Shropshire Community Health NHS Trust

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Who is the document aimed at?	All staff involved in the process of seeking consent
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No	Date	Amendment
1	Jun 2012	Policy reviewed and updated to reflect changes in organisation and updated NHSLA requirements
2	Oct 2015	Review to update links to relevant legislation, regulations and guidance. Updating the details of responsible staff.
3	Aug 2018	Review to update links to relevant legislation, regulations and guidance. Updating the details of responsible staff. Addition of RiO / EPR specific guidance. Addition of learning from Dental Never event
4	July 22	Review and updating and incorporation of the GMC guidance on shared decision making
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Contents

1 Introduction

Consent is a fundamental legal and ethical principle. All people, regardless of age, have the right to be involved in decisions about their treatment and care and to make informed decisions if they can. The exchange of information between healthcare professional and client is essential to good decision making. Serious harm can result if people are not listened to, or if they are not given the information they need - and time and support to understand it - so they can make informed decisions about their care.

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision and not be acting under duress.

If a person does not have the capacity to make a decision about their treatment, processes outlined here must be followed to ensure decisions about their care are made in accordance with the principles of the Mental Capacity Act (2005).

The following guidance has been drawn on to develop this policy:

DOH Reference guide to consent for examination or treatment

GMC Decision making and consent

Consent in England and Wales | Consent | Royal College of Nursing (rcn.org.uk)

GDC Standards

Professional standards of practice and behaviour for nurses, midwives and nursing associates

Consent to treatment - NHS

Mental Capacity Act (MCA) Code of Practice

CQC regulations: need for consent

Shared decision making NICE guideline [NG197]

Shropshire Multi Agency Mental Capacity Act guidance.

2 Purpose

This policy sets out the standards and procedures in Shropshire Community Health NHS Trust to ensure that healthcare professionals working with adults, children and young people are able to comply with good practice in obtaining consent. Whilst this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain care, such as those that involve touching the patient or client.

3 Definitions

Term / Abbreviation	Definition
Advance Decision/ Advance Directive	A decision to refuse specified treatment made in advance by a person who has capacity to do so.
Assessing Lack of Capacity	The Mental Capacity Act (MCA) sets out a single clear test for assessing whether a person lacks capacity to take a particular

Term / Abbreviation	Definition
	decision at a particular time. It is a "decision-specific" and "time specific" test. No one can be labelled 'incapable' simply as a result of a particular medical condition or diagnosis. Section 2 of the MCA makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which might lead others to make unjustified assumptions about capacity.
Best interests	An act done or decision made for or on behalf of a person who lacks capacity must be in that person's best interests. The MCA provides a statutory checklist of factors that decision makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person making the determination must consider. Also, people involved in caring for the person who lacks capacity gain a right to be consulted concerning a person's best interests.
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the MCA 2005.
Carer	Someone who provides unpaid care by looking after a friend or neighbour who needs support because of sickness, age or disability. In this document, the term carer does not mean a paid care worker.
Consent	Agreeing to a course of action – specifically in this document to examination, a care plan or treatment regime.
CQC	Care Quality Commission
Court Appointed Deputy	A person appointed by the Court of Protection to deal with a specific issue or range of issues to help a person who lacks capacity and has not got an attorney.
Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions.
Deprivation of Liberty	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.
Deprivation of Liberty Safeguards (DoLS)	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.
Deputy	Someone appointed by the Court of Protection with ongoing legal authority, as prescribed by the Court, to make decisions on behalf of a person who lacks capacity to make particular decisions.
Enduring Powers of Attorney	When someone (a donor) appoints someone else (an attorney) to act for them with regard to their property and financial affairs. New EPAs cannot be made but existing ones remain valid.

Term / Abbreviation	Definition
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions about serious medical treatment or a long term care move where the person has no-one else to support them. May also be appointed in adult protection cases. The IMCA service was established by the Mental Capacity Act 2005 and is not the same as an ordinary advocacy service. The purpose of the Independent Mental Capacity Advocacy Service is to help people who lack capacity and who are un-befriended to make important decisions about serious medical treatment and changes of accommodation.
Lasting Power of Attorney	A Power of Attorney created under the Mental Capacity Act 2005 appointing an attorney (donee), or attorneys, to make decisions about the donor's personal welfare, including health care, and/or deal with the donor's property and affairs.
Mental Capacity Act 2005 (MCA)	Legislation that governs decision-making for people who lack capacity to make decisions for themselves or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this.
Mental Disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs. This includes all learning disabilities.
Mental Health Act 1983	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It covers detention in hospital for mental health treatment, supervised community treatment and guardianship.
Office of the Public Guardian (OPG)	Monitors court appointed deputies, keeps registers of and investigates complaints about attorneys and deputies.
PDA	Patient Decision Aids
POhWER	An independent advocacy agency originating in Hertfordshire. POhWER stands for People of Hertfordshire Want Equal Rights
Restriction of Liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.

