Consent to Examination or Treatment Policy

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Equality Impact

Bolton NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of healthcare Bolton NHSFT aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individuality. The results are shown in the Equality Impact Assessment (EIA).
## Version Control Schedule

<table>
<thead>
<tr>
<th>Version</th>
<th>Type of Change</th>
<th>Date</th>
<th>Revisions from previous issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>V6</td>
<td>Reviewed</td>
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<tr>
<td>Section</td>
<td>Page</td>
<td></td>
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</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction and Purpose</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Statement</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scope</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duties</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Implementation and Review</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guidance on Consent</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recording Consent &amp; Documentation</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When should Consent be Sought</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision of Information</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who is Responsible for Taking Consent</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refusal of Treatment</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tissue</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Photography and Conventional or Digital Video Recordings</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix A Key points on consent: the law in England</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix B Current consent forms in use in this organization</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix C Proforma for record of assessment of capacity and best interests decision</td>
<td>71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix D Guidance on the test of Mental Assessment Capacity</td>
<td>74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix E Useful Contacts</td>
<td>78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix F How to seek a Court Declaration</td>
<td>79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix G Remembering the patient’s perspective</td>
<td>80</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 1

1.0 INTRODUCTION and PURPOSE
This policy provides guidance for taking and recording of patient consent to examination or treatment within the Trust. The policy is based on the Department of Health (DoH) document, Reference guide to consent for examination or treatment.

2.0 POLICY STATEMENT
This policy describes the activities required to take and record patient consent to examination or treatment and the forms to use to record consent.

3.0 SCOPE
This policy applies to all Trust staff who take/obtain patient consent to examination or treatment.

4.0 DUTIES

Chief Executive
The Chief Executive has overall accountability for ensuring correct patient consent is taken. The responsibility for ensuring correct patient consent procedures are followed is delegated to the Medical Director. Where Nursing/Midwifery or Allied Health Professional take consent, the responsibility for ensuring correct patient consent procedures are followed is delegated to the Director of Nursing.

Medical Director
The Medical Director is the professional lead for medical staff within the Trust and as such will promote and monitor compliance with the Trust Consent to Examination and Treatment Policy.

The Director of Nursing
The Director of Nursing is the professional lead for Nursing/Midwifery and has overall professional regard for allied Health Professional Staff within the Trust and as such will promote an monitor compliance with the Trust Consent to Examination and Treatment Policy.

Consultant Medical Staff
All Medical Consultants will ensure that correct patient consent is taken. Where they delegate consent taking to another member of their team, they will ensure that team members receive appropriate training to take consent.

All Health Professional Staff
All Health Professional Staff who take patient consent will ensure they are competent to take patient consent and that they comply with the this Policy. In particular, junior Medical staff in training or Health Professionals new to taking consent, will receive training on taking consent for the specific procedures they are delegated to take consent for.
5.0 POLICY IMPLEMENTATION & REVIEW

The Consent to Examination or Treatment Policy will be implemented locally via clinical divisions.

The policy will be reviewed every 3 years or sooner should new Department of Health guidance be issued.

6.0 GUIDANCE ON CONSENT

Why consent is crucial

1. It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. This principle reflects the right of patients to determine what happens to their own bodies and is a fundamental part of good practice. Working in partnership with patients to assist them in their decision-making about their healthcare choices is also a key element in building positive relationships.

A healthcare professional (or other healthcare staff) who does not respect this principle may be liable both to legal action by the patient and to action by their professional body.

Employing bodies may also be liable for the actions of their staff. Case law (Common Law) has established that touching a patient without valid consent may constitute the civil wrong of battery or criminal offence of assault.

Further, if proper consent is not obtained and the patient suffers harm as a result of treatment, then the health professional may be deemed to have not discharged their duty of care to the patient and could be held to be negligent.

You must work in partnership with your patients. You should discuss with them their condition and treatment options in a way they can understand, and respect their right to make decisions about their care. You should see getting their consent as an important part of the process of discussion and decision-making, rather than as something that happens in isolation. In deciding how much information to share with your patients you should take account of their wishes.

The information you share should be in proportion to the nature of their condition, the complexity of the proposed investigation or treatment, and the seriousness of any potential side effects, complications or other risks. Serious or persistent failure to follow this guidance will put your registration at risk. You must, therefore, be prepared to explain and justify your actions (GMC Making Decisions Together 2008)
This policy

2. This policy sets out the standards and procedures in this Trust, which aim to ensure that health professionals are able to comply with the guidance. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client. Guidance in Consent has also been issued by the Department of Health see Reference Guide to Consent for examination or Treatment (2nd edition 2009 https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition)

Guidelines have been published by the healthcare regulatory bodies and, in addition, your professional body may also have published additional guidance with which you should be familiar.

Please see :


In addition you should check with your professional body if they have any addition guidance in relation to obtaining consent from patients to treatment or examination. It should be noted that this guidance is specific to consent for physical interventions involving living patients, and the following areas are therefore not included:

• participation in observational studies
• the use of personal information
• the use of organs or tissue after death (see paragraph 7 of this introduction).

What consent is – and isn’t

3. ‘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;
• Not be acting under duress
• Have received sufficient information

4. The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient’s values and preferences and the health professional's clinical knowledge.

5. Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no-one else can give consent on their behalf.

A mental capacity assessment must be undertaken to determine whether the patient lacks capacity, if the patient does lack capacity treatment can 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 directive. For further details on advance directives, see the Department of Health’s Reference ‘Guide to Consent for Examination or Treatment’ (Chapter 1, paragraph 19, and the Mental Capacity Policy).

6. 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 provides a comprehensive summary of the current law on consent and includes requirements of regulatory bodies such as the general Medical Council where theirs are more stringent. Copies may also be accessed on the Internet at www.dh.gov.uk/consent.

12 key points on consent: the law in England has been distributed widely to health professionals working in England. This one–page document summarises those aspects of the law on consent which arise on a daily basis and is attached at Appendix A. Further copies area available from www.dh.gov.uk/consent.

Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available from the Clinical Governance Department on ext. 5292/5111 (update?)and via the internet at www.dh.gov.uk/consent.
Section 2 - Recording Consent and Documentation

The consent forms used in this Trust can be found at Appendix B.

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 documentation in the patients notes that they have given oral consent.

Written consent

1. **Consent is often wrongly equated with a patient's signature on a consent form.** A signature on a form is evidence that the patient has given consent, but is not proof of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent–giving, not a binding contract.

2. 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
   - the treatment is part of a project or programme of research approved by this Trust.

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

4. It will not usually be necessary to document a patient’s consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be helpful to do so.
5. **Mental Capacity Act 2005**

Adults Lacking Capacity

Consent to examination or treatment for adults who lack capacity is governed by the provisions of the Mental Capacity Act 2005.

The Mental Capacity Act 2005 came fully into force on 1st October 2007 and provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The Mental Capacity Act introduced a duty on NHS bodies to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. The act affects people aged 16 and over and provides a statutory framework to empower and protect people who may lack capacity to make some decisions for themselves.

The Act allows people to plan ahead for a time when they may not have capacity and allows them to appoint a personal welfare attorney to make health and social care decisions including medical treatment, on their behalf under a lasting Power of Attorney or to make an advance decision to refuse medical treatment.

