Yeovil District Hospital NHS
NHS Foundation Trust

CONSENT FOR EXAMINATION OR TREATMENT POLICY

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1. RATIONALE

Why Consent is Crucial?

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

The 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 requirements on consent. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

2. AIM

This policy sets out the standards and procedures in this Trust, which aims to ensure that health professionals are able to comply with the guidance. The aim of this policy therefore is to describe the process for managing the risks associated with consent including the following:

- Identifies the process for obtaining consent
- Identifies the forms to be used to document consent
- Details the training requirements associated with consent

This policy is to be read in conjunction with the Data Protection policy and the Safeguarding Vulnerable Adults policy.

3. DEFINITIONS

3.1 Definition of Consent: - "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:

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

The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them.

Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, Relatives cannot be asked to sign a form on behalf of an adult who lacks capacity to consent for themselves, unless they have been given the authority to do so under a Lasting Power of Attorney (Section 3.3) or as a court appointed deputy.

Treatment may be given if it is in their best interests, for instance in an emergency situation as long as it has not been refused in advance in a valid and applicable advanced directive.

For further details on advance directives see the Department of Health's *Reference guide to consent for examination or treatment. Revised 2nd edition, July 2009.* (Chapter 1, Paragraph 2, page 9).

Also, refer to the Safeguarding Vulnerable Adults policy Assessment of Capacity and Best Interests Flowchart.

3.2 Guidance on Consent

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.

Reference guide to; consent for examination or treatment (2nd Edition. July 2009) 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.

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.

3.3 Lasting Power of Attorney

The Mental Capacity Act 2005 introduces a number of changes in the way that people can plan ahead for a time when they may not have mental capacity.

The Lasting Power of Attorney (LPA) allows for the patient to nominated a person to make decisions on their behalf if they loose the mental capacity to do so themselves. There is a separate LPA for health and welfare decisions and for financial concerns.

The LPA for health and welfare decisions must be documented and allows for the person to determine what is in the patient's best interests.

4. DOCUMENTATION PROCESS FOR OBTAINING AND RECORDING CONSENT

For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussion which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's notes if necessary), or through documenting in the patient's notes that they have given verbal consent. All entries should be signed and dated clearly.

4.1 Written Consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid

consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

It is rarely a legal requirement to seek written consent, [1]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.

4.1.1 Completed Consent Forms

Completed forms should be kept with the patient's notes. Any changes to a form, made after the patient has signed the form, should be initialled and dated by both patient and health professional.

It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past); it would be helpful to do so.

4.2 Procedures to Follow when Patients Lack Capacity to Give or Withhold Consent

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

At this stage the Capacity Assessment and Best Interests flow chart within the Safeguarding Vulnerable Adults policy will guide the health professional. It is at this stage whilst using this tool that the use of an Independent Mental Capacity Advocate (IMCA) may be considered appropriate. All wards and departments are able to contact and obtain the services of an IMCA for a patient. The IMCA provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them.

[1] The Mental Capacity Act 2005

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. You should involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequence of having, or not having, the treatment is potentially serious, a court declaration may be sought. This should be done through the Senior Manager-on-call with referral to Trust approved Solicitors.

4.3 Availability of Forms

Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in **Appendix 1**, available from Wards and Departments.

- **Form 1**; for adults or competent children;
- **Form 2**; for parental consent for a child or young person; and
- **Form 3**; for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care. The use of form 3 is optional but may be thought more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decision about additional procedures because they will be in a position to make any such decisions at the time if necessary.
- **Form 4**; for adults who are unable to consent to investigation or treatment.
  To adhere to changes in Department of Health guidance and legislation contained within the Mental Capacity Act, the form for capacity assessment and **Best Interest Checklist** form should be completed in addition to Consent Form 4 to clearly document the decision making process, therefore protecting the individual rights of the patient and at the same time providing a level of protection against liability for staff.

  These are available on the Trust Intranet site under Clinical Services/Safeguarding Vulnerable Adults/ Mental Capacity Act.

