



SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

CLINICAL SERVICES POLICY & PROCEDURE (CSPP No.21)

CONSENT POLICY & PROCEDURE

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**SOUTH CENTRAL AMBULANCE
SERVICE NHS FOUNDATION TRUST**

**CONSENT
POLICY AND PROCEDURE**

1. Introduction

1.1 The Department of Health has issued a range of guidance documents on consent, and these should be consulted for details of the law and good practice on seeking and gaining consent. This policy sets out the standards expected and procedures to be followed, which aim to ensure that health professionals/health assistants are able to comply with the guidance. This policy is for all staff that provides care to patients, irrespective of the route by which they came into contact with them and covers emergency and urgent care/treatment, 111 consultation, and PTS transport.

2. Policy Statement

2.1 The Trust Board of South Central Ambulance Service NHS Foundation Trust recognise and accept its responsibilities to ensure that patient consent to examination and treatment is sought and gained from patients by all staff that have contact with patients irrespective of the medium of contact or which branch of the organisation they work in. The organisation accepts that patients have a right to consent, refuse to consent or withdraw consent at any time in line with the published legal and ethical guidelines.

3. Scope of the Policy

3.1 This policy defines the standards expected and the procedures to be followed by all South Central Ambulance Service NHS Foundation Trust staff when seeking or gaining patient consent for examination, treatment, consultation and transportation. The content of this policy applies to all staff that provides care to patients, irrespective of the route by which they come into contact with them and covers emergency and urgent care/treatment, 111 consultation, and PTS transport. This policy does not address patient consent in relation to media, publication of investigations of complaints/concerns or the sharing of information.

4. Duties

4.1 Executive Director of Quality and Patient Care

The Executive Director of Quality and Patient Care has Board level responsibility for consent within South Central Ambulance Service NHS Foundation Trust.

4.2 Assistant Director of Patient Care

The Assistant Director of Patient Care has senior management responsibility for consent. The role also has a co-ordinating function between departments to ensure the effectiveness of the policy.

4.3 Patient Safety Group

The Patient Safety Group will assess the effectiveness of the policy and provide a gap analysis and action plans for the Quality and Safety Committee to monitor.

4.4 Quality and Safety Committee

The Quality and Safety Committee will monitor compliance with this policy within the Trusts clinical governance structure on behalf of the Trust Board.

4.5 Area Managers/ Emergency Service Managers/Team leaders, Shift Managers and Contract Managers.

It is the responsibility of all Area Managers, Emergency Services Managers, Team Leaders, Shift Managers and Contract Managers to ensure that this procedure is adhered to by the staff under their line management.

4.6 All Staff

The Healthcare professional carrying out the procedure or consultation by CSD or 111 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. Healthcare Assistants must ensure that the patient consents to transport.

Accurately documenting the consent process where necessary, e.g., recording consent on the Patient Clinical Record and if consent changes at any time during examination or treatment.

All staff have a duty to comply with this policy, clinicians will be expected to follow this policy and procedure and accurately complete patient clinical records as evidence that consent has been sought and gained prior to examination or treatment.

All staff have a duty to ensure that they familiarise themselves with guidance issued by the Department of Health, NHS England and any guidance on consent issued by their own regulatory bodies.

5. Definitions

5.1 Mental capacity

Is, broadly speaking, the ability of an individual to make decisions regarding specific elements of their life. It is also sometimes referred to as “competence” and is always decision and time specific

5.2 Capacity

Is not an absolute concept, different degrees of capacity are required for different decisions, with the level of competence required increasing with the complexity of the decision.

5.3 Consent

Is the voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of the purpose, nature and likely effects and risks of that intervention; including the likelihood of its success and any alternatives to it. Permission given under any undue or unfair pressure is not consent.

Since October 2007, “Personal Welfare” Lasting Powers of Attorney will enable appointed attorneys to make a number of decisions about a person’s life, when that person loses capacity to do so. This may include the power to give or refuse consent to medical examination and / or treatment.

6. Deviation from the advice and guidance given within this policy

Should there be a need to deviate from the guidance contained in this policy then that decision must be documented on the patient clinical record, given the comprehensive nature of this policy it is strongly advised that staff contact the Clinical Support Desk in EOC if further guidance is required.

7. Mental Capacity Act 2005

The Mental Capacity Act 2005 (MCA) applies to those aged 16 years, or over, in England and Wales. Children and young people under the age of 16 are protected by the Children Act 1989.