The act enshrined in statute existing best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. It replaces current statutory schemes for Enduring Power of Attorney and court of protection receivers with reformed and updated schemes.

Everyone working with or caring for an adult, who may lack capacity needs to be aware of and behave in accordance with the act ([please see Mental Capacity Act Code of Practice / refer to the Mental Capacity Act Policy](#))

For consent to be valid it must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment. Consent must be provided by an appropriately informed person who has capacity to consent to the intervention.

If the patient is an adult lacking capacity then the only person who may provide consent on their behalf is someone authorised to do so under a Lasting Power of it Attorney or someone who has the authority to make treatment decisions as a court appointed deputy, for further information on making treatment decisions in respect of adults lacking capacity please refer to the Mental Capacity Act 2005 Policy.

Where there is evidence that an adult may lack capacity a full capacity assessment must be undertaken and documented. Any decisions taken regarding their treatment must be taken in accordance with the process as described as described in the Mental Capacity Act Policy.
Provision of information for patients with other communication or learning difficulties

Patients with communication or learning difficulties will need extra time to comprehend the information and reach a decision. A record should be kept in the notes, and by the patient, of the information given during the discussion, which may be in the form of key written words, pictures etc. The patient can use this to refer back to and ask further questions, and use as a basis to make or change a decision.

If possible, the patient should be assisted to make and communicate their own decision, by providing information in non-verbal ways where appropriate, for example, pointing to their choice of your written words or picture writing, drawing, using gesture (e.g. nodding or shaking head). In these circumstances, the healthcare professional must document how the patient has agreed.

The patient may already be using a communication aid, in which case, appropriate advice should be sought from a Speech and Language Therapist.

Carers of patients with learning or communication difficulties should be provided with the appropriate written information and contact details.

6. Advance Decisions to Refuse Treatment ADRT

Advance decisions to refuse treatment that are both valid and applicable under the requirements of the Mental Capacity Act 2005 will be legally binding for everyone involved in the care of the individual. The Act and Code of Practice clearly define that the responsibility for making an advance decision lies with the person making it.

In order for an advance decision to be valid it must be clear that the person made this decision whilst retaining full capacity to make such a decision and that the decision specifically applies to the current circumstances.

In the case of refusal of life saving treatment certain provisions apply under the Mental Capacity Act 2005. In such cases the person who has issued the advance decision must:

- Specifically acknowledge that they intend to refuse treatment even where their life may be at risk.
- The decision must be in writing
- The decision must be signed by the person making the decision or a representative in that person’s presence.
- The signature must be witnessed
Where there is doubt about the applicability or validity of such a decision the further advice should be sought from Legal Services as there may be a requirement to make an application to the Court of Protection. If there is indication that the Advance Decision may have been withdrawn then the Advance Decision may no longer valid and further steps should be taken to ascertain whether this is the case. If a Lasting Power of Attorney has been appointed since making the Advance Decision then the decision will no longer be valid.

Staff may be involved in the process of helping give patients information to enable them to make advance decisions by giving relevant information as they would in any consent process but the decision must be the patient’s own. Staff should not be involved in the witnessing of such documents but rather advise the patient to find an independent witness.

If staff are made aware of an advance decision by a patient this can be logged in the patients medical record.

Further information can be found at

7. Availability of forms

Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in Appendix B and are available in all wards and departments (extra copies can be ordered from supplies department). There are three versions of the standard consent form:

Form 1: for adults or competent people
Form 2: for parental consent for a child or a 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 though more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.

There is one other form: Form 4 for adults who are unable to consent to investigation or treatment themselves. A proforma must be completed to demonstrate the patient’s mental capacity has been assessed (see appendix C)
Section 3 - When should consent be sought?

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

2. 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.

3. 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.

4. In most cases where written consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital 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.

5. 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 outpatients, 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?’
6. While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that this 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.

Seeking consent for Anaesthesia

7. Where an anaesthetist is involved in a patient’s care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks. However, in elective treatment it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the Anaesthetist: at such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in outpatients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient’s notes or on the consent form. Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

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

Emergencies

9. 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.

Children

10. In order to give consent to examination or treatment for a child consent must be given by a person with the legal authority to do so. It is important that the health professional has clarity over who may be legally able to give consent before proceeding with treatment.
Treatment of children and young people

There are different legal rules governing consent for children and young people depending on their age, ability to give consent and their family circumstances. The situation for children is complex: see the Department of Health’s *Seeking consent: working with children* for more detail.

It is important that clinicians are clear about who is able to give consent for the child they propose to treat and recognise that this may be more than one person.

A ‘child’ is defined in law as someone under the age of 18. People with ‘parental responsibility’ are entitled to give consent on behalf of their children. Adults with parental responsibility may give consent for children aged 16 and 17. Parental responsibility may also be held by the Courts (via the Local Authority) for children subject to an interim care order, emergency protection order or child assessment order, or by the Local Authority for children on a care order.

On 1st December 2003 Section 111 of the Adoption and Children Act was brought into force. This extends the way in which an unmarried father can acquire parental responsibility

In addition to acquiring parental responsibility by way of a formal parental responsibility agreement, or by order of the Court, a child’s father can now acquire parental responsibility if he becomes registered as the child’s father on the birth certificate. This means that where a birth is registered after 1 December 2003 and the unmarried father is named on the birth certificate, he will automatically have parental responsibility. In addition, where no father has been named on a birth certificate, the particulars can be re-registered to name the unmarried father, who again will have parental responsibility.

The provisions above are not retrospective, i.e. any father who is named on their child’s birth certificate prior to 1 December 2003 does not automatically have parental responsibility. He can only acquire this by way of a parental responsibility agreement or by order of the Court.

The effect of the new provisions means that a much wider group of fathers will have parental responsibility and consequently will be able to consent to treatment for their children.

Young people aged 16-18 are presumed in law to be competent, and are able to give consent to their own surgical or medical treatment and any ancillary procedures involved in that treatment, such as an anaesthetic. As with adults for consent to be valid it must be given voluntarily by an appropriately informed young person capable of
consenting to the particular intervention\textsuperscript{1}. However, unlike adults, the refusal of a competent person aged 16-17 may in certain circumstances be overridden by either a person with parental responsibility or a court.

In order to establish whether a young person aged 16-18 has the required capacity to consent to the proposed intervention, the same criteria as for adults should be used. If a young person lacks capacity to consent because of an impairment of, or a disturbance in the functioning of the mind or brain then the Mental Capacity Act 2005 will apply in the same way as it does to those who are 18 or over.

Best practice encourages young people aged 16-17 to inform their families. If a competent child requests confidentiality this should be respected unless the doctor considers that failing to disclose information would result in significant harm to the child.

Children under the age of 16 are not deemed automatically legally competent to give consent. The courts have determined that such children can be legally competent if they meet the \textit{Gillick competency}. That is, having sufficient understanding and intelligence to understand fully what is proposed and to be able to make an informed decision. The child’s capacity to consent should be assessed carefully in relation to each decision that needs to be made as the understanding for different interventions will vary. Thus the child under 16 may have capacity to consent to some interventions but not others.

If the child is Gillick competent and is able to give consent voluntarily after receiving appropriate information that consent is valid and additional consent by a person with parental responsibility will not be required. It is however, good practice to involve the child’s family in the decision making process. There may, however be circumstances where the child refuses to give consent to share this and this decision should be respected unless there is a clear risk of harm to the child.