5. WHEN SHOULD CONSENT BE SOUGHT

When a patient formally gives their consent to a particular intervention, this is only one section of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking consent'. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient's condition.

5.1 Single Stage Process

In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed.

5.2 Two or More Stage Process

In most cases where **written** consent is being sought, treatment options should 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 outpatient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, however, a member of the healthcare team **must** check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

5.3 Seeking Consent for Anaesthesia

Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks. However, in elective treatment it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia. The anaesthetist should ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient's notes or on the consent form.

5.4 Emergencies

Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.

5.5 The Treatment of Minors

5.5.1 Consent for procedures involving children and young people

A minor is any child or young person under the age of 18 years.

From the age of 16 years, however, healthcare professionals may reasonably assume that a young person's consent to treatment is as effective as if he or she were an adult.

A young person's ability to make decisions depends more on their ability to understand and weigh up options, than on their age.

Below 16 years, a young person may be able to consent to a specific treatment or therapeutic procedure provided that they are able to understand the nature and purpose of the treatment / procedure proposed, the consequences of the treatment, including risks and side-effects, and any available alternatives, including non-treatment. The past experiences of a child or young person are significant in determining their ability to consent; a young person is more likely to be able to fully appreciate the nature of a procedure that they have undergone many times before, than is a young person who has never been similarly treated.

If a young person is able to understand, retain, use and weigh this information, and communicate their decision to others, they may be regarded as competent to give valid consent.

Their capacity to consent may vary depending upon the nature of the treatment proposed. A young person may be judged to be competent to consent to a relatively simple procedure, or one with few consequences, but unable to similarly consent to a more complex procedure with significant consequences. Their capacity to consent may also be affected by their physical and emotional development and by changes in their health and treatment. The young person's capacity to consent must be assessed for each proposed treatment, therefore.

It is the responsibility of the treating clinicians to ensure that any young person consenting to a treatment / therapeutic procedure has the capacity to do so.

The General Medical Council has published guidance to help healthcare professionals support children and families through the consent process[2].

If a young person under 16 years is assessed as competent to consent to treatment, their decision should be respected. You should, however, encourage young people to involve their parents in making important decisions. You should also consider involving other members of the multi-disciplinary team, an independent advocate or a named or designated doctor for child protection, if their involvement would help young people in making decisions.

If a young person aged 16 or 17 years lacks the capacity to consent, a person, usually a parent, with parental responsibility can consent to treatment that is in the young person's best interests. Treatment can also be provided in the young person's best interest without parental consent, though the parents' views may be important in assessing the young person's best interests.

Children and young people should, wherever possible, be actively involved in discussions about their care, even if they are not able to make decisions on their own.

[2] 0 – 18 years: guidance for all doctors, General Medical Council (2007)

If a child lacks the capacity to consent, consent must be gained from someone with parental responsibility. This will usually be a parent. It is usually sufficient to have consent from only one parent. Not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

Once a young person is judged to be competent to consent to treatment, however, the young person's right to consent prevails over the wishes of the parent.

When babies or young children under 16 years are cared for in hospital, it may not seem practicable to seek the parents' consent for every routine intervention (e.g. blood or urine tests, x-rays etc). In law, however, such consent is required. When a child is admitted, therefore, you should discuss with their parent(s) what routine procedures may be necessary, and ensure that you have their consent in advance. This consent may be verbal consent, and should be documented. 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.

5.5.2 Refusal of Consent by a competent minor

If a competent minor (aged below 18 years) refuses to consent to treatment, doctors may legally still proceed with the treatment if consent is obtained from someone with parental responsibility, such as a parent. Consent, however, does not create an obligation to treat, and clinicians must consider the wishes of the young person in deciding how to proceed.

5.6 Clinical Research Trials

All clinical trials and research projects will have been agreed through the Trust Research Ethics Committee (REC). There will be a very structured and robust requirement for informed consent from patients and staff involved in these trials. This can involve children and adults and for specific advice please refer to the Research and Development department.