Mental capacity is central to giving or withholding consent for treatment (except in circumstances where a person has been detained under the Mental Health Act 1983); it is the ability to make a decision at the time the decision needs to be made, and is always decision and time specific. The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with the MCA when making decisions or acting for that person, when the person lacks the capacity to make a

particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

An assessment of capacity should be completed in **all** situations where doubts arise about the patient's ability to give/withhold informed consent. This should be completed in line with the MCA Five Principles and the current SCAS MCA Policy (CSPP 16 Mental Capacity).

MCA Five Statutory Principles:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

8 Summary of Guidance on consent

This guidance is designed to clarify roles and responsibilities of Trust staff in relation to consent or refusal to examination or treatment.

8.1. Gaining Consent

- 8.1.1 "Consent" is a patient's agreement for a health professional/ health assistant to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must be competent to take the particular decision, have received sufficient information to take it and not be acting under duress.
- 8.1.2. Gaining the consent of a patient to examination, treatment, consultation or transport will most often happen as a natural progression of the interaction of staff with the patient. However, staff must never assume that the patient will consent to examination, treatment, consultation or transport, even if they have called for our assistance. Staff must ensure a full discussion takes place with the patient, a course of action is agreed and that these decisions and actions are fully documented. The staff must respect the patient's wishes and needs throughout this process and always bear in mind that the patient is entitled to withdraw consent at any time.

8.2. Actions to take if consent to examination or treatment is refused

- 8.2.1. It is not uncommon in pre-hospital situations for patients to refuse care, treatment, consultation or transportation. Although patients may refuse, there is still, in certain circumstances, an on-going duty of care and therefore a legal responsibility for Trust staff to try and provide further care. This may be via friends / relatives or carers, or via other agencies such as Social Services.
- 8.2.2. If a patient refuses examination, treatment, consultation or transport against the advice of Trust staff, then consider if a mental capacity act assessment should be completed to assess whether the patient has capacity to make this decision
- 8.2.3. If a patient with capacity is refusing treatment, consultation or transport the crew may be acting unlawfully if they continue against their wishes. In these circumstances this must be recorded on the patient clinical record including a summary of all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative, a friend or the Clinical Support Desk. Staff should notify the Emergency Operations Centre (EOC)/ PTS Operations Centre (OC) of their actions. EOC/ PTS OC staff must record this in the relevant electronic call log.
- 8.2.4. Where a patient who does not have capacity is refusing treatment, the health professional/health assistant must consider the consequences of the patient not receiving treatment, consultation or transport and must consider the least restrictive approach to meeting the assessed need. The healthcare professional/health assistant should always act in the patient's best interests when the patient lacks capacity to make the decision needed, regardless of the urgency of intervention Healthcare professional/health assistant and patient safety must be paramount in this decision. Occasionally the police may be of assistance but lack of capacity does not automatically mean that the police should be called.
- 8.2.5. In these circumstances they must document fully and carefully on the patient clinical record, all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative, a friend or the Clinical Support desk. Unless the patient has appointed a personal welfare lasting power of attorney, or the Court has appointed a personal welfare deputy who has the authority to consent to the specific treatment proposed, no-one else can give consent on behalf of such a patient. They may only be treated if that treatment is believed to be in their "best interests".
- 8.2.6. Where a patient is deemed not to have capacity, the police may also be of assistance if a breach of the peace, or other unlawful act, is likely to take place. However, in these cases all parties on scene have a duty to ensure the patient receives the best possible care and treatment. Consideration must be given as to whether the proposed

treatment or course of action could be carried out as effectively in a way that is less restrictive of the patient's rights and freedom of action.

8.3. Assessment of capacity for examination or treatment without consent

- 8.3.1. This assessment within the patient clinical record is intended to be used where a patient is refusing to be treated and doubts have arisen about their capacity to do so but in the opinion of the member of staff, the patient is in need of urgent treatment. This will therefore mean that the staff member will be treating the patient without their explicit consent. Whilst this is in fact permissible in certain circumstances, the staff member must be able to justify all their reasoning, actions and treatments. Health professional/health assistant and patient safety should be a consideration at all times.
- 8.3.2. The patient clinical record has been devised to assist staff in both the reasoning process and the need to document decisions and actions in these difficult circumstances. It is understood that staff may not be able to complete the form as the process develops, but, it must be completed as soon as is practically possible.
- 8.3.3. To reach a decision on whether you will need to treat a patient without their consent you must first decide if the patient has capacity. Within the patient clinical record there is a tool "capacity to consent" for this purpose. Use the Mental Capacity Act 2005 Assessment Form CAS150 V2.3 or the Electronic Patient record (ePR) to record each assessment.
- 8.3.4. This section of the patient clinical record should be completed in all cases where there are concerns that the patient lacks the capacity to consent.
- 8.3.5. A copy of the appropriately completed patient clinical record should be sent to the GP in all cases where treatment was commenced without consent.

