each patient. The process of consent should begin when the anaesthetist and the patient meet. Where appropriate, patients should be provided with a patient friendly information leaflet around the time he/she is booked in, or pre-assessed for surgery. The anaesthetic room is not a suitable time or place to provide patients with new information other than in exceptional circumstances.

3.5.2 Anaesthetists should tell the patient:

- What procedures they intend to do, and why they intend to do them
- What the significant risks of these procedures are and what the significant foreseeable consequences of these risks might be.

3.5.3 All patients should be given the opportunity to ask questions and honest answers should be provided.

3.6 Documentation

3.6.1 A formal signed consent form is not necessary for anaesthesia and anaesthesia-related procedures. In many cases, verbal consent for anaesthesia is acceptable. However, for significant planned procedures (invasive) or which carry significant risks, it is essential to document clearly about the discussion and the patient's agreement. Sometimes the anaesthetic procedure is the primary therapeutic intervention. e.g. (epidural blood patch) in these circumstances, the procedure should be explained and documented.

3.6.2 Documentation is particularly important in circumstances when the patient's decision goes against the anaesthetist's advice.

3.7 Critical Care

3.7.1 Patients in the ICU should not be considered to lack the competence to decide about their medical treatment, merely because they are gravely ill, are receiving sedative drugs or lack of ability to communicate orally. These patients should be allowed to indicate their consent, and wherever possible, written documentation of consent discussions should be recorded. Clear documentation should be made if adequate capacity could not be achieved despite best efforts. Doctors may treat patients in their best interests if patients are unconscious or have fluctuating levels of consciousness. Discussion about best interest should involve other health professionals, and be informed by the patient's relatives or next of kin.

3.7.2 Further detailed information is available from the association of anaesthetists at www.aagbi.org

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

3.8 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 notes 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 they can be given, but should not affect its quality.

3.9 Treatment of young children

3.9.1 When babies or young children are being cared for in hospital, it will not usually seem practicable to seek their parents' consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you should remember that, in law, such consent is required. Where a child is admitted, you should discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

3.9.2 Only people with 'parental responsibility' are entitled to give consent on behalf of their children. **You 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). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

3.9.3 Additional summary guidance is available at Appendix E to this document, and the Department of Health Seeking Consent: working with children is available on the Trust intranet of the DoH.

4. Provision of information

4.1 The provision of information is central to the consent process. Before patients can come to an informed decision about treatment, they need clear information about their condition, 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.

4.2 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 health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the *presumption* must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

4.3 The following general sources of patient information are available in this Trust:

- Patient information leaflets are available at various locations for specified operations
- Patient Advice & Liaison Service (PALS)

4.4 Where information is provided to a patient regarding their procedure, either verbally or in the form of an information leaflet (or other format) it must be properly documented on the patient consent form in the relevant sections for benefits/risks and confirming where a leaflet/tape has been provided.

4.5 Provision for patients whose first language is not English

4.5.1 Barnsley Hospital NHS Foundation Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff.

4.5.2 It is not appropriate to use children or other family members to interpret for people who do not speak English, however it is recognised that this may be the only option available.

4.5.3 There will be emergencies, or urgent cases where clinicians' will be required to act in the patients best interest.

4.6 Staff should use 'The Big Word' which is a telephone interpreting service that is accessed directly by the Ward or Department on 0800 862 0653; each area has the procedure for using this service. If a face to face interpreter is required this is accessed via the PALS office ext 2430 during office hours and the 219 duty manager out of hours. (See procedure for Patient Interpreting Services on the Hospital Intranet Website under useful documents). For patients who require a

signing interpreter, contact PALS. 48 hours notice is required to arrange this service

4.7 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. This Trust has made the following arrangements to assist patients to obtain such information:

- The PALS team may facilitate additional information, assist with requirements for patients with special needs, or arrange clinical appointments
- Individual clinicians may provide 'agreed' information via the internet
- NHS Evidence

4.8 Access to health professionals between formal appointments

After an appointment with a health professional in out-patients, 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).