4 Duties

4.1 Chief Executive

The Chief Executive has responsibility for meeting all statutory requirements and for implementing guidance issued by the Department of Health in respect of Integrated and Clinical Governance.

4.2 Medical Director and Director of Nursing and Quality (Caldicott Guardian)

The Medical Director and Director of Nursing and Quality (Caldicott Guardian) are directly responsible for the Trusts Consent policy and are assured that trust healthcare professionals have access to and apply the requirements of the policy appropriately.

4.3 Managers

Managers must ensure that trust healthcare professionals act in line with the Trust's Policy, staff are competent to obtain consent and that when written consent is required only the correct forms are used.

They must ensure services they manage define what kind of consent is required for relevant treatments or interventions, and define those clinical procedures where written consent is required.

4.4 Healthcare Professionals

Healthcare professionals must maintain their competence and adhere to the trust policy and be satisfied that they have a patient's consent or other valid authority before providing treatment or care. It is a healthcare 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.

Healthcare professionals must also be aware of and comply with any guidance on consent issued by their own professional and regulatory bodies.

5 Principles of Consent

Consent must be sought by all healthcare professionals. It is a continuous process and a person has the right to change their mind. Healthcare professionals must work in partnership with the person, listen to and respond to concerns and preferences. Different approaches may be necessary and the amount of information shared will vary dependent on the individual person's circumstances.

Healthcare professionals must be satisfied that they have a person's consent or other valid authority before any decision about their care, examination, treatment, investigation or referral.

The GMC identify seven principles that can be considered regarding decision making and consent that can usefully considered by all health professionals seeking consent:

Principle one	All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.
Principle two	Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.
Principle three	All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.
Principle four	Health Professionals must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.
Principle five	Health Professionals must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements
Principle six	The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.
Principle seven	Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible.

6 Who is Responsible for Seeking Consent?

The healthcare professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to the particular intervention: it is they who will be held responsible in law if this is challenged.

6.1 Delegation of Responsibility for the Consent Process

You may decide to delegate part of the decision-making process. When deciding whether it is appropriate to delegate, you should consider:

- the nature of the intervention and the complexity of the information about it
- the level of uncertainty surrounding the outcome
- whether the patient has already developed a trusting relationship with you or the person you would delegate to
- anything unusual about the patient's condition(s) and any concerns that you anticipate the patient may have.

You must make sure the person you delegate to:

- is suitably trained and competent

- has sufficient knowledge of the intervention and its associated benefits and harms, as well as alternative options for treatment and care
- has the skills to have a dialogue with the patient that's in line with this guidance
- feels competent to carry out the delegated task

If part of the decision-making process has been delegated, you are still responsible for making sure that the patient has been given the information they need to make the decision, has had time and support to consider it, and has given their consent before you provide treatment or care. You should also check that the patient has a realistic expectation of the outcome.

7 Consent Process

7.1 Principles of Consent

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.

- **voluntary** – the decision to either consent or not to consent to treatment must be made by the person, and must not be influenced by pressure from medical staff, friends or family
- **informed** – the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead

For consent to be valid the person must have capacity to give consent- which means they understand the information given to them and can use it to make an informed decision

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.

The legal position concerning consent and refusal of treatment by those under the age of 16 is different from the position for adults and is set out in detail in section 10.

7.2 Assessing Capacity in Adults and young people over 16

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. The MCA code of practice states:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise
- wherever possible, help people to make their own decisions
- do not treat a person as lacking the capacity to make a decision just because they make an unwise decision
- if you make a decision for someone who does not have capacity, it must be in their best interests
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms

It also sets out a 2-stage test of capacity:

- Does the person have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use?
- Does the impairment mean the person is unable to make a specific decision when they need to? People can lack capacity to make some decisions, but have capacity to make others. Mental capacity can also fluctuate with time – someone may lack capacity at one point in time, but may be able to make the same decision at a later point in time.

Where appropriate, people should be allowed the time to make a decision themselves. A person is unable to make a decision if they cannot:

- understand the information relevant to the decision
- retain that information long enough to be able to make the decision
- use or weigh up that information as part of the process of making the decision

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 unless they have been legally appointed to act for them- eg a Health and Welfare Lasting Power of Attorney, Court appointed Deputy or the patient may have made an Advance decision to refuse treatment.