6. PROVISION OF INFORMATION

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: where to go, how long they will be in hospital, how they will feel afterwards and so on.

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 in the patients notes.

The provision of information to support the consent process should be documented by the person taking consent. Patient Information leaflets are available via the Trust Intranet; the individual form used should be recorded on the consent form and/or recorded in the patients notes when used to support the process.

In addition:

- The PALS service can be contacted on extension 4706 and can give support to patients through the consent and information process to liaise between clinical teams and individuals.

- The Clinical Governance Directorate can provide further advice and support and can be contacted on Extension 4291 (Mon-Fri) Out of hours the Clinical Site Manager and/or On-Call Manager will provide advice and support.

- An Acute Learning Disabilities Liaison Nurse is available as a resource for issues around communication with people with learning disabilities.

6.1 Provision for Patients Whose First Language is Not English

This 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. Information regarding interpretation and translation is available on the Trust's Intranet.

6.2 Consent Forms Translations

Consent form translations and explanations in several languages are available on the Consent key documents page found on the Department of Health (DH) website.

6.3 Access to Health Professionals between Formal Appointments

After an appointment with a health professional, a patient will often think of further questions which they would like answered before they take their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or to wait until the date of an elective procedure (by which time it is too late for the information genuinely to affect the patient's choice). Contact details will be made available at out patients consultations.

6.4 Open Access Clinics

Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. The professional undertaking the procedure should ensure that patients have the information they need before the health professional proceeds with an investigation or treatment.

7. WHO IS RESPONSIBLE FOR SEEKING CONSENT

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

Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the healthcare professional 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 another member of the clinical team to obtain consent on their behalf e.g. specialist nurse, nurse, therapy consultant or junior doctor.

It is a health professional's own responsibility to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent and authorised to do so.

7.1 Authorisation to Take Consent

The actions of staff who **are not capable** of performing the procedure (but are authorised to obtain consent for that procedure) are the responsibility of the healthcare professional who will be ultimately performing the procedure. This includes procedure specific training and on-going support and updating should there be any changes to the consent requirements. Training must include familiarisation of procedures and the current forms used if consent is to be recorded.

An audit will take place at least annually to identify those healthcare professionals in the Trust that are delegating responsibility for taking consent. This will be recorded through Clinical Governance under divisional areas. An authorisation form requires to be completed by the healthcare professional with any staff member whom they are delegating consent identifying the specific training points required for authorising staff to carry this out on their behalf. The form used will be a Trustwide form unless a local speciality form is designed for use, copies of the completed forms with signatures of all parties will be held by Clinical Governance. These forms must be reviewed when any changes occur that affect the consenting process and be updated with approving signatures. Procedure specific training must be evidenced through this process.

The Clinical Research & Development will record the authorisation for delegating consent through there standard operating procedures.

7.1.1 Those not Authorised to Obtain Consent

Individual clinical staff must work within their own competence and must not agree to perform tasks which exceed their training, experience or authorisation. If staff do not feel competent to take consent on behalf of others advice should be sought from the line manager in the first instance, referring upwards through the management structure until there is a satisfactory resolution.

An Incident report must be completed for any occasion when consent has been taken by a member of staff who are not authorised to do so. An investigation will take place in accordance with the Incident Reporting and Investigation policy to identify the reasons why the incident happened which will be fed back through divisional arrangements for review and action as necessary.

Complaints regarding consent will be reviewed through the complaints process.

7.2 Completing Consent Forms

The standard consent form provides space for a healthcare professional to provide information to patients and to sign confirming that they have done so. The person providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations.

If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

If the patient has any remaining questions it may be assumed that, on occasion, the admitting healthcare professional may not be able to provide the necessary information. In this instance, a suitable member of the healthcare team must be contacted to respond to the patient's questions.

If the healthcare professional is unable to answer patient's questions during the 'confirmation' of consent process, they should contact the healthcare professional who signed the front of the consent form.

