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CHEC

CONSENT POLICY

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1. INTRODUCTION

1.1 The purpose of this policy is to set out Community Health and Eyecare Limited's overall approach to consent and the way in which the principles of consent will be put into practice.

1.2 Where possible a clinician must be satisfied that a patient understands and consents to a proposed treatment, immunisation or investigation.

1.3 This will include the nature, purpose and risks of the procedure, if necessary, by the use of drawings, interpreters, videos or other means to ensure that the patient understands and has enough information to give 'Informed Consent'.

1.4 Patients have a fundamental legal and ethical right to determine what happens to their own bodies and healthcare information. Valid consent to treatment is therefore absolutely central in all forms of healthcare from providing personal care to undertaking major surgery.

1.5 'Consent' is a patient's agreement for a health professional 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 appropriate information to take it
- Not be acting under duress

1.6 The context of consent can take many different forms ranging from the active request by a patient of a particular treatment (which may not be appropriate or available) to the passive acceptance of a health professional's advice.

1.7 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.

1.8 Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments.

1.9 Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, currently no one else can give consent on their behalf unless the patient has a Personal Welfare Attorney1.10 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.

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1.11 Adults shall be deemed to have mental capacity to consent if all the following four criteria are present:

- Understand the nature, purpose and reasonably foreseeable consequences of the proposed procedure and
- Retain information relevant to the decision and
- Use or weigh the necessary information to arrive at a choice and
- Communicate that decision (whether by talking, using sign language or by any other means).

2. LEGAL AND PROFESSIONAL FRAMEWORK

2.1 Common Law

There is no statute setting out principles of consent in England. Practitioners must be mindful of case law/common law when seeking consent to examination, investigation or treatment.

2.2 The following key points highlighted in recent decisions must be noted:

- Consent must be obtained before starting treatment or physical intervention or providing personal care for a person.
- Touching a patient without valid consent may constitute the criminal offence of battery.
- Patients should be told of any possible significant adverse outcomes of a proposed treatment. This includes a small but well-established risk of a serious adverse outcome.
- The fact that a person has a mental illness does not automatically mean they lack capacity to make a decision about medical treatment.
- An individual's capacity to make particular decisions may fluctuate or be temporarily affected by factors such as pain, fear, confusion or the effects of medication.
- A competent patient has the right to refuse treatment and their refusal must be respected, even if it will result in their death.
- Patients cannot lawfully be detained and compulsorily treated for a physical condition under the terms of the Mental Health Act.
- A patient's consent to a particular treatment will not be valid if it is given under pressure or duress exerted by another person.
- Doctors are under no legal or ethical obligation to agree to a patient's request for treatment if they consider the treatment is not in the patient's interests.

2.3 Mental Capacity Act 2005

The legal framework for making treatment decisions in people who are unable to make decisions for themselves is set out in the Mental Capacity Act 2005. The fundamental test to determine whether a person has capacity to make a specific decision is:

- The person can understand the information they are being told and
- The person retains that information for long enough to make the decision and
- The person uses or weighs that information and communicates their decision.

2.4 If the person cannot do any of the four stages above the next stage is to evidence why their inability is *because of* an impairment or disturbance of the mind or brain such as dementia or learning disability.

2.5 A patient may have capacity to make one decision (e.g. to have an eye examination) but lack capacity to make other decisions (i.e. cataract surgery).

2.6 **Young people aged 16 or 17**
Section 8 of the Family Law Reform Act 1969 sets out that people aged 16 or 17 are presumed capable of consenting to their own medical treatment.

2.7 However, their refusal of treatment may be overridden by a person with parental responsibility or the court. The refusal of treatment may be overridden in cases where:

- Refusal of treatment will lead to death or severe permanent injury.
- Or if there is an imminent risk that the young person will suffer grave and irreversible mental or physical harm.

2.8 The provisions of the Mental Capacity Act also apply to this age group.

2.9 If a 16 or 17-year-old is capable of giving valid consent there is no further legal requirements to obtain consent from a person with parental responsibility, however this would be good practice.

2.10 **General Medical Council guidance**
The professional guidance published by the GMC is set out in 'Consent: patients and doctors making decisions together'. Doctors must follow this guidance in their practice.