8.4. Advance Decisions

- 8.4.1. An Advance Decision is an oral or written decision made by an adult with capacity to make the decision, that if:
 - At a later time in specific circumstances a specified treatment is proposed by a health professional;And
 - The patient lacks capacity to consent to the carrying out of that treatment;
- 8.4.2. If an advanced decision is in place and valid the specified treatment should not be carried out or continued. Where the Advance Decision relates to life sustaining treatment then specific criteria must be met as set out in CSPP 3 Resuscitation Policy section 13.4 (page 14)

- 8.4.3. Advance Decisions must be respected – see CSPP 3 Resuscitation Policy section 13.4 (page 14). An advance refusal of treatment will be binding where:
- 8.4.4. At the time it was made the patient had the capacity to make it.
- 8.4.5. The circumstances that have arisen are the circumstances that were contemplated when the advance decision was made.
- 8.4.6. At the time the advance decision was made, there was no duress on the patient.
- 8.4.7. In order to ascertain the validity of an advance decision, clarification may need to be sought from either the patient's GP, the clinician involved in that aspect of the patient's care, or any person (if any) named in the decision, which may include the patient's solicitor. Where there is real doubt over the validity of an advance decision and any delay in treating and/or transferring the patient is likely to lead to a significant or irreversible deterioration on health, then staff should do what is practicable in order to treat/transfer the patient having consulted with EOC/PTS OC. Where doubt exists as to the validity of an advance decision, treatment must be continued until the patient is able to discuss their current treatment wishes. However, only that treatment, which is immediately necessary and in the patient's best interests should be provided.

9. Detailed guidance on consent

9.1. 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. 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.

9.2. What consent is – and isn't

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

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

9.2.2. The context of consent can take many different forms, ranging from the active request by a patient for 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.

- 9.2.3. Where an adult patient lacks the mental capacity to give or withhold consent for themselves at the time of contact with the South Central Ambulance Service NHS Foundation Trust, unless the patient has appointed a personal welfare Lasting Power of Attorney, or the Court has appointed a personal welfare deputy who has the authority to consent to the specific treatment proposed, **no-one else can give consent on their behalf**. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance decision. For further details on advance decisions see the Department of Health's *Reference guide to consent for examination or treatment* (chapter 1, paragraphs 47 -52 19) and CSPP 3 Resuscitation Policy section 13.4 (page 14)

9.3. Documents with guidance on consent

- 9.3.1. 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, (such as the Health Care Professions Council's Code of Conduct, Performance and Ethics).
- 9.3.2. 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. Copies are available on the internet at www.doh.gov.uk/consent
- 9.3.3. 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 on the internet at www.doh.gov.uk/consent.

9.4. Gaining, Recording and Documenting Consent

- 9.4.1. Consent is often wrongly equated when consent obtained is indicated on the patient clinical record. An indication on the patient

clinical record is *evidence* that the patient has given consent, but it is not *proof* of valid consent. If a patient is rushed into agreeing, on the basis of too little information, the consent may not be valid, despite it being recorded. Similarly, if a patient has given valid verbal or implied consent, the fact that they are physically unable to sign a form is no bar to treatment. Patients may, if they wish, withdraw consent after they have given it; the agreed consent obtained is not a binding contract. It is vital, therefore that the process leading to the patient's consent or refusal should be carefully and fully recorded, including any advice given.

- 9.4.2. Whilst written consent will rarely be an absolute legal requirement it is good practice to do so especially if the treatment is part of a project or programme of research approved by the South Central Ambulance Service NHS Foundation Trust.

9.5. Refusal of Treatment

- 9.5.1. If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. An adult patient, who has capacity to make the decision required at the time of needs to be made, 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.
- 9.5.2. If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented on the patient clinical record. If the patient has already agreed to consent, but then changes their mind, you (and, where possible, the patient) should note this on the patient clinical record.
- 9.5.3. 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.
- 9.5.4. 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.