- Appointments or ward attendances can be made with Medical Staff via their secretary in special circumstances such as complex operations
- Matrons or Lead Nurses may offer advice by telephone

4.9 Open access clinics

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

4.9.2 It is good practice to check what information the patient has been given by their GP or primary care worker and discuss the procedure further if required.

4.9.3 Services where this will apply include, Open Access Endoscopy, Medical Imaging, Children's Services, Antenatal Day Unit and Audiology. Careful review of patients with an open appointment facility is also advised.

5. Who is responsible for seeking consent?

- 5.1 The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.
- 5.2 Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the health professional responsible. Where written consent is being sought it must be obtained by a person who is competent and capable to undertake the procedure. In exceptional circumstances where there is a need to delegate the taking of consent to another member of the clinical team, strict systems and processes must be adhered to. In these circumstances and where the taking of consent is delegated to another health professional that is not capable and competent to perform the procedure, reference must be made to the Trusts Consent Training Policy ([insert hyperlink of this policy](#)).

5.3 Completing consent forms

- 5.3.1 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 because they themselves can carry out the procedure, or they are fully capable of doing so.

6. Refusal of treatment

- 6.1 If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983*. The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults.
- 6.2 If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. 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.
- 6.3 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.
- 6.4 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 health professional 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 health professional.
- 6.5 Refusal to treatment may also occur during the procedure, for example under local anaesthetic. It is advisable to reassess the risks and benefits of stopping the procedure with the patient, and seek advice as necessary. However, the procedure must stop at the direction of the patient.

6.6 Advanced Decisions to Refuse Treatment

- 6.6.1 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 'advanced directive'). A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment. This is a well-established rule of common law, and the Mental Capacity Act 2005 now puts advance decisions on a statutory basis. The Act sets out the requirements that such a decision must meet to be valid and applicable.
- The person must be 18 or over
 - The person must have the capacity to make such a decision
 - The person must make clear which treatments they are refusing
 - If the advanced decision refuses life-sustaining treatment, it must be in writing (it can be written by someone else or recorded in the medical records), it must be signed and witnessed and it must state clearly that

the decision applies even if life is at risk

- A person with capacity can withdraw their advance decision at any time.

7. Tissue

7.1 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.

7.2 The Trust requires that patients are given the opportunity to refuse permission for tissue taken from them, during surgery or other procedure, to be used for education or research purposes. The Trust requires that a discussion is held with the patient at the time of consent and documented on the consent form under the section which list the procedures which the patients does not wish to be carried out without further discussion.

7.3 Such an objection must then be recorded on a patient alert form and notified to the Pathology Department appropriately. Patients must also be able to record any objections to particular uses or use of particular tissues.

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

7.5 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.

7.6 The patient must be informed of the use of tissue for this purpose, and if they object, this must be recorded on the consent form, and alert form and notified to the histopathology accordingly.

7.7 Consent is needed for storage and use of tissue for obtaining scientific or medical information which may be relevant to any other person, now or in the future; research in connection with disorders or the functioning of the human body; public display, and transplantation.

7.8 The Human Tissue Authority has issued 6 Codes of Practice effective from September 2006:

- Code of Practice 1 Consent
- Code of Practice 2 Donation of Organs, tissue and cells for transplantation
- Code of Practice 3 Post mortem examinations
- Code of Practice 4 Anatomical examinations
- Code of Practice 5 Removal, storage and disposal of human organs and tissue
- Code of Practice 6 Donation of allogenic bone marrow and peripheral blood stem cells for transplantation

7.9 It is the policy of the Trust to adopt the best practice recommended by the Human Tissue Authority where it applies.

7.10 From 1st September 2006 the Trust has adopted the Sheffield Children's NHS Foundation Trust Consent to a hospital post mortem examination on a baby or child (VERSION 1 28/08/2006 HPOST 1) and the associated booklet "A guide to a hospital post mortem procedure on a baby or child".