Where advice or treatment relates to contraception, or the child’s sexual or reproductive health, the healthcare professional should try to persuade the child to inform their parent(s) or allow a medical professional to do so. If the child cannot be persuaded advice/treatment should still be given if the healthcare professional considers that the child is very likely to begin or continue having sexual intercourse with or without advice or treatment.

If a child seeks advice or treatment in relation to abortion and cannot be persuaded to inform their parent(s) every effort should be made to help the child find another adult (such as another family member or youth support worker) to provide support to the child.

\section{Refusal of Consent by a Child}

In law the right to give consent for the treatment of a child may be held by several people. This includes the child if aged 16-17 or if \textit{Gillick} competent but also includes

\textsuperscript{1} Family Law Reform Act 1969 s8(1)
those who hold parental responsibility. Legally consent by any one of these is sufficient to constitute valid consent. It is not usually necessary to seek the views of all those who can consent, however, where it is apparent that there is disagreement there may be a need to try and ensure consensus and further advice may be required.

Where a young person of 16 or 17 who could consent to treatment or a child under 16 who is Gillick competent, refuses treatment, it is possible that such a refusal could be overruled if it would in all probability lead to the death of the child/young person or to severe permanent injury. Such a decision is likely to involve the need to seek legal advice and possible involvement of the courts.

12. Blood Transfusion

SaBTO (Safety of Blood, Tissues and Organs) – Advisory Committee to the DoH have produced recommendations (Oct 2011) which requires Trusts to ensure valid consent is recorded for blood transfusion [link]. It also requires Trusts to have a specific approach for consent for blood transfusion, for patients with long term transfusion requirements.

Valid consent must be obtained for the transfusion of blood components (red cells, plasma and platelet products). This should be obtained prior to the transfusion taking place, by an appropriate healthcare professional i.e. doctor, registered nurse or midwife. The consent process must include the patient receiving information regarding the rationale, risks and benefits of the treatment. If prior consent is not possible (e.g. in an emergency situation), the patient must receive information retrospectively at an appropriate time (before discharge). There may be situations where consent is not possible (e.g. patient lacks capacity). This must be recorded in the appropriate section on the Transfusion Clinical Record Document (HM-FRM-TEC-0037). Patient information leaflets are available to support this process (see Transfusion Clinical Process policy for details). Patients with predicted long term transfusion requirements (e.g. some haematology patients), may receive counselling and information for the first transfusion, removing the requirement for giving repeated information for subsequent transfusions. In this case, valid consent must be recorded by the appropriate healthcare professional on sticker (LM-BS-GEN-121) which is affixed to the history sheet in the medical notes. Consent for subsequent transfusions must be recorded on the Transfusion Clinical Record document as described above.

13. Medical Students

Medical students should not be directly involved with taking consent for procedures, but will require educational exposure to the process of consent and be involved with training consent for intimate examinations. Issues regarding medical student consent should be bound by Good Medical Practice values. [GMC Good Medical Practice – consent: patients and doctors making decisions together 2008] - patients must be given informed consent to any activity. This includes participation in teaching or research as well as any activity undertaken by a student.
DOH guidance – reference guide to consent for examination or treatment (second edition 2009) – suggests that whilst it is not a legal requirement to tell a patient that the clinician is a student if procedures relate to ongoing care, assuming appropriately trained, it would always be good practice to do so…..failure to provide relevant information may render the practitioner vulnerable to claims of negligence if a person subsequently suffers harm as a result of the treatment.
Section 4 - Provision of information

1. The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensive information about their condition and about possible treatments/investigation and their risks and benefits (including the risks/benefits of doing nothing). Serious though rare risks should be discussed and documented. They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on.

2. 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 judgment 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.

3. Written patient information leaflets are available within the Trust. Written information is no substitute for face to face contact and discussion and therefore should not be given instead of verbal information and discussion but to support/supplement this.

4. Each ward/department will have a range of information leaflets appropriate to their services and specialities. All locally produce leaflets must be approved through the Trust’s patient information policy and process. This policy is overseen by the Trust’s Head of Communications, who holds all leaflets on a central database for archiving purposes.

Provision for patients whose first language is not English or with a sensory impairment.

5. The Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use family members including children to interpret for patients who do not speak English.

6. The Trust provides a range of services to ensure effective communication is maintained. This ranges from in-house link workers; telephone interpreting services; access to outside agencies (face to face interpreters/translators) and access to British Sign Language (BSL) interpreters.
7. Procedures for Accessing Interpreting

The Trust employs link workers who provide interpretation for the following languages: Gujarati, Hindi, Punjabi, Urdu.

The Link Worker service at the Royal Bolton Hospital site is open Monday – Friday 8.00am to 5.00pm on 01204 390517 (Int. 5517) or bleep numbers 3035 and 3107.

If a different language to those above is required, or the above services are fully booked or not available e.g. during weekends, evening and Bank Holidays the Trust has access to a range of services to provide telephone interpretation, face to face interpretation, translation services or British Sign Language.

**Telephone Interpreting Service: will require updating**

**Applied Language Solutions**  
Tel: 0800 004 2000  
Fax: 0845 367 7007  
Website: [www.appliedlanguage.com](http://www.appliedlanguage.com)

**Language Line Services**  
Tel: 0845 310 9900  
Fax: 0800 783 2443  
E-mail: enquiries@languageline.co.uk  
Website: [www.languageline.co.uk](http://www.languageline.co.uk)

**Face to Face Interpreting/Translation Service:**

**Applied Language Solutions**  
Tel: 0800 004 2000  
Fax: 0845 367 7007  
Website: [www.appliedlanguage.com](http://www.appliedlanguage.com)

- British Sign Language

**Applied Language Solutions**  
Tel: 0800 004 2000  
Fax: 0845 367 7007  
Website: [www.appliedlanguage.com](http://www.appliedlanguage.com)

Please note there is a minimum booking charge of 1 hour for face to face interpretation and therefore telephone interpretation should always be considered as a first option.
8. **Access to more detailed or specialist information**

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

- Via the pre-admission service, during the consultation process
- Many divisions and specialities have specialist roles/services, where further information can be obtained
- Patient Advice and Liaison Service (PALS) available on 5193 between 9.00am and 4.00pm.

Information can be made available in different languages or formats. The costs for this will be met by the divisions. For further advice, please contact the PALS department or the Link Workers.

9. **Access to health professionals between formal appointments**

After an appointment with a health professional in primary care or in outpatients, patients 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).

Following consultation, the patient **will** (needs clarification) be given a comprehensive information sheet which aims to provide them with as much information as possible about their intended procedure/treatment. The information sheet will provide details of how the patient can access more information if it is required. Individual clinicians and nurse specialists will also advise patients of how the team can be contacted in between appointments.

10. **Open access clinics**

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

In accordance with the Freedom of Information Act, the Trust has a publication scheme which includes methods for obtaining a wide range of information.
Section 5 - Who is responsible for seeking consent?

The clinician providing the treatment or investigation is responsible for ensuring that the person has given valid consent before treatment begins, although the consultant responsible for the person’s care will remain ultimately responsible for the quality of medical care provided. The GMC guidance states that the task of seeking consent may be delegated to another person, as long as they are suitably trained and qualified. In particular, they must have sufficient knowledge of the proposed investigation or treatment, and understand the risks involved, in order to be able to provide any information the patient may require.