Local detailed guidance is defined separately in the Shropshire Multi Agency Mental Capacity Act guidance. and formal mental capacity assessment can be completed using the Shropshire Mental Capacity Assessment Tool.

If a person does not have the capacity to make a decision about their treatment and they have not appointed a lasting power of attorney (LPA), the healthcare professionals treating them can go ahead and give emergency treatment if they believe it's in the person's best interests. But clinicians must take reasonable steps to discuss the situation with the persons friends or relatives before making these decisions.

7.3 Recording decisions made about consent

Discussions and decisions made about consent, including information provided about procedures and interventions, and patient information leaflets given to patients in order for them to help in making an informed decision, should be recorded in the clinical record.

8 Shared Decision making

All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.

The exchange of information between health professionals and patient is central to good decision making. It's during this process that you can find out what's important to a patient, so you can identify the information they will need to make the decision.

The purpose of the dialogue is:

- to help the patient understand their role in the process, and their right to choose whether or not to have treatment or care

- to make sure the patient has the opportunity to consider relevant information that might influence their choice between the available options
- to try and reach a shared understanding of the expectations and limitations of the available options

Every person should have basic information about their condition, treatment and care so that they can engage in and manage their health. Some information is only designed to inform the person rather than to aid decision making.

You must give patients the information they want or need to make a decision. This may include:

- diagnosis and prognosis
- uncertainties about the diagnosis or prognosis, including options for further investigation
- options for treating or managing the condition, including the option to take no action
- the nature of each option, what would be involved, and the desired outcome
- the potential benefits, risks of harm, uncertainties about and likelihood of success for each option, including the option to take no action

The information people need for shared decision making is the same as needed for informed consent. Patient Decision Aids (PDAs) are sometimes helpful in supporting this process.

See **Appendix 7**: Standards framework for shared-decision-making support tools, including patient decision aids

8.1 Accessible Information Standards

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. It is of particular relevance to individuals who are blind, deafblind and / or who have a learning disability, although it will support anyone with information or communication needs relating to a disability, impairment or sensory loss, for example people who have aphasia or a mental health condition which affects their ability to communicate. The Standard applies to service providers across the NHS and adult social care system, and it specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing.

There are five basic steps which make up the Accessible Information Standard:

1. Ask: identify / find out if an individual has any communication / information needs relating to a disability or sensory loss and if so what they are

2. Record: record those needs in a clear, unambiguous and standardised way in the patients clinical record

3. Alert / flag / highlight: ensure that recorded needs are ‘highly visible’ whenever the individual’s record is accessed, and prompt for action

4. Share: include information about individuals’ information / communication needs as part of existing data sharing processes (and in line with existing information governance frameworks)

5. Act: take steps to ensure that individuals receive information which they can access and understand and receive communication support if they need it

To give valid consent, the person needs to understand the nature and purpose of the procedure in the same way as anyone else. It is essential that they are given sufficient information in the right format to enable them to determine whether or not to accept or decline treatment and care. See the Trust Accessible Information Policy for further information on meeting this standard.

8.2 Provision for Patients Whose First Language is not English

The 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. It is not appropriate to use children under the age of 18, to interpret for family members who do not speak English. Depending on the nature of the consultation, it may be inappropriate to ask any member of the family, regardless of age, to interpret.

For more advice and guidance on any of the above and additional specific needs see the trust Interpreter and Translation services guidance.

8.3 Access to More Detailed or Specialist Information

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

Trust staff will be aware of sources of information in their own clinical area and of other approved sources of information relevant to their own department. In some cases printed information for patient is available regarding assessments and treatments commonly undertaken within the Trust. Approved sources of information for patients

- Patient information on Shropshire Community Health NHS Trust website www.shropscommunityhealth.nhs.uk
- Patient Advice and Liaison Service (PALS)
  Tel: 0800 032 1107 email: shropcom.customerservices@nhs.net
- From the reception areas for specific services
- Parent held records for under 5's
- Immunisation information
  https://www.gov.uk/government/collections/immunisation
- Health Information Online www.library.nhs.uk

9 Types of Consent

Consent can be given:

- **in writing** – for example, signing a consent form for surgery
- **verbally** – for example, a person saying they're happy to have an X-ray
- **non-verbally**– for example, holding out an arm for a blood test

9.1 Written Consent

Completion of a consent form is in most cases not a legal requirement (exceptions include certain requirements of the Mental Health Act 1983 and of the Human Fertilisation and Embryology Act 1990 as amended by the Human Fertilisation and Embryology Act 2008).

However the use of consent forms is good practice where a high-risk intervention such as surgery is to be undertaken. (See Trust consent forms Appendices 1-5).