8. Clinical photography and conventional or digital video recordings

- 8.1 Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.
- 8.2 Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. The one exception to this principle is set out in paragraph 3 below. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.
- 8.3 Photographic and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient, as long as this policy is well publicised. However, express consent must be sought for any form of publication.
- 8.4 If you wish to make a photographic or video recording of a patient specifically for education, publication or research purposes, you must first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it. Patients must know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.
- 8.5 The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.
- 8.6 If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of some-one close to the patient. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or

use, any

such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

9. Training

- 9.1 A corporate curriculum has been developed for staff training requirements and is held on the trusts intranet site. Staff are expected to refer to the corporate curriculum to identify the training needs of relevant groups of staff with regard to generic consent training. Staff being trained to seek delegated consent must have completed general consent training within the previous 12 months.
- 9.2 Consent Awareness Training for Foundation 1 and 2 Junior Doctors is undertaken at hospital induction for the February & August Rotations.
- 9.3 Clinical and nursing staff may be trained to seek consent for the approved list of procedures in their specialty. Training must ensure these staff have sufficient understanding and knowledge of the process of consent and the procedure, in order to provide complete and accurate information, appropriate to the needs of the individual patient and are therefore competent to seek informed consent.

Appendix A

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 fetus.

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.

This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment*, below at Appendix F.

Appendix B

Current forms in use in this organisation

NATIONAL CONSENT FORMS

CONSENT FORM 1

Patient Agreement to Investigation or Treatment

CONSENT FORM 2

Parental Agreement to Investigation or treatment for a Child or Young Person

CONSENT FORM 3

Patient/parental agreement to investigation or treatment (procedures where consciousness not impaired)

CONSENT FORM 4

Form for adult who are unable to consent to investigation or treatment

All Consent Forms must comply with Circular HSC 2001/023 and the Good practice in consent implementation guide. Text included in the implementation guide should not be amended or removed. However it may be appropriate to customise the documentation to reflect local needs.

Where clinical services wish to develop a 'bespoke' consent form support must be obtained via the Quality and Safety Improvement and Effectiveness Board and/or NICE and Clinical Policy Guideline Group. Please discuss proposals with Chief Nurse or Medical Director appropriately.

Appendix C

Useful contact details:

Medical Director	4336
Director Nursing and Quality	4351
Head of Quality and Governance	2300
Risk Manager	2209
PALS Team	2430
Director of Research and Development (Ethics)	2389

Appendix D

How to seek a court declaration

In exceptional circumstances it may be necessary to seek a court order to carry out treatment; such as in circumstances where there is issue over the patient's capacity or discrepancy over treatment in the best interest. In such circumstances Legal Advice is necessary and should be obtained via:

- Medical Director (ext. 4336) or Risk Manager (ext. 2209) or the Duty Manager and On-Call Administrator out-of-hours.
- The Trust's Solicitors provide Legal Services out-of-hours and contacts are listed in the Duty File.

**BARNSELY HOSPITAL
NHS FOUNDATION TRUST**

**SEEKING CONSENT:
WORKING WITH CHILDREN**

JANUARY 2010, reviewed November 2013

Introduction

If your work involves healthcare of any kind for children, anything from helping a child get dressed to carrying out major surgery, you need to make sure you have consent to do what you propose to do.

The Trust follows national guidance and this document is based on the Department of Health documents:

- *Good practice in consent implementation guide: consent to examination and treatment;
- *Seeking consent: working with children; and
- National Service Framework for Children, young people and maternity services
- *Trust Policy on Consent to treatment (September 2011)

* Available on the hospital intranet under Risk Management

This guideline aims to provide a briefer guide to situations around children's consent issues that may arise. Each exceptional case needs to be considered on its own merit.

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

Useful contact details:

Clinical Director for Children's Services

228

0 Director Nursing & Quality4351

Nurse Advisor for Children and Young People Bleep 407

Safeguarding Nurse Specialist Bleep 217

Risk Manager 2209

PALS Team 2430

Children's NSF

The principle of the Children's NSF is to provide a framework for the delivery of Child-centred care. That is *'to deliver hospital services that meet the needs of children, young people and their parents, and provide effective safe care, through appropriately trained and skilled staff working in suitable child-friendly and safe environments'*.

One of the main principles is treating children, young people and parents as partners in care. Parent and carers are usually the experts in the child's care. A parent's or other carer's presence is recognised as a positive factor in aiding a child's recovery; and their practical contribution to care at the bedside is often essential.