2.11 **Nursing and Midwifery Council guidance**
Section 2 of the NMC code sets out the professional standards required by Registered Nurses and Midwives in their approach to consent.

3. GENERAL CONSENT GUIDELINES

3.1 Implied consent

Implied consent means that consent can be assumed if a patient has mental capacity. An example of implied consent is that a patient holds their arm out to apply a blood pressure cuff prior to taking a blood pressure measurement. Implied consent will be assumed for many routine physical contacts with patients. Where implied consent is to be assumed by the clinician, in all cases, the following will apply:

- An explanation will be given to the patient what he/she is about to do and why.
- The explanation will be sufficient for the patient to understand the procedure.
- In all cases where the patient is under 18 years of age a verbal confirmation of consent will be obtained and briefly entered into the medical record.
- Where there is a significant risk to the patient an 'Expressed Consent' will be obtained in all cases (see below).

3.2 Expressed consent

Expressed consent (written or verbal) will be obtained for any procedure which carries a risk that the patient is likely to consider as being substantial. A note will be made in the medical record detailing the discussion about the consent and the risks. A consent form may be used for the patient to express consent.

3.2.1 Written consent should be sought in the following circumstances:

- Where the treatment or procedure is complex or involves significant risks.
- Where the treatment or procedure requires anaesthesia or sedation.
- Where providing health or social care is not the primary purpose of the procedure.
- Where there may be significant consequences for the service user's employment, social or personal life.
- Where consent is required by a regulatory body.

3.2.2 Completed written consent forms must be retained with the patient's records.

3.3 Obtaining consent

- Consent (implied or expressed) will be obtained prior to the procedure and prior to any form of sedation.
- The clinician will ensure that the patient is competent to provide a consent (16 years or over) or has 'Gillick Competence' if under 16 years. Further information about Gillick Competence and obtaining consent for children is set out below.
- Consent will include the provision of all information relevant to the treatment.
- Questions posted by the patient will be answered honestly and information necessary for the informed decision will not be withheld unless there is a specific reason to withhold. In all cases where information is withheld then the decision will be recorded in the clinical record.
- The person obtaining the consent will be fully qualified and will be knowledgeable about the procedure and the associated risks.
- The scope of the authority provided by the patient will not be exceeded unless in an emergency.
- The patient has a right to refuse consent, delay the consent, seek further information, limit the consent or ask for a chaperone.
- Clinicians will use a consent form where procedures carry a degree of risk or where for other reasons, they consider it appropriate to do so (e.g. malicious patients).
- No alterations will be made to a consent form once it has been signed by a patient.
- Clinicians will ensure that consents are freely given and not under duress (e.g. under pressure from other present family members, etc).
- If a patient is mentally competent to give consent but is physically unable to sign the consent form the clinician should complete the form as usual and ask an independent witness to confirm that the patient has given consent orally or non-verbally.
- Where a procedure is a major procedure or involves anaesthesia or sedation the process of obtaining consent must be started either on a pre-assessment appointment or at the appointment where a decision is made to provide this treatment to the patient.
- The issue of consent must not be raised for the first time on the day of the procedure where the procedure requires anaesthesia or sedation.
- Where there are concerns that a patient is being coerced into consent please raise your concerns with your line manager.

3.3.1 Other aspects which may be explained by the clinician include:

- Details of the diagnosis, prognosis and implications if the condition is left untreated.
- Options for treatment including the option not to treat.

- Details of any subsidiary treatments (e.g. pain relief).
- Patient experiences during and after the treatment including common or potential side effects and the recovery process.
- Probability of success and the possibility of further treatments.
- The option of a second opinion.

3.4 **Written consent**

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

- The treatment or procedure is complex or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications').
- The procedure involves general/regional anaesthesia or sedation.
- Providing clinical care is not the primary purpose of the procedure.
- There may be significant consequences for the patient's employment, social or personal life or effects on the patient's appearance.

3.4.1 The written consent must be documented on the consent form.

3.4.2 The health professional carrying out the procedure retains ultimate responsibility for seeking consent. If another member of the team seeks consent the health professional carrying out the procedure must ensure that consent has been taken properly.

3.4.3 For interventional procedures it is CHEC Policy that consent will only be obtained by a qualified medical practitioner.