Patient's written consent should be obtained if:

- the investigation or treatment is complex or involves significant risks there may be significant consequences for the patient's employment, or social or personal life (including surgery)
- providing clinical care is not the primary purpose of the investigation or treatment
- the treatment is part of a research programme or is an innovative treatment designed specifically for their benefit

If it is not possible to get written consent, for example, in an emergency or if the patient needs the treatment to relieve serious pain or distress, oral consent can be relied on. But the patient must still be given the information they want or need to make a decision and these discussions, information given and the fact that they have given consent, must be recorded in their clinical medical record.

Written consent must be re-checked prior to any procedure and recorded in the clinical record. This is especially important when there is an extended period of time between signing the form and attending for treatment.

Completed forms must be retained within the clinical record and any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and healthcare professional.

If the person has capacity but is unable to read or write, a mark can be recorded on the consent form and witnessed by a third person. The process must be recorded in the clinical record.

If the person has capacity and wishes to give consent but is physically unable to mark the form, this fact should be recorded in the clinical record. Alternatively the person can direct someone to sign the form on their behalf, but there is no legal requirement for them to do so.

If consent has been given validly, the lack of a completed 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.

10 Children and Young People

The legal position concerning consent and refusal of treatment by those under the age of 18 is different from the position for adults. For the purposes of this guidance children refers to people aged below 16 and young people refers to people aged 16–17.

Resources on consent in children and young people:

Department of Health and Social Care (2021). Parental rights and responsibilities

Gillick competency and Fraser guidelines

Care Quality Commission (2018). Gillick competency and Fraser guidelines

General Medical Council (2018) 0 - 18 years: Guidance for all doctors

10.1 Young People aged 16–17

Young people are presumed to be capable of consenting to their own medical treatment, and any ancillary procedures involved in that treatment. As for adults,

consent will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16–17 may in certain circumstances be overridden by either a person with parental responsibility or a court.

In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults should be used. For further information see chapter 12 of the Mental Capacity Act (2005) Code of Practice.

If the 16/17-year-old is capable of giving valid consent then it is not legally necessary to obtain consent from a person with parental responsibility for the young person as well. It is, however, where appropriate, good practice to involve the young person's family in the decision-making process, but this will itself require the consent of the young person, and their consent to share information.

10.2 Children aged below 16

The right of younger children to provide independent consent is proportionate to their competence - a child's age alone is clearly an unreliable predictor of his or her competence to make decisions.

You should always encourage a child to tell their parents or carers about the decisions they are making. If they don't want to do this, you should explore why and, if appropriate, discuss ways you could help them inform their parents or carers. For example, you could talk to the young person's parents or carers on their behalf.

In an emergency, it is justifiable to treat a child who lacks capacity without the consent of a person with parental responsibility, if it is impossible to obtain consent in time and if the treatment is vital to the survival or health of the child.

Gillick Competency

If the young person still wants to go ahead health practitioners trying to decide whether a child is mature enough to make decisions about things that affect them need to consider Gillick competency.

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

It is good practice to involve the young person's family in the decision-making process, but this will itself require the consent of the young person, and their consent to share information.

If the young person has informed their parents of the treatment they wish to receive but their parents do not agree with their decision, treatment can still proceed if the child has been assessed as Gillick competent.

For further information see section 3 of the *Reference guide to consent for examination or treatment, second edition 2009* and the NSPCC guidance A child's legal rights Gillick competency and Fraser guidelines

Parental Responsibility

Where a child under the age of 16 lacks capacity to consent (i.e. is not Gillick Competent), consent can be given on their behalf by any one person with parental responsibility or by the court. The Children Act 1989 sets out persons who may have parental responsibility. Even where a child lacks capacity to consent on their own behalf, it is good practice to involve the child as much as possible in the decision-making process.

In order to consent on behalf of a child, the person with parental responsibility must themselves have capacity. Where the person with parental responsibility for a child is themselves under 18, they will only be able to give valid consent for the child's treatment if they themselves are Gillick Competent.

Where there is doubt about whether a parent is acting in the interest of the child or young person, then the healthcare practitioner would be unwise to rely on the parent's consent alone. In such cases advice will have to be sought through the line manager and social services legal advice may be required.

It must not be forgotten that in certain situations the responsible parent is the local authority and has to be part of the consent process this situation occurs when children are subject to care orders through the Children Act. It is the clinicians imperative to ascertain if a child is under a care order in all situations.

Fraser Guidelines

Where advice or treatment relates to contraception, or the child's sexual or reproductive health, the healthcare professional can use the Fraser guidelines which specifically relate only to contraception and sexual health.