Within this context it is important to recognise that children's legal status in respect of consent to treatment differs from that of adults; and also the legal status of the person with 'parental responsibility' has specific legal interpretation.

Can children give consent for themselves?

Before examining, treating or caring for a child, you must 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.

If children and young people are competent to give consent for themselves, you should seek consent directly from them. Once children have reached the age of 16 they are presumed in law to be competent to give consent for themselves for their own surgical, medical or dental treatment.

However, it is still good practice to encourage competent children to involve their families in decision making. Where a competent child does ask you to keep their confidence, you must do so (unless you can justify disclosure on the basis that the child is or may suffer significant harm).

Competency

For any patient to make a particular decision, and therefore for you to obtain valid consent they must be able to:

- Comprehend and retain information material to the decision, especially as to the consequence of having or not having the intervention, and
- Use and weigh this information in the decision-making process.

Treatment of young children

When babies, children or young people are being cared for in hospital, it will not usually seem practicable to seek their parents' consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you should remember that, in law, such consent is required. Where a child is admitted, you should therefore discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. You 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). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

This may be as simple as talking with the child and individuals present to substantiate the relationship, or alternatively further and better inquiries may be necessary.

People with parental responsibility

This will often, but not always, be the child's parent. Legally you only need consent from one person with parental responsibility, although clearly it is good practice to involve all those close to the child in the decision making process.

Exceptionally, parental responsibility can be complicated, and when that is the case it will be best to stop, check and take advice.

However, in general circumstances it is reasonable to request a verbal confirmation of the attending adult to establish their appropriate responsibility for the child and this should be documented.

Parental responsibility is defined as follows;

- The child's parents if married to each other at the time of conception or birth
- (Prior to 1/12/2003, the child's mother, but not father if they were not married unless the father has acquired parental responsibility via a court order or a parental responsibility agreement, or the couple subsequently marry)??
- Effective from 1 December 2003 the child's mother, and father provided the father's name appears on the birth certificate

In the following circumstances the approved documentation must be asked for and a copy kept in the records as necessary.

- The child's legally appointed guardian
- A person in whose favour a court has made a residence order
- A local authority designated in a care order in respect of the child

The following people do not automatically have parental responsibility:

- Foster parents, step-parents and grandparents

While only a person exercising parental responsibility can give valid consent, persons with parental responsibility can arrange for some or all of that responsibility to be met by others. Parents might, for example, give authority for someone who cares for a child on a regular basis, such as a grandparent or child-minder, to give consent under defined circumstances (for example in emergencies or for routine treatment for coughs and colds).

Where such explicit authority has been given, the consent of the person with the authority will be valid and you will not need to contact those with parental responsibility as well, unless you have reason to believe that the parent's view may differ.

The Children Act does not specify that such authority should be in writing, but clearly it is helpful for healthcare workers if it is.

In certain exceptional circumstances it is the responsibility of the treating clinician to assure themselves that reasonable steps have been taken to verify the delegation, for example by contacting the person with parental responsibility and confirm that the attending adult has been authorised to consent on their behalf. This may be by telephone, or other communication, and carefully documenting the outcome to any discussion or decision taken to proceed bearing in mind the potential risk and best interests of the child. The child themselves may also be able to assist in this process by confirming relationships, and raising or allaying any concerns.

The Children Act also allows a person who does not have parental responsibility for a child but who 'has care' of a child 'to do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. This might apply for example to child-minders or teachers, where explicit authority to consent on behalf of a child has not been given by the person with parental responsibility. However, it would rarely be 'reasonable' for those with care of a child to consent to treatment on the child's behalf if a parent could be contacted instead. In an emergency it would certainly be reasonable for a teacher or child-minder to take a child for appropriate medical care.

It is apparent that requirements in outpatients, day cases, inpatients or emergencies may vary, dependent on the circumstances, and to the degree of scrutiny required to validate an authority or to confirm the parental status. The aim should be to satisfy the law but also to be reasonable and considerate of the child and the family in trying to come to an acceptable accommodation.

It is therefore preferable to obtain valid consent from the natural parents wherever possible or reasonable to do so, but as always, each case has to be considered on its own merits and where professional judgement is required to ensure this is properly documented.