The practitioner who eventually carries out the investigation or treatment must also be able to determine whether the person has the capacity to make the decision in question and what steps need to be taken if the person lacks the capacity to make that decision. Inappropriate delegation (for example where the clinician seeking consent has inadequate knowledge of the procedure) may mean that the ‘consent’ obtained is not valid. Clinicians are responsible for knowing the limits of their own competence, and should seek the advice of appropriate colleagues when necessary.

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 naturally be done by the health 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 other members of the team to participate in the process of seeking consent.

Completing consent forms

The validity of consent does not depend on the form in which it is given. Written consent merely serves as evidence of consent: if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not make the consent valid.

Although completion of a consent form is in most cases not a legal requirement (exceptions include certain requirements of the Mental Health Act 1983 and of the Human Fertilisation and Embryology Act 1990 as amended by the Human Fertilisation and Embryology Act 2008) the use of such forms is good practice where an intervention such as surgery is to be undertaken. Where there is any doubt about the person’s capacity, it is important, before the person is asked to sign the form, to establish both that they have the capacity to consent to the intervention and that they have received enough information to enable valid consent to be given. Details of the assessment of capacity, and the conclusion reached, should be recorded in the case notes and on the EPR system.
If the person has capacity, but is unable to read or write, they may be able to make their mark on the form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the clinician seeking consent, and for the fact that the person has chosen to make their mark in this way to be recorded in the case notes.

Similarly, if the person has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes. Or, the person can direct someone to sign the form on their behalf, but there is no legal requirement for them to do so. If consent has been given validly, the lack of a completed form is no bar to treatment, but a form can be important evidence of such consent.

The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: 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 and are subject to audit.

Health professionals are authorised to obtain consent if they are capable of performing the procedure, or have been trained to a standard so that they are knowledgeable of all associated risks, benefits and alternatives. All training should be held on record by the Trust and the individual. The training will be provided at the staff member’s local induction and, for medical staff, a list of all procedures they will be expected to obtain consent for will be included in their induction booklet.

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 and ensure that any questions or queries the patient may have are dealt with by an appropriate person.

If the patient has any remaining questions it will 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 will be contacted to respond to the patient’s questions. Each clinical area has a list of up to date contact details for the respective healthcare teams to facilitate easy access to appropriate colleagues. See Appendix C for contact details.

**Responsibility of health professionals**

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 to do so; and
• to work within their own competence and not to agree to perform tasks which exceed that competence (See Appendix F Delegated Consent Training).

If you feel that you are being pressurised to seek consent when you do not feel competent to do so please contact your Head of Division or the Executive Medical Director (Appendix C).

Duration of consent
When a person gives valid consent to an intervention, in general that consent remains valid for an indefinite duration, unless it is withdrawn by the person.

However, if new information becomes available regarding the proposed intervention (for example new evidence of risks or new treatment options or a change in the patient’s circumstances) between the time when consent was sought and when the intervention is undertaken, the GMC guidance states that a doctor or member of the healthcare team should inform the patient and reconfirm their consent. It is necessary to confirm that the person who has given consent (assuming that they retain capacity) still wishes the intervention to proceed, even if no new information needs to be provided or further questions answered.

Delegated Consent

In the “12 key points on consent: the law in England” it states that “It is always best for the person actually treating the patient to seek the patient’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

Doctors in training are particularly vulnerable in taking consent as they may be expected to take consent for a procedure of which they have little or no expertise. If they have knowledge of the procedure they may still not have been taught the principles of taking consent for that particular intervention. Also they may be at risk of coercion or pressure from senior staff.

It is unlikely that foundation doctors will gain sufficient depth of understanding in undertaking consent for a complex procedure. It is possible with training, initial supervision and experience, that they may develop competence in consent of low risk, high volume procedures such as endoscopy.

Directly Observed Procedural Skill (DOPS Appendix I) for consent provides evidence that the trainee:-

• Understands the legal aspects of consent
• Understands ethical issues of consent
• Chooses appropriate environment and time for taking consent
• Explains clearly to patient purpose of consent process
• Explains clearly the planned procedure to patient in an understandable fashion
• Explains risks of procedure to patient
• Is able to answer any questions raised clearly and accurately

Any doctor taking consent must:-
• Have sufficient knowledge of the proposed investigation or treatment and understand the risks and benefits involved
• Understand and agree to act in accordance with the General Medical Council and Department of Health guidance on consent (see references 3 and 4)

Foundation trainees (year 1) taking consent must:-
• Not take consent for any complex invasive procedure
• Have attended a course or session on consent (either undergraduate course or session within induction)
• Have been observed while taking consent for low risk procedures, and have been deemed as competent by their trainer, using an assessment tool such as DOPS.

In summary: Foundation year doctors should not take consent for any invasive procedure without direct supervision but with suitable training can take consent for low risk, high volume procedures such as endoscopy

Core and Specialist Trainees must:-
• Be encouraged to be involved with the consenting process
• Have been formally delegated with the responsibility of taking consent by the senior operator for the procedure (with supportive documentation – see above)
• Have demonstrated competence to take consent by having completed the tasks and experience set out above in points i, ii and iii for Foundation trainees, and be familiar with the operative procedure and its potential complications.

Specialty grades should have a clearly defined step by step approach for training in taking consent. This should be performed as a Directly Observed Procedural Skill (DOPS) whereby the early stages are formative and build incrementally to result in a combined assessment of the entire process.

The marking of an operating site should only be done by an operating surgeon who is deemed competent in the consent process for that particular operation. This may include a trainee surgeon providing they are guaranteed to be an active part of the operating team. Ideally however this should be done by the most senior surgeon involved with the operation.
If you feel that you are being pressured to seek consent when you do not feel competent to do so, you can get help from your Divisional Associate Medical Director, Educational Supervisor, Post Graduate Tutor, Education Centre Manager, Head of Clinical Governance, Medical Director.

**Reporting issues relating to consent**

If an individual believes that a procedure has been performed or would have been performed on a patient who had not given valid consent then this should be reported as an incident using the Trust Datix incident reporting system to enable a full investigation to take place.

If concerns about improper consent-taking have been identified trusts may submit information on the steps they have taken to prevent recurrence using the form below. This information will be shared with the NHSLA for the risk assessment.

The form to report these concerns to the GMC can be found at [http://www.gmc-uk.org/NHSLA_Consent_Form.doc_47409657.doc](http://www.gmc-uk.org/NHSLA_Consent_Form.doc_47409657.doc)

The form should be returned to [quality@gmc-uk.org](mailto:quality@gmc-uk.org)
Section 6 - Refusal of treatment

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

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

3. Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

4. If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient’s stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient’s care to that health professional.
Section 7 - Tissue

The Human Tissue Act 2004 (updated?) regulates the storage and use of human organs and tissue from living individuals and the removal, storage and use of human organs and tissue from the deceased. Human tissue is referred to in the Act as ‘relevant material’ and includes any material from the human body that consists of or includes human cells (including blood samples and other bodily fluids provided for testing. It will be explained to the patient that in some procedures (investigations), tissues or biological samples may be removed for investigation or treatment of the patient’s condition. The specimens will be analysed within the Pathology Laboratory or, if required, at other specialist laboratories. It will be explained that when biopsies or surgical specimens are taken, small samples of the tissue would normally be retained indefinitely in the department archive as part of the medical record. Once diagnostic process is complete, the samples may be used for quality control.