3.5 **Mental Capacity Act (2005)**

The Mental Capacity Act (2005) provides a statutory framework that details how vulnerable people can be empowered to make their own decisions. It rests on the following key principles:

- Presumption of capacity
- Right to be supported to make your own decisions
- Individuals retain the right to make what might be seen as eccentric or unwise decisions
- Best interests.
- Least restrictive intervention

3.5.1 The Act deals with the assessment of capacity and acts by carers who lack capacity. The decision that an individual lacks capacity is specific to the particular decision and the particular time. If an individual is deemed to lack capacity, everything that will be done on behalf of that individual must be in their best interests.

3.6 **Patients lacking capacity**

The health professional responsible for carrying out the procedure is ultimately responsible for ensuring that an assessment of capacity has been made and that it is appropriate to carry out the treatment or procedure in the best interests of the patient.

3.6.1 This best interest's assessment is set out in law and is a statutory requirement under section 4 of the Mental Capacity Act 2005.

3.6.2 The health professional should seek advice3 from a senior colleague or a Professional Indemnity Insurer if there is any uncertainty about any of these matters.

3.6.3 Where an adult patient does not have the capacity to give or withhold consent to any intervention, this fact should be documented along within the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests and the involvement of people close to the patient.

3.6.4 Standard consent forms should never be used for adult patients unable to consent for themselves.

3.6.5 It should be noted than an apparent lack of capacity may in fact be due to communication difficulties. All efforts must be made to resolve these difficulties, potentially including involvement of specialist teams, such as the Learning Difficulties team or Speech and Language Therapists.

3.7 **Advance decisions**

People who have capacity can state which treatment they wish to refuse in an advance decision.

3.7.1 This is only to be followed if they lack capacity as long as it is valid and applicable to the proposed treatment.

3.7.2 This can be a written or verbal statement, signed printed card or records of a discussion in a patient's file.

3.7.3 Decisions must comply with the provisions of the Mental Capacity Act 2005.

3.7.4 The following information must be documented on the relevant assessment form when making an assessment of capacity and decision to proceed with treatment in the patient's best interests:

- The decision to be taken
- An assessment of capacity:

- Details of the impairment or disturbance in the functioning of the person's mind or brain
- Whether the impairment or disturbance is permanent, fluctuating or temporary
- Whether the patient is able to understand information related to the decision
- Whether they are able to retain information related to the decision
- Whether they are able to use or weigh information whilst considering the decision
- Whether they are able to communicate the decision by any means
- Steps taken to maximise the patient's capacity to make the decision
- Whether the decision can be delayed as the patient is likely to retain capacity in the near future
- Is one in place?
- What the decision was
- Is the decision applicable?

3.7.5 Best interests determination, the following must be considered:

- Relevant information – consider all relevant circumstances (diagnoses, history, emotional and psychological factors, etc).
- The Persons beliefs, past and present wishes, feelings and statements.
- Consult as practicable and appropriate people who have an interest in the welfare of the person.
- Less restrictive option: Consider if there are less restrictive options in terms of the person's rights and freedom of action.
- Can you wait? – consider if the person will have capacity sometime in the near future in relation to the matter.
- Involve – as far as reasonably practicable encourage and permit the person to participate.
- Do not discriminate; do not base the decisions solely on age, appearance, behaviour or condition.
- Discussed all alternatives.
- Final decision reached.
- If this information is documented on a written rather than a computer record, it must be signed, dated and timed.

4. DEPRAVATION OF LIBERTY SAFEGUARDS

4.1 The safeguards should ensure that a care home or hospital only deprives someone of their liberty in a safe and correct way and that this is only done when it is in the best interests of the person and there is no other way to look after them.

4.2 The safeguards apply to vulnerable people aged 18 or over who have a mental disorder (this includes dementia), who are in hospitals or care homes and who do not have the mental capacity (ability) to make decisions about their residence.

4.3 A deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave and the person lacks capacity to consent to these arrangements'.

4.4 The key elements of the safeguards are:

- To provide the person with a representative
- To give the person (or their representative) the right to challenge a deprivation of liberty through the Court of Protection
- To provide a mechanism for deprivation of liberty to be reviewed and monitored regularly

4.5 There have been several test cases in the European Court of Human Rights and in the UK that have clarified which situations may constitute a deprivation of liberty:

- A patient being restrained in order to admit them to hospital.
- Medication being given against a person's will.
- Staff having complete control over a patient's care or movements for a long period.
- Staff making all decisions about a patient, including choices about assessments, treatment and visitors.
- Staff refusing to discharge a person into the care of others.
- Staff restricting a person's access to their friends or family.