Advice can be given to children in this situation as long as:

- they have sufficient maturity and intelligence to understand the nature and implications of the proposed treatment
- the child cannot be persuaded to tell her parents or to allow the doctor to tell them
- they are very likely to begin or continue having sexual intercourse with or without contraceptive treatment
- their physical or mental health is likely to suffer unless he/she received the advice or treatment
- the advice or treatment is in the young person's best interests

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

In such circumstances safeguarding issues regarding vulnerable children must be assessed and appropriate measures taken in line with the trusts safeguarding policies

11 Consent for Clinical Photography, visual and audio recordings

Consent should be obtained for any visual or audio recording, including photographs or other visual images. The purpose and possible future use of the recording must

be clearly documented and explained to the person before their consent is sought for the recording to be made. If it is to be used for teaching, audit or research, people must be aware that they can refuse without their care being compromised and that when required or appropriate it can be anonymised.

GMC guidance gives more detailed advice, including situations when permission is not required and about obtaining consent to use recordings as part of the assessment or treatment of patients and for training or research. Making and using visual and audio recordings of patients - guidance for doctors April 2011

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

If a recording is to be used for education, publication or research purposes, consent must be obtained in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. *Consent Form 5* may be used for this purpose. For additional advice and guidance on photographing wounds refer to the Trust's Clinical Photography Guidelines.

12 Refusal of Treatment

If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment (whether contemporaneously or in advance), this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983. This is the case even where this may result in the death of the person (and/or the death of an unborn child, whatever the stage of the pregnancy).

However, unlike adults, the refusal of a competent person aged 16–17 may, in certain circumstances, be overridden by either a person with parental responsibility or a court.

Healthcare professional must consider any safeguarding related concerns relating to refusal of treatment and seek further advice and guidance as required.

Where a patient has refused a particular intervention, the healthcare professional must ensure that any other appropriate care to which they have consented continues to be provided. The healthcare professional 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, the patient should be advised accordingly.

If a patient consents to a particular procedure but refuses certain aspects of the intervention, the healthcare professional must explain to the patient the possible consequences of their partial refusal. If it is genuinely believed that the procedure cannot be safely carried out under the patient's stipulated conditions, the healthcare professional is not obliged to perform this procedure. The professional must, however, continue to provide any other appropriate care. Where another healthcare professional believes that the treatment can be safely carried out under the conditions specified by the patient, the patient's care, on request, must be transferred to that other healthcare professional.

12.1 Advance Decisions to Refuse Treatment

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

The Mental Capacity Act 2005 gave advance decisions a statutory basis and sets out the requirements that such a decision must meet to be valid and applicable. Further details are available in Advance decisions to refuse treatment A guide for health and social care professionals and chapter 9 of the Mental Capacity Act (2005) Code of Practice, but in summary these are:

- 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 advance decision refuses life-sustaining treatment, it must be in writing (it can be written by someone else or recorded in healthcare notes), 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.

Healthcare professionals **must follow** an advance decision if it is valid and applicable, even if it may result in the person's death. If they do not, they could face criminal prosecution or civil liability.

However the Mental Capacity Act 2005 does protect healthcare professionals from liability for:

- treating or continuing to treat a person in the person's best interests if they are not satisfied that an advance decision exists which is valid and applicable
- the consequences of withholding or withdrawing a treatment if at the time they reasonably believe that there is a valid and applicable advance decision

If there is genuine doubt or disagreement about an advance decision's existence, validity or applicability, the case should be referred to the Court of Protection.

While a decision is awaited from the courts, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration in the patient's condition.

If an advance decision is not valid or applicable to current circumstances, healthcare professionals must consider the advance decision as part of their assessment of the person's best interests. Advance decisions made before the Mental Capacity Act came into force may still be valid if they meet the provisions of the Act.

13 Withdrawal of Consent

A person with capacity is entitled to withdraw consent at any time, including during examination or treatment. Where a person does withdraw consent during treatment, it is good practice, if at all possible, to stop the procedure, establish the person's concerns and explain the consequences of not completing the procedure. If stopping the procedure at that point would genuinely put the life of the person at risk, the practitioner may reasonably continue until that risk no longer applies.

Where consent has been withdrawn all the information surrounding the process will need to be carefully recorded in clinical notes, in some circumstances there are

forms that can be signed to accompany this such as self-discharge from a hospital (Appendix 6). If the patient has already signed a consent form, but then changes their mind, the healthcare professional (and where possible the patient) should note this on the consent form.

Assessing capacity during a procedure may be difficult and, as noted above, factors such as pain, panic and shock may diminish capacity to consent. The practitioner should try to establish whether at that time the person has capacity to withdraw a previously given consent. If capacity is lacking, it may sometimes be justified to continue in the person's best interests, but this should not be used as an excuse to ignore distress.