Medical Photography

Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

Special evidential arrangements are in place for child protection where there are allegations of non-accidental injury. Advice should be taken from the senior

paediatric doctor/Consultant and Safe guarding team to ensure proper procedures are followed.

Current forms in use in this organisation for Children

Consent Form 2

Parental Agreement to Investigation or treatment for a Child or Young Person

Information Leaflets

Consent – what you have a right to expect: a guide for children and young people (2001)

Consent – what you have a right to expect: a guide for parents (2001)

DEPARTMENT OF ANAESTHESIA

GUIDELINES FOR CONSENT FOR ANAESTHESIA

This guideline is based on consent for anaesthesia (revised addition 2006) from Association of Anaesthetists of Great Britain and Ireland.

Information about anaesthesia, preferably in the form of a patient leaflet, should be provided to patients undergoing elective surgery. Anaesthetists should record details of the elements of a discussion in the patient's records, or anaesthetic record, noting what risks, benefits and alternatives were explained. A separate formal consent form signed by the patient is not required for anaesthetic procedures that are done to facilitate another treatment or as part as an inter-related process.

Capacity, Incapacity and Voluntariness

Adults have the legal capacity to consent to a medical procedure if they are able to understand and remember the information given to them about the procedure, and to use that information in order to decide whether or not to undergo the treatment proposed. Incapacity may be predictable, (e.g. Alzheimer's disease), permanent (persistent vegetative state), or temporary (e.g. head injury, or during general anaesthesia). In the case of predictable incapacity, where their competence is likely to be lost through future illness, patients may choose to prepare an advance decision (advance directive) stating which treatment they will accept and refuse. It is good practice to consult with relatives; no one can consent to treatment on behalf of an incapable adult patient. Treatment of the incompetent adult is carried out without consent, and must be directed in the patient's 'best interest'. If a patient lacks capacity, practitioners must make a clear record of the grounds on which they have reached this decision and how this treatment will be in the patient's best interest.

Mental illness may impair patient's capacity to provide valid consent for treatment.

Voluntariness

For decision by the individual to be valid, it must have been taken voluntary, that is without coercion. It is good practice for the clinician to indicate whether they favour one therapeutic option over another.

Information and the Process of Consent

The anaesthetist caring for the patient must take responsibility for the adequacy of information provided for each patient. The process of consent should begin the anaesthetist and the patient meet. Where appropriate, patients should be provided with a patient friendly information leaflet around the time he/she is booked in, or pre-assessed for surgery. The anaesthetic room is not a suitable time or place to provide patients with new information other than in exceptional circumstances.

Anaesthetists should tell the patient:

- What procedures they intend to do, and why they intend to do them

- What the significant, risks of these procedures are, and what the significant, foreseeable consequences of these risks might be.

All patients should be given the opportunity to ask questions and honest answers should be provided.

Documentation

A formal signed consent form is not necessary for anaesthesia and anaesthesia-related procedures. In many cases, verbal consent for anaesthesia is acceptable. However, for significant planned procedures (invasive) or which carry significant risks. It is essential to document clearly about the discussion and the patient's agreement. Sometimes the anaesthetic procedure is the primary therapeutic intervention. E.g. (epidural blood patch) in these circumstances, the procedure should be explained and documented.