For quality control purposes wherever possible the samples will be anonymised by removal of identifiers. When this is not possible (for example when samples have to be returned to the archive) identity will be maintained by the use of the numerical laboratory number only.

Bolton NHS Foundation Trust does not routinely remove tissue from living patients for research purposes. Where the Trust does participate in local or national research projects and this requires removal of tissue for research purposes, specific informed consent must be obtained from the patient by a senior clinician and this must be clearly documented in the patient’s health records. The senior clinician must ensure that any research has received appropriate ethical approval and local research & development approval.

Explicit consent is not necessary for public health surveillance using the unlinked anonymous method.

Consent to Post Mortem: Forms and Information leaflets

The Department of Health published a Code of Practice ‘Families and Post Mortems’ (April 2003) (updated?) which established model forms and information leaflets about post mortem examination. Together, these offer guidance on good practice in communications with families about post mortem examination when agreed between the family and the hospital. The Trust has developed a standard operating procedure for consent to Post Mortems (PM) which is available on the Trust intranet. This is in line with the Human Tissue Act.

There are separate forms for adult and child hospital post mortems. All forms and patient leaflets are available in the Hospital Bereavement Office based on the Ground Floor, Trust Headquarters, contact number 01204 390807

The Trust has adopted the use of the Department of Health model consent forms for hospital post mortems.
**Hospital PM consent form 1:** for use when consent is sought from the next of kin for a hospital post mortem on an adult, and (if applicable) for the retention and use of tissue and/or organs afterwards.

**Hospital PM consent form 2:** for use when consent is sought from the parent for a hospital post mortem on a child, baby or foetus, and (if applicable) for the retention and use of tissue and/or organs afterwards.

HM Coroner’s post mortems are carried out under a direct instruction from HM Coroner who will decide where the post mortem will take place. Coroner’s post mortems are not subject to the above procedure.
Section 8 - Clinical photography and conventional or digital video recordings

1. For all clinical recordings made of patients you should follow the Trust’s Policy for Clinical Photography and Video Recordings of Patients: Confidentiality, Consent, Copyright and Storage. If you need to make a clinical recording of a patient in the first instance you should contact the Medical Illustration Department for assistance. For recordings to be made out of department hours, you can use your own camera (not a mobile or mobile device) providing it has been registered with the Medical Illustration Department and guidance from the policy has been followed.

2. Photographic and video recording 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.

3. 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 written consent of the patient or a person with parental responsibility for the patient. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be 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.

4. The practice of obtaining the patient’s written consent only in the case of full length or facial recording, from which the patient can easily be identified, is not sufficient. Nor is it sufficient to rely on the photographer’s or consultant’s judgement that a particular patient is unlikely to be identified from a photograph. It must also be borne in mind that people can be identified from other views, e.g. showing a tattoo or other distinguishing features.

The responsibility of obtaining informed consent rests with the clinician treating the patient. However, it is the responsibility of the clinical photographer to ensure that such consent has been obtained and evidenced before the photograph is taken or, where circumstances require (i.e. out of hours / images not taken by Medical Illustration staff), prior to its release from the Medical Illustration Department. In such circumstances, Medical Illustration will not be able to release or upload the photographs onto PACS until consent has been evidenced.

5. 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 sealed and stored within the medical record with a full explanation. 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.

**Clinical Photographs/videos must not be used for any purpose other than that for which the original consent was granted, unless further consent is obtained.**

6. 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 written consent for its use, and if the patient does not consent to any form of use, the recordings must be sealed and stored within the medical record with a full explanation.

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

8. Where clinical photography and digital recordings form part of the patient record they constitute personal data and are subject to the Data Protection act. Patients are entitled to ask for copies under the Trust Data Protection Policy.

9. Copyright of all such recordings belongs to Bolton NHS Foundation Trust
Section 9 – Training

All staff groups will be advised of the consent policy during corporate induction.

Individual consent training requirements (including procedure specific consent) will be clarified during local induction between any new clinician and their clinical supervisor.

Each Directorate will identify those procedures for which consent may be delegated.

All junior doctors in training will participate through the Corporate Medical Induction Learning Needs Assessment (LNA) and, if necessary, complete the e-learning in relation to Delegated Consent. (Any participant who does not score 100% in the questions undertaken as part of this assessment on informed consent will be required to complete the e-learning package on Synapse within 4 weeks of receipt of results). Their clinical supervisor must be assured that the clinician has an appropriate understanding of the Trust’s consent process before delegating any consent.

Any individual health care professional (other than Doctors in training) who are to obtain consent but are unable to carry out the procedure must prior to completing procedure specific training must complete the Trust’s online e-learning resource in relation to consent. This can be accessed via the Trust’s Intranet

http://intranet.srht.nhs.uk/policies-resources/on-line-system/

Each Directorate will provide speciality specific training in the risks, benefits and alternatives for all procedures where a doctor in training or other qualified Health Care Professional is expected to obtain informed consent. A training record should be maintained by the staff member acquiring consent rights, the supervising consultant and the trust (via the electronic delegated consent database as referenced above)

All practitioners undertaking consent should undertake the Mental Capacity Training offered by the Trust, this can be found at:

http://elearning.hope-academic.org.uk/srht_elearn_dept/
Section 10 - Monitoring

Abstract for Consent policy: Clinical Audit

On a yearly basis the Clinical Effectiveness Department audits the consent process. The minimum requirements to be monitored are; the process of obtaining and recording consent, identifying staff who has obtained the consent and monitoring of delegated consent. As from 2014 the Annual Clinical Audit consists of 3 components.

1. Auditing of consent forms via Casenotes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>How will this be Measured?</th>
<th>Frequency</th>
<th>Responsible Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide evidence of Appropriate consent form usage, Procedures, Risk &amp; Benefits, Signature and Grade Legibility, Counter-signatures.</td>
<td>Audit of minimum 150 Hospital Casenotes</td>
<td>Annually (1 day per year)</td>
<td>Clinical Effectiveness Department</td>
</tr>
<tr>
<td>Demonstrate 100% Junior Drs have received training to undertake delegated consent for relevant procedures</td>
<td></td>
<td>Annually</td>
<td>Clinical Effectiveness Department Medical Education</td>
</tr>
<tr>
<td>Appropriate completion of Mental Capacity Assessment</td>
<td>Audit of minimum 150 Hospital Casenotes</td>
<td>Annually</td>
<td>Clinical Effectiveness Department</td>
</tr>
</tbody>
</table>

2. In-patient Consent Questionnaire
This is a new process for 2014 to increase Quality and Assurance and a Recommendation from 2013. We will gather data which will identify the patient experience and the level of information provided.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>How will this be Measured?</th>
<th>Frequency</th>
<th>Responsible Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% patients given additional information either verbally or written</td>
<td>In-patient questionnaire</td>
<td>Annually</td>
<td>Clinical Effectiveness Department</td>
</tr>
</tbody>
</table>

3. Audit of the Provision of Leaflets

Clinical Effectiveness will audit the process of how more detailed/specialist information is provided in the form of patient Information Leaflets (in conjunction with any work that runs parallel with this process).