13.1 Consent to Decline Advice

When a patient, parent or carer refuses to take practical advice after a procedure, e.g. after an immunisation, or wishes to leave an inpatient facility against advice, then healthcare professionals may use the Patient Consent to Decline Clinical Advice Form. See the Trust website and Appendix 6 for an example form.

Its purpose is to provide the healthcare professional with an opportunity to require the patient, parent or carer to formally acknowledge their decision to decline to accept the advice given. It has no legal status but may encourage the patient, parent or carer to reconsider their decision.

14 Research and Innovative Treatment

Informed consent is one of the founding principles of research ethics. Its intent is that human participants can enter research freely (voluntarily) with full information about what it means for them to take part, and that they give consent before they enter the research.

The same legal principles apply when seeking consent from patients for research purposes as when seeking consent for investigations or treatment. Patients should be told how the proposed treatment differs from the usual methods, why it is being offered, and if there are any additional risks or uncertainties.

Further guidance on this can be found at GMC Ethical Guidance on Consent to research.

15 Consultation

In the development of this policy the following have been involved in the consultation process:

- Director of Nursing
- Chief Operating Officer
- Medical Director
- Associate Medical Directors
- Corporate Risk Manager
- Heads of Nursing (Adults and Children & Families)
- Adult Safeguarding and Compliance Lead
- Patient Safety Officer

- Representative professional leads, clinical staff and service managers
- Information Governance Lead
- Clinical Records Lead

16 Dissemination and Implementation

This policy will be disseminated by the following methods

- Published on the Trust website and disseminated to Directors and Senior Managers via the Datix system for cascading to all staff.
- Awareness raising by the Caldicott Guardian and support staff

16.1 Mandatory Training

Consent training is part of the mandatory training matrix for all healthcare professionals and is part of the Trust's induction programme. Mandatory Training also includes training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Refer to the Trust Mandatory (Risk Management) Training Policy and procedure

16.2 Role and Procedure Specific Consent Training

It is acknowledged that all healthcare professionals carrying out procedures and treatments have the appropriate knowledge, experience of risks and benefits and alternatives to treatment to ensure valid treatment is obtained.

Specific requirements may be defined within health professional roles and require role specific essential training.

Further information and guidance on consent in genomic studies is available from the Royal College of Physicians in Consent and confidentiality in genomic medicine.

17 Monitoring

- This policy will be monitored by the Service Delivery Groups (Adults and Children and Families) by through annual clinical record keeping audit
- Incident Reporting: ensuring incidents involving consent issues and concerns are investigated and appropriate actions are taken and lessons learnt disseminated to all staff concerned
- Where consent has been obtained without authorisation cases will be fully investigated and where necessary the Trust will notify the relevant professional body, i.e. General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the Health Professions Council (HPC)

18 References

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11
- Care Quality Commission (CQC) - Regulation 11: Need for consent
- Reference Guide to Consent for Examination or Treatment
- Consent in England and Wales | Consent | Royal College of Nursing (rcn.org.uk)
- GDC Standards

Consent Guidance:

- Consent to treatment
- Consent to treatment - Children and young people:
- NSPCC guidance: A child's legal rights Gillick competency and Fraser guidelines
- Consent – what you have a right to expect - A guide for children and young people
- Consent – what you have a right to expect - A guide for parents
- Assessing capacity to give consent
- Consent – a guide for adults with learning difficulties
- Treatment and care towards the end of life: good practice in decision making
- General Medical Council (GMC) Decision making and consent
- Health Professions Council (HPC): standards of conduct, performance and ethics
- Nursing and Midwifery Council (NMC) The Code
- GMC - Making and using visual and audio recordings of patients
- National Wound Care Strategy Practical Recommendations for the use of Digital Images in Wound Care

Mental Capacity Act related:

- Mental Capacity Act
- Mental Capacity Act Code of Practice
- 'Making Decisions – A Guide for People who work in Health and Social Care'
- The Shropshire Multi Agency Mental Capacity Act guidance

19 Associated Documents

The following Trust documents contain information that relates to this framework:

- Confidentiality Code of Practice
- Cardiopulmonary Resuscitation (CPR) and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Policy
- Advance Decision Policy
- Mental Capacity Act Policy
- Deprivation of Liberty (DOLS) Safeguards Policy
- Data Protection Policy
- Information Security Policy
- Clinical Record Keeping Policy
- Records and Documentation Management Policy
- Clinical Photography Guidelines

20 Appendices:

The forms listed below and included **as examples** are all available on the Trust's Clinical Documentation Library under the Consent subcategory.