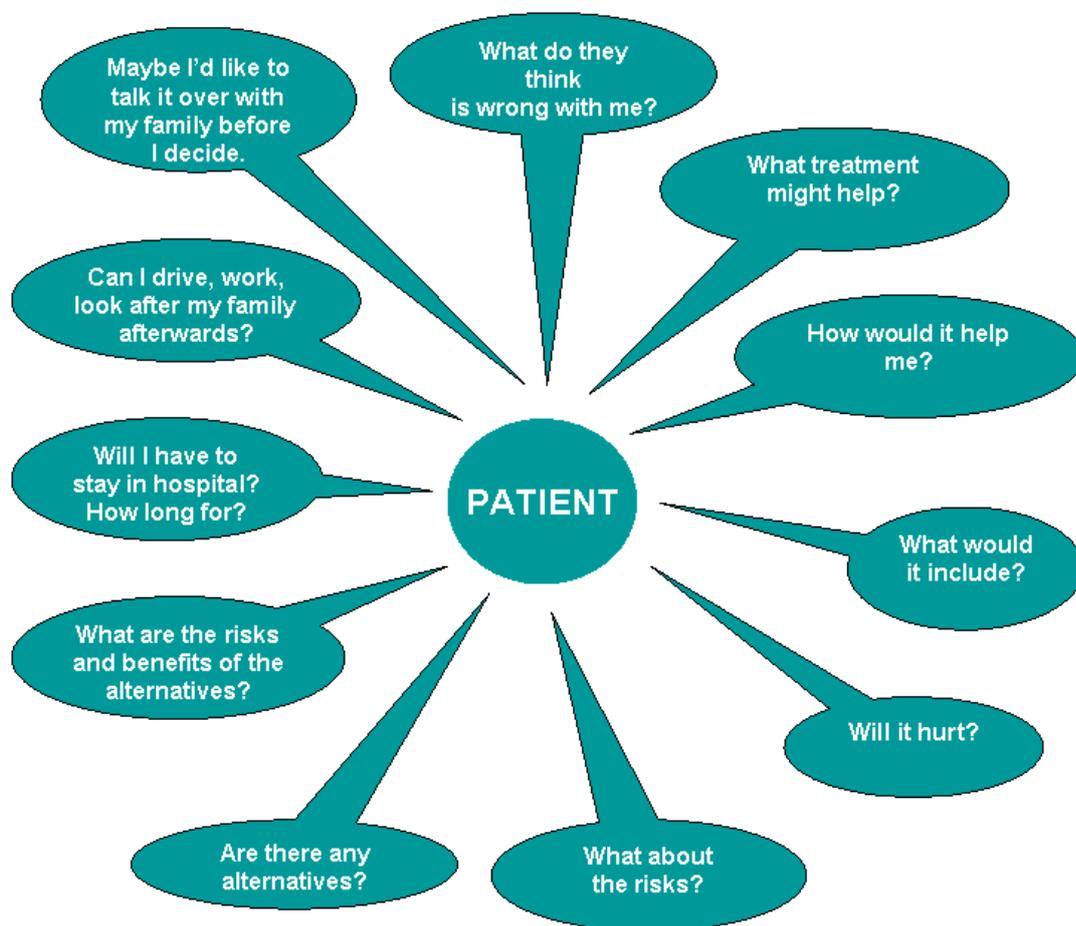
Documentation is particularly important in circumstances when patient's decision goes against the anaesthetist's advice.

Critical Care

Patients in the ICU should not be considered to lack the competence to decide about their medical treatment, merely because they are gravely ill, are receiving sedative drugs or lack of ability to communicate orally. These patients should be allowed to indicate their consent, and wherever possible, written documentation of consent discussions should be recorded. A clear documentation should be made if adequate capacity could not be achieved despite best efforts. The doctors may treat patients in their best interests if patients are unconscious or have fluctuating levels of consciousness. Discussion about best interest should involve other health professionals, and be informed by the patient's relatives or next of kin.

Appendix G

Seeking consent: remembering the patient's perspective



Template

The purpose of Equality Analysis is to ensure that the Trust does not unwittingly discriminate against any groups recognised under the Equality Act 2010. These are: Age, Disability, Gender reassignment, Sexual Orientation, Race, Religion or Belief, Sex, Sexual orientation, Marriage & Civil partnership, Pregnancy and Maternity. An EqIA is a process which ensures the Trust eliminate unlawful discrimination, foster good relations between others and promote equality of opportunity in the take up of its services and employment practices.