4.6 Following application for a DOLS the decision will be taken by a supervisory body as to whether to apply the DOLS or not.

5. INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCA)

5.1 IMCA is statutory advocacy introduced by the Mental Capacity Act 2005 (Act).

5.2 The Act gives some people who lack capacity a right to receive support from an IMCA. Local Authorities have commissioned IMCA services in England and Local Health Board have commissioned them in Wales.

5.3 Responsible bodies, the NHS and Local Authorities all have a duty to make sure that IMCAs are available to represent people who lack capacity to make specific decision, so staff affected will need to know when an IMCA must be involved.

5.4 IMCA services are provided by organisations that are independent from the NHS and Local Authorities.

5.5 Any patient who needs support to express their views and wishes, secure their rights, have their interests represented, access information and services and explore choices and options can be referred to an IMCA.

5.6 A person accessing advocacy could be someone with learning difficulties or an older person with dementia.

5.7 Where eligibility criteria are met staff have a duty under the Mental Capacity Act to instruct an IMCA. In particular, a referral should be considered where a decision is being made about serious medical treatment where there is a fine balance between risks and benefits, a choice of treatments or if the treatment proposed may involve serious consequences (such as pain, distress, side effects, major consequences) for the patient or serious impact on future life choices.

6. MENTAL HEALTH ACT 1983

6.1 The Mental Health Act allows for the detention and treatment of mental disorders if the lack of treatment could lead to harm to either the patient, or to others. Treatment under the Mental Health Act cannot be given for physical illness.

7. REFERENCES

INSERT REFERENCES HERE

APPENDIX A

BEST INTEREST ASSESSMENT

See Assessment of Mental Capacity Procedure

APPENDIX B

CONSENT FORM

ICP Cataract surgery edited version .pdf

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Document Owner and Approval

The (INSERT DETAILS) is the owner of this document and is responsible for ensuring that this policy is reviewed by the due date.

A current version of this document is available to members of staff on the CHEC intranet.

Change history record

Issue	Description of Change	Approval	Date of Issue
1.0	Initial issue		Unknown
2.0	Review		June 2019
3.0	Review		15 July 2020
4.0	Review		March 2023

EQUALITY IMPACT ASSESSMENT FORM

PART A - INITIAL SCREENING FORM

Section One	
Name of proposal, policy, service review or report *(referred throughout as proposal)*	**Consent Policy**
Directorate / Service carrying out the assessment	Clinical services
Name and role of person undertaking this EIA	Alison Fitzsimmons
Give an overview of the aims, objectives, and purpose of the proposal: To help support CHEC's disabled colleagues.	

Section Two

Equality Groups:	**Could the proposal have a positive impact**	**Could the proposal have a negative impact**

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People of different ages.	Yes	
People with disability (incl. sensory, mobility, mental health, learning disability, neurodiversity, long term ill health) and carers of disabled people.	Yes	
People of different Race (including culture, nationality/national origin, ethnic origin/race, skin colour).	Yes	
People of different religions & beliefs.	Yes	
People of different sexual orientation (inclusive of LGB groups) and marriage/civil partnership.	Yes	
Sex, gender and gender identity (including men, women, non-binary, lesbian, gay, bisexual and transgender people), and pregnancy and maternity.	Yes	
People experiencing multiple needs such mental health problems and or anxiety.	Yes	
Refugees and asylum seekers.	Yes	
Human Rights breaches.	Yes	

Section Three			
Is this proposal a major change in terms of scale or significance for CHEC? Is there a clear indication that, although the proposal is minor it is likely to have a major affect for people due to their protected characteristic?			
Yes		**No**	X
High risk:		Low risk:	X

Section Four
It this proposal is low risk please give evidence or justification for how you reached this decision:
This Policy is to ensure compliance with clinical risk and therefore supports all people.

Sign off that this proposal is low risk and does not require a full Equality Impact Assessment:

EAI Reviewer Signed: Alison Fitzsimmons

Date: **March 2023**