<table>
<thead>
<tr>
<th>Indicator</th>
<th>How will this be Measured?</th>
<th>Frequency</th>
<th>Responsible Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are written leaflets for all common procedures</td>
<td>Spot audit of applicable areas</td>
<td>Annually</td>
<td>Clinical Effectiveness Department</td>
</tr>
</tbody>
</table>

The audit is completed on a yearly basis and is feedback to Trust Quality Assurance Committee and Divisional Governance Meeting. The Action Plan will be monitored by Clinical Effectiveness Department with support from Clinical Governance Leads and Heads of Divisions.
Appendix A

Key points on consent: the law in England

When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain consent.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: ‘can this patient understand and weigh up the information needed to make this decision’? Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children give consent for themselves?

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

Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information
as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

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

Current forms in use in this Organisation

The forms used by Royal Bolton Hospital NHS Foundation Trust are the approved forms developed by the Department of Health with no local amendment.

The Trust utilizes the Department of Health central printing contract to purchase a stock of the forms.

These are as follows:

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.

Form 4 - for adults who are unable to consent to investigation or treatment themselves

In addition procedure specific forms are encouraged. These relate to common procedures and are introduced following development and approval at specialty governance groups. They are encouraged if compliant with this policy and based on national best practice and evidence.
Consent form 1
Patient Agreement to Investigation or Treatment
(to be retained in the patients notes)

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Surname/Family name</td>
<td>…………………</td>
</tr>
<tr>
<td>Patient’s First names</td>
<td>…………………</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>…………………</td>
</tr>
<tr>
<td>Age</td>
<td>…………………</td>
</tr>
<tr>
<td>Responsible Health Professional</td>
<td>…………………</td>
</tr>
<tr>
<td>Job title</td>
<td>…………………</td>
</tr>
<tr>
<td>NHS Number (or other identifier)</td>
<td>…………………</td>
</tr>
<tr>
<td>Male □ Female □</td>
<td>…………………</td>
</tr>
<tr>
<td>Special Requirements (eg, other language/other communication methods)</td>
<td>…………………</td>
</tr>
</tbody>
</table>

**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 unavoidable 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 may involve:

- General and/or Regional Anaesthesia
- Local Anaesthesia
- Sedation

I have explained to the patient that excess tissues may be used for teaching and research purposes: □ YES □ NO.

If the answer is No, this must be documented on the histopathology request form, in the appropriate tick box.

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 he/she can understand.

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

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

Statement of Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 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 understand that tissue samples may be used for audit and quality assurance purposes.

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 he/she has no further questions and wishes the procedure to go ahead.

Signature ......................................................... 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 minds 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 age 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 someone 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.

Where a young person of 16 or 17 or a Gillick competent child under 16 refers treatment it is possible that such a refusal could be over-ruled if it would in all probability lead to the death of the child or to severe permanent injury. It would be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.

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 lack the capacity to consent to investigation or treatment) instead of this form. A patient lacks capacity if they have an
impairment of the mind or brain or disturbance affecting the way their mind or brain works and they cannot:

- Understand information about the decision to be made
- Retain that information in their mind
- Use or weigh that information as part of the decision–making process, or
- Communicate their decisions (by talking, using sign language or any other means)

You should always take all reasonable (for example, involving more specialist colleagues) to support a patient in making their own decisions, before concluding that they are unable to do so. Relatives cannot be asked to sign a form on behalf of an adult who lacks capacity to consent for him or herself.
**Consent form 2**

Parental (or person who has parental responsibility) agreement to investigation or treatment for a child or young person. (to be retained in patient’s notes)

**Patient details (or pre-printed label)**

<table>
<thead>
<tr>
<th>Patient’s surname/family name</th>
<th>Patient’s first names</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Responsible health professional</th>
<th>Job title</th>
<th>NHS Number (or other identifier)</th>
<th>Male ☐ Female ☐</th>
<th>Special Requirements (eg, other language/other communication methods)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of proposed procedure or course of treatment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Significant, avoidable or frequently occurring risks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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 parent(s).

☐ The following leaflet/tape has been provided

This procedure will involve:

☐ General and/or Regional Anaesthesia  ☐ Local Anaesthesia  ☐ Sedation

I explained to the parent that their child’s excess tissues may be used for teaching and research purposes.  ☐ YES  ☐ NO

If the answer is No, this must be documented on the histopathology request form, in the appropriate tick box.

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 child and his or her parent(s) 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 parent: yes/no (please ring)

Statement of Parent

Please read this form carefully.  If the 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 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 my situation prevents this. (This only applies to children having general or regional anaesthesia).

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

I understand that my child’s tissue samples may be used for audit and quality assurance purposes,

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……………………………..

Childs 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 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 he/she has no further questions and wishes the procedure to go ahead.

Signature ………………………………………………. 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)
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 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, someone 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 a number of years both the child and a person with parental responsibility have the right to give consent to the child’s treatment. This means that in theory it is lawful to provide treatment to a child under 18 which a person with parental responsibility has authorized, even if the child refuse. 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 of 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 judgment of a reasonable patient’. ‘Significant’ has not been legally defined but the General Medical Council requires doctors to tell about significant, avoidable 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)
Consent form 3
Patient/Parental (or person who has parental responsibility) Agreement to Investigation or Treatment (procedures where consciousness not impaired)
(to be retained in patient’s notes)

Patient’s Surname/Family name…………………………………………………………………………………

Patient’s first names…………………………………………………………………………………………

Date of Birth……………………………………………………………………………………………………

Responsible health professional………………………………………………………………………………

Job title………………………………………………………………………………………………………………

NHS Number (or other identifier)………………………………………………………………………………

Special Requirements (eg, other language/other communication methods)
……………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………

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:
……………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………

Significant, unavoidable 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 to the best of my ability and in a way in which I believe he/she/they can understand.

Signature……………………………………………… 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)

What a consent form is for

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) of 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 age 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 a well. If the child is not able to give consent for himself or herself someone 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.

Where a young person of 16 or 17 or a Gillick competent child under 16 refuses treatment it is possible that such a refusal could be over-ruled if it would in all probability lead to the death of the child or to severe permanent injury. it would be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.

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 lack the capacity to consent to investigation or treatment) instead of this form. A patient lacks capacity if they have an impairment of the mind or brain or a disturbance affecting the way their mind or brain works and they cannot:

- understand information about the decision to be made
• use or weigh that information as part of the decision making process or
• communicate their decision (by talking, using sign language or any other means)

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decisions, 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 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 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 judgment of a reasonable patient’. ‘Significant’ has not been legally defined but the General Medical Council requires doctors to tell about significant, avoidable 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.

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](http://www.doh.gov.uk/consent)).
**Consent form 4**

*Form for adults who lack the capacity to consent to investigation or treatment* (to be retained in patient’s notes)

| Patient’s Surname/Family name | ………………………………………………………………………………………………………………………….. |
| Patient’s first names | ………………………………………………………………………………………………………………………….. |
| Date of Birth | ………………………………………………………………………………………………………………………….. |
| Age | ………………………………………………………………………………………………………………………….. |
| Responsible health professional | ………………………………………………………………………………………………………………………….. |
| Job title | ………………………………………………………………………………………………………………………….. |
| NHS Number (or other identifier) | ………………………………………………………………………………………………………………………….. |
| Special Requirements (eg, other language/other communication methods) | ………………………………………………………………………………………………………………………….. |

**A. Details of procedure or course of treatment proposed**

(NB. see guidance to health professionals 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 of an impairment of the mind or brain or disturbance affecting the way their mind or brain works (for example a disability, condition or trauma, or the effect of drugs or alcohol) and they cannot do one or more of the following:

- [ ] understand information about the procedure or course of treatment
- [ ] use or weigh that information as part of the decision making process or
- [ ] communicate their decision (by talking, using sign language or any other means).