7.3 Generic Training in the Consent Process

Generic training on the consent process is provided through the following ways:

- Consent training as part of professional development for Student Nurses recorded through the programme educator.
- The F1 programme include an ethics session which covers consent and a separate taught session on consent is provided. This is recorded through the Academy Medical Education Administrator for the Severn Deanery.
- E-learning through the Yeovil Academy – This is to be recorded through the individual Staff Passport.
- Changes to the Consent Process will be provided through Rolling Governance arrangements.

All training is to be recorded through the Yeovil Academy. A Training Needs Analysis (TNA) is maintained by the Yeovil Academy and will include staff groups for whom training is required.

8. REFUSAL OF TREATMENT

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983*. The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults.

If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, you (and where possible the patient) should note this on the form.

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.

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.

Refer to **Annex A** for guidelines for patients withdrawing consent during endoscopic procedures.

At all stages with any refusal of treatment situation, documentation of discussions must be recorded in the patient's notes.

9. A 'DO NOT ATTEMPT RESUSCITATION' ORDER

A Do-Not Attempt Resuscitation Order (DNAR) must be clearly understood by the person documenting DNAR. Refer to the Resuscitation Status/Do Not Attempt Resuscitation (DNAR) Policy for further guidance.

10. TISSUE & ORGAN DONATION

The Human Tissue Authority (HTA) details a 'Code of Practice for Consent' (1st July 2006) including consent for donation of organs and cells for transplant. Refer to the HTA website. **Contact ICU for the Transplant Co-ordinator contact details (24hrs cover).**

11. CLINICAL PHOTOGRAPHY AND CONVENTIONAL OR DIGITAL VIDEO RECORDINGS

Consent must be obtained before any pictures or recording takes place whether this is for training purposes, for use in media or education, publication or research. Refer to **Annex B**. Relevant forms can be found on the Intranet under Clinical Governance /Consent.

12. OBTAINING A COURT ORDER & ADVICE

In the event of a court order being required then the General Manager for the Clinical Governance Directorate on extension 4291, or the Deputy General Manager for the Clinical Governance Directorate on extension 4589, should be contacted for advice and support. They will coordinate this process.

Out of hours the Clinical Site Manager is the first point of contact and they will follow the procedure for obtaining legal advice.

13. IMPLEMENTATION, MONITORING AND EVALUATION

This policy will be implemented, monitored and evaluated in line with the Policy on Procedural documents.

An annual audit is undertaken both on consent authorisation for those delegated to take consent this will form a report back to the Divisional Teams for review and action. This will be conducted through Clinical Governance Audit Lead with the Head of Nursing for Theatre Services.

An annual audit will also take place on the consent process to identify the use of patient information data, compliance with using the consent forms, and consent standards set out in this policy. This will form part of the annual audit process with reports sent back through divisional arrangements for monitoring and action.

14. APPLICABILITY

This policy applies to all staff employed by the Trust, whether on a permanent or temporary basis.

15. EQUALITY IMPACT ASSESSMENT

This policy has been assessed and implemented in line with the policy on procedural documents and an equality impact has been carried out to ensure the policy is fair and does not discriminate any staff groups. A completed Equality Impact assessment can be found at **Annex C** at the end of this policy.

APPENDIX 1 – TO THE CONSENT FOR EXAMINATION OR TREATMENT POLICY

CONSENT FORMS

Consent Form 1	**Patient agreement to investigation or treatment**
Consent Form 2	**Parental agreement to investigation or treatment for a child or young person**
Consent Form 3	**Patient/parental agreement to investigation or treatment**
Consent Form 4	**Form for adults who are unable to consent to investigation or treatment,** and, **Best Interests Checklist** (to be used alongside Form 4)

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
CONSENT FORM 1

Patient agreement to investigation or treatment

Patient details (or pre-printed label)

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

Patient's first names .....

Date of birth .....

Responsible health professional.....

Job title .....

NHS number (or other identifier).....