Division/Department	Clinical Governance	
Policy/Service	Consent Policy	
Is this policy/service New/Existing	Existing	
Name of Assessor(s)	Wayne Robson	
Date of EqIA	03/03/2017	
Aims/Objectives/ Purpose of Policy	Patients have a legal and ethical right to determine what happens to their own bodies and therefore valid consent to treatment is vital.	
Associated Objectives for this Service e.g. National frameworks, Equality Act.	Department of Health: Reference Guide to consent for examination or treatment. Second Edition 2009. Department of Health: Mental Health Act 1983. Mental Capacity Act 2005 Human Tissue Authority code of Practice 1: Consent	
Does this policy/service Affect patient or the workforce?	Yes	
What outcomes do you want to achieve from this process?	Improved safety and quality assurance for obtaining consent for procedures at BHNFT	
What factors could	Contribute	Detract

contribute/detract from the effective delivery of this policy/service?			
	Implementation of this policy	Failure to follow the policy	
Are there any concerns that this service or policy could have a differential impact on or due to the following?	Race	No	The Trust has systems and processes in place to ensure the accessibility of this and all other Trust wide policies and associated clinical documentation to individual's whose first language is not English. This would include the adaptation/translation of any supporting patient information.
	Age	No	This policy has been developed and will be in a manner which will have no differential impact on or due to age. The policy has been consulted upon by relevant groups and committees before approval and ratification and will be managed under the governance arrangements of the Trust.
	Disability	Yes	The Trust has systems and processes in place to adapt the format of this and other Trust wide policies to ensure its accessibility by those individuals with a disability. This would include the adaptation of any supporting patient information or clinical documentation e.g. consent forms; braille, for patients with hearing impairments, for patient's requiring reasonable adjustments.
	Gender Reassignment	No	This policy has been developed and will be in a manner which will have no differential impact on or due to gender re-assignment. The policy has been consulted upon by relevant groups and committees before approval and ratification and will be

			managed under the governance arrangements of the Trust.
	Religion/Belief	No	<p>The Trust has processes in place to ensure that patient's and carers are involved in their own care and treatment decision making and that information on the risks, benefits and alternatives of treatments are made available by the Trust.</p> <p>The Trust has processes in place to provide patients and carers with information to support any informed decisions.</p>
	Sexual Orientation	No	<p>This policy has been developed and will be in a manner which will have no differential impact on or due to sex. The policy has been consulted upon by relevant groups and committees before approval and ratification and will be managed under the governance arrangements of the Trust.</p>
	Pregnancy Maternity	No	<p>This policy has been developed and will be in a manner which will have no differential impact on or due to pregnancy/maternity. The policy has been consulted upon by relevant groups and committees before approval and ratification and will be managed under the governance arrangements of the Trust.</p>
	Marriage Civil Partnership	No	<p>This policy has been developed and will be in a manner which will have no differential impact on or due to marriage/civil partnership. The policy has been consulted upon by relevant groups and committees before approval and ratification and will be managed under the</p>

			governance arrangements of the Trust.
	Gender	No	This policy has been developed and will be in a manner which will have no differential impact on or due to gender. The policy has been consulted upon by relevant groups and committees before approval and ratification and will be managed under the governance arrangements of the Trust.
	Human Rights	No	The Trust has processes in place to ensure that patient's and carers are involved in their own care and treatment decision making and that information on the risks, benefits and alternatives of treatments are made available by the Trust. The Trust has processes in place to provide patients and carers with information to support any informed decisions.
If you have answered yes to any of the above, please describe or attach any evidence of action which will mitigate your EqlA and ensure your policy/service will be able to show: <ul style="list-style-type: none"> • Eliminate discrimination • Promote equal opportunities • Foster good relations between others 	<p>All staff to undertake Equality and Diversity training during their induction.</p> <p>The Trust has access to signing interpreters.</p> <p>There is a high level of illiteracy in Barnsley. (BMBC 2008) It should be ascertained that the patient completely understands the implications of the treatment/procedure before making their mark. This should be undertaken by the person seeking the consent.</p> <p>Access to language line via the PALS Department during working hours and the 319 bleep out of hours.</p> <p>Access to the British Sign language is via the PALS Department and requires pre-booking.</p>		
Should the EqlA proceed to a full EqlA for the areas identified for attention?	Yes	No	Comments
Comments			

Send to: Equality and Diversity Advisor for signature and authorisation	
Send to: Line Manager for signature and authorisation	
Head of Department Responsible for policy or service	
When is the next review (please note review should be immediate on any amendments to your policy etc.)?	
1 Year	
2 Year	
3 Year	

Version	Date	Comments	Author
3	15/03/17		Medical Director

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Clinical Effectiveness Group (CEG)	15/03/17