Further details for example how above judgments reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful.
I have completed the trust record of assessment of capacity and best interest decision and a copy is retained in the patient’s medical records

C. Assessment of patient’s best interests
I am satisfied that the patient has not refused this procedure in a valid advanced decision. As far as is reasonably possible, I have considered the patient’s past and present wishes and feelings (in particularly if they have been written down) any beliefs and values that would be likely to influence the decision in question. As fare as possible I have consulted the patient’s families and friends and other people (those involved in caring for the patient, interested in their welfare or the patient has said should be consulted) as appropriate. I have considered the patients best interests in accordance with the requirements of the Mental Capacity Act and believe the procedure to be in their best interests because:

where incapacity is likely to be temporary, for example if patient is unconscious, or
where the 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.

Unless the person has an attorney or deputy the final responsibility for determining what is in a person best interest lies with the relevant health professional. However the healthcare professional must consult with those close to the patient (spouse/partner, family and friends, carer, supporter or advocate as far as is practicable and as appropriate). ‘Best interests’ go far wider that ‘best medical interests', and included 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 the 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 consent, based on the criteria set out in this form. I/We understand that treatment can lawfully be provided if it is in her/his best interests to receive it.

Any other comments (including concerns about decision)
I/We understand that tissue samples may be used for audit and quality assurance purposes.

I/We consent to excess tissues being used for teaching and research purposes.

☐ YES  ☐ NO

If the answer is NO, this must be documented on the histopathology request form, in the appropriate tick box.

Name……………………………………………Relation 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

Independent Mental Capacity Advocate (IMCA) for decisions about serious medical treatment where there is no-one appropriate to consult other than paid staff has an IMCA been instructed

☐ YES  ☐ NO

Signature ………………………………………………..Date………………………………………………

---

**E. The patient has an attorney or deputy**

Where the patient has authorised an attorney to make decisions about the procedure in question under a Lasting Power of Attorney or a Court Appointed Deputy has been authorized to make decisions about the procedure in question, the attorney or deputy will have the final responsibility for determining whether a procedure is in the patient’s best interests.
Signatures of attorney or deputy .................................................................

I have been authorised to make decisions about the procedure in question under a Lasting Power of Attorneys/ as a Court Appointed Deputy (delete as appropriate). I have considered the relevant circumstances relating to the decision in question (see section c) and believe the procedure to be in the patient’s best interests.

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

Signature………………………………………………………………………………Date…………………………

Signature of health professional undertaking treatment.

The above procedure is, in my clinical judgment, 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 a second opinion is sought he/she should sign below to confirm agreement.

Signature …………………………………………………………………………………Date…………………….

Name (print)………………………………………………………………………………………….

Job Title………………………………………………………………………………………….

Guidance to health Professionals

This form should only be used where it would be usual to seek written consent but an adult patient (16 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 made a valid advance decision to refuse treatment that is applicable to two proposed treatment then you must abide by that refusal. 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.
All decisions made on behalf of a patient who lacks capacity must be made in accordance with the Mental Capacity Act 2005. More information about the Act is given in the Code of Practice². Treatment can be given to a patient who is unable to consent, only if:

- the patient lacks the capacity to give or withhold consent to this procedure and
- the procedure must be in the patients best interests.

Capacity
A person lacks capacity if they have an impairment or disturbance (for example, a disability, condition or trauma, or the effect of drugs or alcohol) that affects the way their mind or brain works which means that they are unable to make a specific decision at the time it needs to be made. It does not matter if the impairment or disturbance is permanent or temporary. A person is unable to make a decision if they cannot do one or more of the following things:

- understand the information given to them that is relevant to the decision.
- retain that information long enough to be able to make the decision.
- use or weigh up the information as part of the decision-making process.
- communicate their decision – this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

You must take all steps reasonable in the circumstances to assist the patient in taking their own decisions. 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 therapist or learning disability teams and independent advocates (as distinct from an IMCA as set out below) or supports. Sometimes it may be necessary for a formal assessment to be carried out by a suitably qualified professional.

Capacity is ‘decision-specific’: a patient may lack capacity to take a particular complex decision, but be able to take other more straight-forward decisions or parts of decisions. Capacity can also fluctuate over time and you should consider whether the person is likely to regain capacity and if so whether the decision can wait until they regain

Best Interests
The Mental Capacity Act requires that health professionals must consider all the relevant circumstances relating to the decision in question, including, as far as possible considering:

- the person’s past and present wishes and feelings (in particular if they have been written down)
- any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors
- the other factors that the person would be likely to consider if they were able to do so.

When determining what is in the person’s best interests a health professional must not make assumptions about someone’s best interests merely on the basis of the person’s age or appearance, condition or any aspect of their behaviour. If the decision concerns the provision or withdrawal of life-sustaining treatment the health professional must not be motivated by a desire to bring about the person’s death.

The Act also requires that, as far as possible, health professionals must consult other people, if it appropriate to do so, and take into account of their views as to what would be in the best interests of the person lacking capacity, especially anyone previously named by the person lacking capacity as someone to be consulted and anyone engaging in caring for patient and their family and friends.

Independent Mental Capacity Advocate (IMCA)
The Mental Capacity Act introduced a duty on the NHS to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. IMCAs are not decision makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision making for people who lack capacity is done appropriately and in accordance with the Act.

Lasting Power of Attorney and Court Appointed Deputy
A person over the age of 18 can appoint an attorney to look after their health and welfare decisions, if they lack the capacity to make such decisions in the future. Under a Lasting Power of Attorney (LPA) the attorney can make decisions that are as valid as those made by the person themselves. The LPA may specify limits to the attorney’s authority and the LPA must specify whether or not the attorney has the authority to make decisions about life-sustaining treatment. The attorney can only, therefore make decisions as authorized in the LPA and must make decisions in the person’s best interests.

The Court of Protection can appoint a deputy to make decisions on behalf of a person
who lacks capacity. Deputies for personal welfare decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the court’s authority or where there is not other of settling the matter in the best interests of the person who lacks capacity then it is the deputy must make decisions in the patients best interest.

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. The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court. Cases involving:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- cases involving organ, bone marrow or peripheral blood stem cell (PBSC) donation by an adult who lacks capacity to consent
- cases involving the proposed non-therapeutic sterilization of a person who lacks capacity to consent to this (e.g for contraceptive purposes) and
- all other cases where there is doubt or dispute about whether a particular treatment will be in a persons best interests (include cases involving ethical dilemmas in untested areas)

should be referred to the Court for approval. The Court can be asked to make a decision in cases where there are doubts about the patient’s capacity and also about the validity or applicability of an advance decision to refuse treatment.
**Consent form 1 (Sterilisation)**

**Patient agreement to sterilisation**
(to be retained in patient’s notes)

<table>
<thead>
<tr>
<th>Patient’s surname/family name</th>
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<tr>
<td>Patient’s first names</td>
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<tr>
<td>Date of birth</td>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>Responsible health professional</td>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>Job title</td>
<td>.......................................................................................................................</td>
</tr>
<tr>
<td>NHS number (or other identifier)</td>
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<tr>
<td>Female ☐</td>
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Special requirements (eg other language/other communications methods)

- ....................................................................................................................... 
- ....................................................................................................................... 
- ....................................................................................................................... 