☐ Male ☐ Female

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

To be retained in patient's notes

Patient identifier/label

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

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

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

The intended benefits ……..…….……
……
……..……..…….
Serious or frequently occurring risks ……..……
...……
……..……
Any extra procedures which may become necessary during the procedure

☐ blood transfusion……..…….……

☐ other procedure (please specify) ……...……..……..……..…….
……..……..……

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

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

This procedure will involve:

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

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

Contact details (if patient wishes to discuss options later) …..……

Statement of interpreter (where appropriate)

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

Signed …….…… Date ……..…….
Name (PRINT) ……..……

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

Statement of patient

Patient identifier/label

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

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 his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature …… Date ……..……
Name (PRINT) ……..…

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

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

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

Important notes: (tick if applicable)

☐ See also advance directive/living will (e.g. Jehovah's Witness form)

☐ Patient has withdrawn consent (ask patient to sign /date here) ……..…….

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

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form 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.doh.gov.uk/consent).

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 2 of the form or in the patient's notes.

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

CONSENT FORM 2

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

Patient details (or pre-printed label)

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

Patient's first names .....

Date of birth .....

Age .....

Responsible health professional.....

Job title .....

NHS number (or other identifier).....

☐ Male ☐ Female

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

To be retained in patient's notes

Patient identifier/label

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) ……..……

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

Statement of parent

Patient identifier/label

Please read this form carefully. If the procedure has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you 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 hat 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) ……...…….

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.doh.gov.uk/consent).

Yeovil District Hospital NHS
NHS Foundation Trust

Yeovil District Hospital NHS Foundation Trust Consent Form 3

Patient identifier/label

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 ……

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

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 (also available at www.doh.gov.uk/consent).

YEOVIL DISTIRCT HOSPITAL NHS FOUNDATION TRUST

Consent form 4

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

Patient details (or pre-printed label)

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

Patient's first names .....

Date of birth .....

Responsible health professional.....

Job title .....

NHS number (or other identifier).....

☐ Male ☐ Female

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

To be retained in patient's notes

Patient identifier/label

All sections to be completed by health professional proposing the procedure

A Details of procedure or course of treatment proposed

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

B ASSESSMENT OF PATIENT'S CAPACITY

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

☐ the patient is unable to comprehend and retain information material to the decision; and/or

☐ the patient is unable to use and weigh this information in the decision-making process; or

☐ the patient is unconscious

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

C Assessment of patient's best interests

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

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

The treatment cannot wait until the patient recovers capacity because:

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

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

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

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

Any other comments (including any concerns about decision)

Name ……Relationship to patient……
Address (if not the same as patient…….
……
……

Signature …….. Date……..

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?)

☐ Yes ☐ No

Details:

Signature of health professional proposing treatment

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

I have/have not sought a second opinion.

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

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

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

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

This form 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.doh.gov.uk/consent).

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 interest's decision include:

- the wishes and beliefs of the patient when competent
- their current wishes
- their general well-being
- their spiritual and religious welfare

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

Unless the patient has clearly indicated that particular individuals 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.

Best Interests Checklist

Mental Capacity Act 2005

Yeovil District Hospital NHS
NHS Foundation Trust

Name of Patient:	*Patient Details Sticker*
Decision to be made:	

The following people should be consulted when determining Best Interests:
? anyone named by the patient as someone to be consulted on the matter in question
? anyone engaged in caring for the person
? anyone with an interest in their welfare including close relatives
? anyone who has been given a Lasting Power of Attorney by the patient / has a Court Appointed Deputy
? an IMCA if the patient is unbefriended and the decision relates to
? Serious medical treatment **OR** ?stay in hospital of more than 28 days **OR** ? change in accomodation