Appendix 1: Consent Form 1: Patient agreement to investigation or treatment (procedures where anaesthesia is involved): to be used for adults/competent children who are able to consent

Appendix 2: Consent Form 2: Parental agreement to investigation or treatment for a child or young person (procedures where anaesthesia is involved): to be used when parental responsibility is needed for children

Appendix 3: Consent Form 3: Patient/parental agreement to investigation or treatment (procedures where consciousness not impaired): To be used for adult patients able to consent/competent and children/those with parental responsibility consenting on behalf of child/young person

Appendix 4: Consent Form 4: Form for adults who are unable to consent to investigation or treatment

Appendix 5: Consent Form 5: Consent to photograph/video recording to be used if a photograph / recording is to be used for education, publication or research purposes

Appendix 6: Patient Consent to Decline Clinical Advice Form: This form is to be used if patients do not wish to comply with treatment or advice recommended by a healthcare professional

Appendix 7: Standards framework for shared-decision-making support tools, including patient decision aids

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Consent Form 1

Patient Agreement to Investigation or Treatment

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 and his or her parents.

☐ The following leaflet/tape has been provided ……

This procedure will involve:

☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed: …… Date: ……

Name (PRINT): …… …… Job title: …… ……

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 they can understand.

Signed …… Date ……

Name (PRINT) ……

Copy accepted by patient: yes/no (please ring)

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Consent Form 1

Statement of Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 1 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.

I agree 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 anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

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 should sign below if the patient is unable to sign but has indicated their 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 they have no further questions and wish 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) ReSPECT, LPA's

Consent form 1: 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 should act as an *aide-memoire* to health professionals and patients, by providing a check-list of the kind of information patients should 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.

The law on consent

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent (also available at www.dh.gov.uk).

Who can give consent

Everyone aged 16 or more 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, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should 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 should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should 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 should 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. The courts have stated that patients should 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 they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should 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 should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 1 of the form or in the patient's notes.

First Name: ____________________

Last Name: ____________________

Date of Birth: __________________

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Consent Form 2

Parental agreement to investigation or treatment for a child or young person

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 child and his or her parent(s). 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 and his or her parents.

☐ The following leaflet/tape has been provided ………………………………………………..

This procedure will involve:

☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed: …………………………………………… Date: ………………………………..

Name (PRINT): ……………………… ……… Job title: …….. ……………………..

Contact details (if child/parent wish to discuss options later) ……………………………

Statement of interpreter (where appropriate)

I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe they can understand.

Signed ………………………………………………… Date ………………………………

Name (PRINT) ……………………………………………………………………………………

Copy accepted by patient: yes/no (please ring)

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Consent Form 2

Statement of Parent

Please read this form carefully. If the procedure has been planned in advance, you should already have your own copy of page 1 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 and your child. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form and **I confirm** that I have 'parental responsibility' for this child.

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 my child and I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of the situation prevents this. (This only applies to children having general or regional anaesthesia.)

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

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

……
……
……

Signature: …….. Date: ……..

Name (PRINT): …… Relationship to child: ……

Child's agreement to treatment (if child wishes to sign)

I agree to have the treatment I have been told about.

Name …… Signature ……..……

Date ……..…

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

On behalf of the team treating the patient, I have confirmed with the child and his or her parent(s) that they have no further questions and wish 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)

☐ Parent has withdrawn consent (ask parent to sign /date here) ……..…….

Consent Form2: Guidance to health professionals
(to be read in conjunction with consent policy)

This form

This form should be used to document consent to a child's treatment, where that consent is being given by a person with parental responsibility for the child. The term 'parent' has been used in this form as a shorthand for 'person with parental responsibility'. Where children are legally competent to consent for themselves (see below), they may sign the standard 'adult' consent form (form 1). There is space on that form for a parent to countersign if a competent child wishes them to do so.

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. The courts have stated that 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. If children are not able to give consent for themselves, some-one with parental responsibility may do so on their behalf.

Although children acquire rights to give consent for themselves as they grow older, people with 'parental responsibility' for a child retain the right to give consent on the child's behalf until the child reaches the age of 18. Therefore, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child's treatment. In law, health professionals only need the consent of one appropriate person before providing treatment. This means that in theory it is lawful to provide treatment to a child under 18 which a person with parental responsibility has authorised, even if the child refuses. As a matter of good practice, however, you should always seek a competent child's consent before providing treatment unless any delay involved in doing so would put the child's life or health at risk. Younger children should also be as involved as possible in decisions about their healthcare. Further advice is given in the Department's guidance *Seeking consent: working with children.* Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the patient's notes.