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

9.6.1. Considerations about a patient's capacity must be guided by the five basic principles contained in the Mental Capacity Act 2005:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act done, or a decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before an act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

9.6.2. Any intervention must also depend on a physical assessment, which considers the likelihood of the imminent risk to the person of loss of life or limb. If it is felt that, without immediate treatment, there would be a significant or irreversible deterioration in health, South Central Ambulance Service NHS Foundation Trust has a duty to intervene safely and provide care in the person's best interests.

9.6.3. If the incident is less serious and patient care can be provided on scene by alternative measures, forced removal is inappropriate.

9.6.4. Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented on the patient clinical record. This will include an 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.

9.6.5. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than a genuine lack of capacity. You should involve appropriate colleagues in making such assessments of capacity, such as specialist learning disability teams, speech and language therapists or translation and interpreting services 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.

- 9.6.6. Occasionally, there will not be a consensus on whether a particular treatment is in the best interests of an adult lacking capacity. Where the consequences of having, or not having, the treatment is potentially serious, a court declaration may be sought.

9.7. Availability of patient clinical records

A patient clinical record is to be completed for all patients if the ePR fails or there are no cas 101's available a cas 102 continuation sheet should be used. An accurate record should be completed at the time of the incident in all cases.

9.8. Gaining consent in straightforward situations.

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

- 9.8.2 If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must consider whether the patient has had sufficient opportunity to absorb the information necessary for them to make their decision. As long as it is clear that the patient had capacity and consents, the health professional may then proceed. This simple process will be most applicable to front line Ambulance staff.

9.9. More complex discussions.

In more complex 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 involved at the provision of information, discussion of options and an initial (oral) decision, followed by a confirmation that the patient still wants to go ahead. The consent section of the patient clinical record should be used as a means of documenting the whole process as well as the patient's confirmation. When confirming the patient's consent and understanding, it is advisable to use open questions which require 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?"

9.10. Emergencies

Clearly in emergencies, discussion of options and confirmation that the patient wishes to go ahead will follow straight on from each

other, and it is appropriate to use the patient clinical record to document any discussion and the patient's consent, The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.

9.11. Conveying patients:

South Central Ambulance Service NHS Foundation Trust's CSPP 7 Care Pathway Policy gives guidance on conveyance decisions and alternative referral pathways.

9.12. Treatment of children

9.12.1 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. If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

9.12.2 When babies or young children are being cared for, it will not usually seem practicable to seek their parents' consent for every routine intervention. However, you should remember that, in law, such consent is required. 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.

9.12.3 Critical situations involving children and young person's which constitute a life threatening emergency may arise when it is impossible to consult a person with parental responsibility, or if they refuse consent. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable for all carers to undertake treatment to preserve life or prevent serious damage to health.

9.12.4 Children under the age of 16, who can fully understand what is proposed, also have the capacity to consent to, or refuse, an intervention. This means that the level of capacity of children varies with the complexity of the treatment/refusal and its consequences. There is no particular age when a child gains capacity to consent or refusal. In some situations, although the consequences of non-treatment may be evident, these must be fully explained to ensure that the child fully understands the consequences of refusal.

9.12.5 As is the case where patients are giving consent for themselves, those giving consent on behalf of children must have the capacity to consent to the intervention in question, be acting voluntarily, and be appropriately informed and be acting in the best interests of the child. If neither the child nor the person with parental responsibility has capacity, staff must act in the child's best interests.

9.13. Provision of Information

- 9.13.1. The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen next.
- 9.13.2. 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.

9.14. Provision for patients whose first language is not English

- 9.14.1. South Central Ambulance Service 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. All staff have access to interpreting services and multi-lingual phrasebooks. Other specific advice can be sought from the Equality and Diversity Lead based at South Central Ambulance Service NHS Foundation Trust's headquarters.
- 9.14.2. It is not appropriate to use children to interpret for family members who do not speak English, or for an adult family member to interpret for a child who does not speak English.

9.15. Access to more detailed or specialist information

Patients may sometimes request more detailed information about their condition. This information could be provided by access to the 111 service or the Clinical Support Desk.

9.16. Who is responsible for seeking consent?

- 9.16.1. The member of staff 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.

9.16.2. Where oral or non-verbal consent is being sought prior to the initiation of the procedure, naturally this will be done by the member of staff responsible. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

9.17. Competency to gain consent

9.17.1. It is the member of staff's own responsibility to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and to work within their own competence and not to agree to perform tasks which exceed that competence.