	Please document clearly your reason for answering yes or no to any of the questions below.		**Information obtained / action taken / who consulted / date**
1	**Has this person been assessed as lacking capacity to make this decision?**	**Yes** ___ **No** ___ If yes, give date of capacity assessment & go to section 2 If no, a capacity assessment must be recorded in relation to this decision	
2	**Does this person have a lasting power of attorney or a Court appointed deputy who has the authority to make this decision?**	**Yes** ___ **No** ___ If yes, the person holding the LPA or deputy MUST be consulted and has the final responsibilty for determining whether this decision is in the patients best interests If no, go to section 3.	Ensure the Attorney / deputy completes section 11.
3	**Has the person made an Advance Decision to refuse this treatment?**	**Yes** ___ **No** ___ If yes, the Advance Decision is legally binding if valid. If no, go to section 4.	
4	**Is it likely that the person will regain capacity in relation to the decision in question?**	**Yes** ___ **No** ___ If yes, go to section 5. If no, go to section 6, 7 and 8. .	
5	**Can the decision wait until the person regains mental capacity?**	**Yes** ___ **No** ___ If yes and it is reasonable to wait then you must do so. If no, state why the decision can not wait then go to sections 6, 7 and 8.	If the decision cannot wait until the person regains capacity please state why:
6	**Has the person been helped to participate in the decision making process as fully as possible?**	**Yes** ___ **No** ___ If yes, go to section7 and 8. If no, this step MUST be taken.	

7 For decisions regarding serious medical treatment, where there is no-one appropriate to consult other than paid carers, has an Independent Mental Capacity Advocate (IMCA) been instructed?

Details: Yes ☐ No ☐

Referral Date: Who made referral:

8 Please record all relevant information about the persons wishes and beliefs in relation to this decision. (In particular, record and relevant statements made when he/she had capacity)

People consulted and their views:

9 Decision(s) reached believed to be in the persons Best Interests because:

10 Alternatives considered and rejected:

(Give reasons for rejecting these alternatives)

11 The patient has an attorney or deputy:

I have been authorised to make decisions about the procedure in question under a Lasting Power of Attorney / as a Court appointed Deputy (delete as appropriate). I have considered the revelvantg circumstances relating the decision in question and believe the procedure to be in the patients best interests.

Any other comments (Including the circumstances considered in assessing the patients best interests)

Signature: **Date:**

12 Name of Decision Maker:	**Date:**
Signature:	**Position Held:**

ANNEX A – TO THE CONSENT FOR EXAMINATION OR TREATMENT POLICY

GUIDELINE FOR THE WITHDRAWL OF CONSENT DURING ENDOSCOPIC PROCEDURES

The purpose of this guideline is to assist clinicians and endoscopy staff when confronted with the situation where a patient wishes to withdraw consent whilst undergoing an endoscopic procedure.

The process of consent starts when options for treatment are first discussed with a patient in the GP surgery, outpatients department or ward. It continues up to and during the procedure. If the process is to be meaningful, refusal must be one of the patient's options. Additionally the patient is entitled to change their mind at any time.

A component of the consent procedure is a discussion with the patient on alternative treatments or test available for their condition. As part of this discussion the patient should be made aware of the consequences should the procedure not be performed or completed.

1 – Directly before their procedure the patient should have the opportunity to discuss withdrawal of consent with the nurse looking after them or the endoscopist. The patient should be informed that:-

- The procedure will only be carried out with their consent
- They can withdraw consent at any time throughout the procedure
- In the event of a life threatening situation, the endoscopist will decide whether to continue the procedure based in the patient's best interests
- Where the patient has signed a consent form and subsequently changes their mind the person taking the consent or the endoscopist performing the procedure (and where possible the patient) should note this on the form or endoscopy report as a record for the patient's medical notes.

2 – Once concern has been raised by either the patient or nurse during the procedure the endoscopist should stop the procedure and assess the situation.