Parental responsibility

The person(s) with parental responsibility will usually, but not invariably, be the child's birth parents. People with parental responsibility for a child include: the child's mother; the child's father if married to the mother at the child's conception, birth or later; a legally appointed guardian; the local authority if the child is on a care order; or a person named in a residence order in respect of the child. Fathers who have never been married to the child's mother will only have parental responsibility if they have acquired it through a court order or parental responsibility agreement (although this may change in the future).

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 children and their parents when making up their minds about treatment. The courts have stated that patients should 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 they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

Guidance on the law on consent

See the Department of Health publications *Reference guide to consent for examination or treatment* and *Seeking consent: working with children* for a comprehensive summary of the law on consent (also available at www.dh.gov.uk).

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Consent Form 3

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

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 anaesthesia.

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: ……

Copy accepted by patient: yes/no (please ring)

Consent Form 3: Guidance to health professionals
(to be read in conjunction with consent policy)

This form

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 anaesthetist is not involved in their care: for example for drug therapy where written consent is deemed appropriate.** In other circumstances you should use either 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 more 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, some-one with parental responsibility may do so on their behalf. Even where a child is able to give consent for himself or herself, you should 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 should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally 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 should 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 should 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 should 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 they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should 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 should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this overleaf or in the patient's notes.

The law on consent

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent.

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Consent Form 4

Form for Adults who are Unable to Consent to Investigation or Treatment

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: ……
……
……
……
……
……

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Consent Form 4

Form for Adults who are Unable to Consent to Investigation or Treatment

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 (eg 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 should sign below to confirm agreement:

Signature: …….…… Date: ..……..…….

Name (PRINT): ……. …… Job title: …….. ……..…

Consent Form 4: Guidance to health professionals
(to be read in conjunction with consent policy)

This form should 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 should 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 should 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* (www.dh.gov.uk).

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 **mus**t 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 taking 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 take 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 interests 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 should not be involved in their care, or unless the urgency of their situation prevents it, you should 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 should 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 PVS 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 interests.

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Consent Form 5

Consent to photograph / video recording

I give my permission for a photograph*/video* of:

Name: …….. **Date of Birth:** …….

Address: …….

…….

…….

Telephone Number: …….

to be taken and used for assessment* / examination* / treatment* / display* / publication* / training* / research* purpose(s) *(* Please delete as appropriate)*

The use of this photograph/video has been fully explained to me.

I consent for this photograph/video to be used indefinitely* / or until expiry date: ……..* *(* Please delete as appropriate)*

I understand that when the photograph/video reaches its expiry date it will be destroyed and no longer used.

However I understand that it may not be possible to destroy or withdraw those recordings that I have consented to be used and held in the public domain.

When the photograph/video is kept as part of the clinical record, it will be stored in a secure area in accordance with the Trust's Records Management Policy

I am the Patient*/ Person with parental responsibility**(* Please delete as appropriate)*

Signature: …….. **Date:** …….

Name: (PRINT) …….

Statement of health professional (to be filled in by health professional photographing or videoing the patient)

I have explained each individual section outlined in the Trust's Policy for Consent to Examination or Treatment to the patient and they understand the whole procedure.

Signature of health professional

Signature: …… **Date:** ……

Name: (PRINT) …… **Job title:** ……

TO BE RETAINED IN THE PATIENT'S NOTES

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Patient Consent to Decline Clinical Advice

This form is to be used if patient's do not wish to comply with treatment or advice recommended by a healthcare professional

I, the undersigned, confirm that I have had the risks and benefits explained to me of the following treatment or procedure:

I do not wish to comply with the recommendation that:

Signature ……Date: ……..

Name (Print): ……

If the patient involved in the treatment or procedure is a child or an adult who has been brought for treatment by another adult:

Name of Patient: ……..

Relationship to Patient: ……..

Date: ……

Healthcare Professional Details:

Signature …… Date: ……..

Name (Print): …… Job Title: ……..

TO BE RETAINED IN THE PATIENT'S NOTES

Appendix 7

Standards framework for shared-decision-making support tools, including patient decision aids

Essential standards

Health condition, decision and available options

Details of the available options

Support for the person's values, circumstances and preferences

Use of language and numbers

For patient decision aids that include screening and diagnostic tests

Formats and availability of patient decision aids aimed at patients

Evidence sources

Patient involvement and co-production

Neutral presentation of risks and benefits

Review cycle and declaration of interests

Enhanced standards, additional to essential standards

Experience of treatments

Presentation of data

Field testing and validation with users

Equality, diversity and health inequalities

For further details of the standards, see NICE's standards framework for shared-decision-making support tools, including patient decision aids.