9.17.2. If you feel that you are being pressurised to seek consent when you do not feel competent to do so, seek advice from Clinical Support Desk.

9.18. Clinical Photography and Conventional or Digital Video Recordings

9.18.1. 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, staff should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

9.18.2. 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.

9.18.3. 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 in the media.

9.18.4. 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. 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.

9.18.5. 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.

9.18.6. 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 someone 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.

10 Monitoring

10.1 The Policy will be monitored for its effectiveness by the Head of Clinical Excellence through the following:

- Responsibilities of staff will be monitored through attendance at meetings, management of systems, development of reports and the appraisal process.
- Consent will be monitored by the Clinical Effectiveness Department and a report produced bi-annually to the Quality and Safety Committee covering:
 - Compliance with procedure;
- an audit of clinical record completion will be carried out bi-annually to ensure compliance by minimum completion where appropriate of:
 - Consent recorded on the Patient Clinical Record;

10.2 These will be conducted on a bi-annual basis and reports provided to the Clinical Review Group and Quality and Safety Committee.

11 Other references

Data Protection Policy
Care Pathways Policy
Resuscitation Policy
Child and Vulnerable Adult Protection Policy
MCA Policy

Appendix 1

Frequently asked question on consent

Frequently Asked Questions (Key Points on Consent)

1. When do staff need consent from patients?

1.1. Before you examine, treat or care for patients with capacity you must obtain their consent, unless they lack the capacity to consent to the proposed course of action. You must be guided by the circumstances existing at the time when deciding how you will best be able to record the decision on the patient clinical record.

1.2. A consideration that must be taken into account is the time taken to explain and complete the form(s), against the imperative for examination, treatment or action existing at the time.

1.3. The patient clinical record is specifically designed to aid the assessment of a patient's capacity and also as a record that a comprehensive capacity assessment has been undertaken. The patient clinical record should be completed where the attending ambulance professional has any doubt about a patient's capacity to consent or refuse. The patient clinical record should also be used to guide the assessment of capacity, and to document any intervention that is taken in the patients best interests if they are deemed to lack capacity. It is also recommended that the patient clinical record is completed for patients who have capacity but are refusing treatment against advice with the potential outcome having a detrimental effect of their health.

1.4. Adults are always assumed to have capacity unless demonstrated otherwise. If you have doubts about their capacity, the question to ask is: "can this patient understand and weigh up the information needed to make this specific decision?" Unconventional decisions, or decisions that may appear unwise to others, do not prove that the patient lacks capacity, but may indicate a need for further information or explanation.

1.5. Patients may have capacity to make some health care decisions, even if they lack it to make others.

1.6. 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.

2. Can children consent for themselves?

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

3. Who is the right person to seek consent?

3.1. 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.

4. What information should be provided to the patient?

4.1. 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.

5. Is the patient's consent voluntary?

5.1. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

6. Does it matter how the patient gives consent?

6.1. Consent can be written, oral or non- verbal. A signature itself does not prove the consent is valid – the most important point is to record the patient's decision and the discussions that have taken place.

7. Who can refuse consent to treatment?

7.1. Adult patients with capacity are entitled to refuse treatment, even where the treatment 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. For example a pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

8. What about adults who lack capacity to give consent?

8.1. **No one** can give consent on behalf of an adult who lacks capacity, unless that person holds a valid "Personal Welfare" Lasting Power of Attorney or has been appointed as a deputy by the Court of Protection and has been given the authority to make that specific decision. However, you may still treat such a patient if the treatment would be in their best interests. "Best interests" are wider than best medical interests and includes factors such as their past and present wishes and beliefs, their general wellbeing 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 an enduring condition that may have prevented them from expressing their own wishes and feelings relatives, carers and friends may be best placed to advise on the patient's needs and preferences and should be consulted, if practical and appropriate.

8.2. If a patient who lacks capacity has clearly indicated in the past, while they had capacity, that they would refuse treatment in certain circumstances (an

“advance decision”), and those circumstances arise, you must abide by that refusal.

8.3. This summary does not cover all situations. For more detail, consult the detailed policy on consent CSPP 21 Consent Policy.

9. How do we record decisions regarding consent?

9.1. Staff must ensure that decisions regarding consent are documented using the patient clinical record.

9.2. It cannot be stressed enough that where consent to treatment is withheld or subsequently withdrawn, having been previously given, that this must be documented on the patient clinical record.

9.3. All staff must ensure that they have with them at all times whilst on duty the ability to document consent decisions.