- The endoscopist will speak with the patient and they will be told how they are doing, how much longer the procedure will take and then asked whether they wish the procedure to stop.
- If the patient indicates they wish the procedure to stop they should be advised whether the procedure will need repeating and the patient should be asked again if they still need it to stop
- If the patient indicates that they wish the procedure to stop again the procedure should be discontinued. This should be documented in the patient notes.
- In some instances it will be in the patient/s best interest to continue the procedure and complete a specific aspect of the procedure. This should be carefully explained to the patient and documented in the notes.
- If there is disagreement between the nurses attending the patient and the endoscopist the event will be reviewed afterwards. The nurses should ask the consultant their rationale for continuing in the individual concerned. Any such incidents should be discussed at the quarterly endoscopy users meeting. If there is still disagreement or concern an incident form should be completed as per Trust policy

3 – When a patient has been sedated it is a reasonable assumption that the patient has impaired ability to give valid consent. The anticipated effect of sedation is that the patient will be able to communicate but is in a relaxed state. However sedation is unpredictable and patients are unreliably affected

- Sedation used for all endoscopic procedures is "conscious sedation" defined as – "a technique in which the use of drug or drugs producing a state of depression of the central nervous system, enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drug and techniques used to provide conscious sedation should carry a margin of safety wide enough to render loss of consciousness unlikely".

- "If purposeful or verbal communication is lost the patient requires a level of care identical to that needed for general anaesthesia"
  (Safety and sedation during endoscopic procedures BSG Guidelines 2003)

- If the patient wishes the procedure to be stopped whilst under the influence of conscious sedation "the endoscopist should try to establish whether the patient has the capacity to withdraw a previously given consent. If capacity is lacking, it may be justified to continue in the patient's best interests"
  (reference guide to consent to examination or treatment DoH Chapter 1;18;1)

- Assessing capacity for consent during a procedure can be difficult therefore the decision to stop the procedure is a matter of clinical judgement. There needs to be a balance between the level of distress being experienced by the patient and the need to complete the endoscopy at that time.

- Doses of sedation or analgesia can be repeated according to clinical need. However in certain patient (e.g. liver disease) increased dosses of sedation can cause increased confusion/disinhibition rather than increased co-operation or tolerance to the procedure.

References

- Good Practice in consent Implementation Guide : Consent to Examination or treatment – Dept of Health Nov 2001 DOH 25751 1p10K
- Reference guide to Consent to Examination or treatment – DOH Oct 2002 24811 3p 15k
- Seeking patients consent, the ethical considerations. GMC guidelines Nov 1998
- Safety and sedation during endoscopic procedures – BSG Guidelines Sept 2003
- Code of Professional Conduct (2002) Nursing & Midwifery Council

Original by K Holbrook & J Gregory of Gloucester Hospitals June 2005. Adapted by S Osborne – Upper GI Specialist Nurse Yeovil District Hospital 2006. Updated by K Scaife – YDH 2011

ANNEX B – TO THE CONSENT FOR EXAMINATION OR TREATMENT POLICY

CLINICAL PHOTOGRAPHY AND CONVENTIONAL OR DIGITAL VIDEO RECORDINGS

Introduction

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

Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. The one exception to this principle is set out in paragraph 3 below. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

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.

Recording Consent

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.

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.

If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of some-one close to the patient. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

Consent forms are available through the Intranet under Clinical Governance.

ANNEX C – EQUALITY INPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Name of Document: **Consent for Examination or Treatment Policy**

1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	**No**	
	• Ethnic origins (including gypsies and travellers)	**No**	
	• Nationality	**No**	
	• Gender	**No**	
	• Culture	**No**	
	• Religion or belief	**No**	
	• Sexual orientation including lesbian, gay and bisexual people	**No**	
	• Age	**No**	
	• Disability	**No**	
2.	Is there any evidence that some groups are affected differently?	**None**	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	**None Identified**	
4.	Is the impact of the policy/guidance likely to be negative?	**No**	
5.	If so can the impact be avoided?	**Not Applicable**	
6.	What alternatives are there to achieving the policy/guidance without the impact?	**Not Applicable**	
7.	Can we reduce the impact by taking different action?	**Not Applicable**	

For advice or if you have identified a potential discriminatory impact of this procedural document, please refer it to The Equality & Diversity Lead, Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

Signed: **Yvonne Thorne** (Head of Nursing; Critical Care)

Date: **28/09/2009; Reviewed 5 Oct 2011**