**Name of proposed procedure or course of treatment.**

Female sterilization – occlusion of the fallopian tubes

**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: **Permanent prevention of fertility**

Serious unavoidable or frequently occurring risks:

Small risk of failure of method to prevent pregnancy
Small risk of subsequent ectopic pregnancy
Small risk of damage to bowel, bladder and vessels which would result in a Laparotomy (an exploratory operation)

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 Bolton Health Authority leaflet on sterilisation for women has been provided. This procedure may involve:

☐ General and/or Regional Anaesthesia

I have explained to the patient that excess tissues may be used for teaching and research purposes

☐ YES  ☐ NO

If the answer is NO, this must be documented on the histopathology request form, in the appropriate tick box.

Signature ........................................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 which I believe she/he can understand.

Signature........................................Date..................................................

Name (print)..........................................................

Top copy accepted by patient: yes/no (please ring)
## Statement of Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 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 understand that tissue samples may be used for audit and quality assurance purposes.

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.

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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 he/she has no further questions and wishes the procedure to go ahead.

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<th>Signature</th>
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<tr>
<th>Name (PRINT)</th>
<th>Job Title</th>
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</table>

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 minds 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 age 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 a well. If the child is not able to give consent for himself or herself someone 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.

Where a young person of 16 or 17 or a Gillick competent child under 16 refuses treatment it is possible that such a refusal could be over-ruled if it would in all probability lead to the death of the child or to severe permanent injury. It would be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.

**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 lack the capacity to consent to investigation or treatment) instead of this form. A patient lacks capacity if they have an impairment of the mind or brain or disturbance affecting the way their mind or brain works and they cannot:

- Understand information about the decision to be made
• Retain that information in their mind
• Use or weigh that information as part of the decision-making process, or
• Communicate their decisions (by talking, using sign language or any other means)

You should always take all reasonable (for example, involving more specialist colleagues) to support a patient in making their own decisions, before concluding that they are unable to do so. Relatives **cannot** be asked to sign a form on behalf of an adult who lacks capacity to consent for him or herself.
Consent form 1 (Vasectomy)
Patient agreement to vasectomy

Patient’s Surname/Family name……………………………………………………………………..

Patient’s First names……………………………………………………………………………………

Date of birth…………………………………………………………………………………………..

Responsible health professional……………………………………………………………………..

Job title……………………………………………………………………………………………………..

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

Male □

Special requirements ( eg other language/other communications methods)
………………………………………………………………………………………………………………..
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Name of proposed procedure or course of treatment.
Bilateral vasectomy for male sterilization by removing a short section of the Vas Deferens on each side and tying the free ends.

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: **A highly effective and permanent method of contraception**

Serious unavoidable or frequently occurring risks:

- 1 in 1000 risk of failure of the operation and becoming fertile again (late reconnection of the vas deferens)
- Wound infection, bleeding into the scrotum, persistent testicular aching in 5-10%

Any extra procedures which may become necessary during the procedure
□ blood transfusion
□ other procedure (please specify) ...........................................................................
I have also discussed how the procedure is performed and the benefits/risk of local and general anaesthetic.

☐ The Royal Bolton Hospital NHS FoundationTrust Bilateral Vasectomy leaflet has been provided.

This procedure may involve:
☐ General and/or Regional Anaesthesia  ☐ Local Anaesthesia  ☐ Sediation

I have explained to the patient that excess tissues may be used for teaching and research purposes.

☐ YES  ☐ NO

If the answer is NO, this must be documented on the histopathology request form, in the appropriate tick box.

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<td>Name(print)</td>
<td>Job title</td>
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**Contact details (if patient wishes to discuss options later):**

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<th>Contact details</th>
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**Statement of interpreter** (where appropriate)

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

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<th>Signature</th>
<th>Date</th>
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<tr>
<td>Name (print)</td>
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Top copy accepted by patient: yes/no (please ring)
Statement of Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 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 understand that tissue samples may be used for audit and quality assurance purposes.

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) .................................................Job Title.............................

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 he/she has no further questions and wishes the procedure to go ahead.

Signature .......................... 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 minds 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.

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Where a young person of 16 or 17 or a Gillick competent child under 16 refuses treatment it is possible that such a refusal could be over-ruled if it would in all probability lead to the death of the child or to severe permanent injury. it would be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.

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 lack the capacity to consent to investigation or treatment) instead of this form. A p[atient lacks capacity if they have an impairment of the mind or brain or disturbance affecting the way their mind or brain works and they cannot:
• Understand information about the decision to be made
• Retain that information in their mind
• Use or weigh that information as part of the decision-making process, or
• Communicate their decisions (by talking, using sign language or any other means)

You should always take all reasonable (for example, involving more specialist colleagues) to support a patient in making their own decisions, before concluding that they are unable to do so. Relatives cannot be asked to sign a form on behalf of an adult who lacks capacity to consent for him or herself.
### Appendix C

**RECORD OF ASSESSMENT OF CAPACITY AND BEST INTERESTS DECISION**

<table>
<thead>
<tr>
<th>Attach patient addressograph here</th>
<th>Ward:</th>
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<tbody>
<tr>
<td></td>
<td>Consultant:</td>
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### Section A - Details of the decision which there is reason to doubt the patient may have the capacity to make *(provide details below)*

**What is the decision:**

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### Section B – Assessment of Capacity

Does the patient have an impairment of, or disturbance in the functioning, of his/her brain or mind?

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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Does the patient have the ability to:

1. Understand the information relevant to the decision
2. Retain the information *(long enough to process it)*
3. Communicate their decision

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<thead>
<tr>
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<th>Yes</th>
<th>No</th>
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On a balance of probabilities, does the patient have mental capacity?

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<th>Yes</th>
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Is a Second opinion necessary?

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<th>Yes</th>
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**If yes, what is the second opinion?**

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### Section C – Assessment of Best Interests

Is it likely that capacity might be regained?

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<th>Yes/No</th>
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If yes, can the decision wait until that is likely to have happened?

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<th>Yes/No</th>
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**Patient’s past and present wishes/views *(if known)*:**

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**Person named by patient as someone to be consulted and their views *(if requested)*:**

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**Page 71 of 84**
<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship to patient</th>
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<tr>
<td>Contact details:</td>
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<td>Views:</td>
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<th>Next of kin/significant other’s views:</th>
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<td>Name:</td>
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<td>Contact details:</td>
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<tr>
<th>Independent Mental Capacity Advocate Service’s (IMCA’S) view (if requested)</th>
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<th>Advance decision/advance directive (if there is one):</th>
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<th>Person with an Enduring or Lasting Power of Attorney’s view (if there is one):</th>
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<tr>
<td>Name:</td>
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<td>Contact details:</td>
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<tr>
<td>Views:</td>
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<tr>
<th>Deputy appointed by the Court of Protection’s view: (if there is one):</th>
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<th>Best interest decision:</th>
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<tr>
<th>Decision made by (please print):</th>
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<td>Signed:</td>
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## Details of others involved in Decision Making Process/ Best Interests Determination

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Appendix D

Mental Capacity Act 2005

The Act is underpinned by a set of five key principles:

- **Presumption of capacity**: every adult is presumed to have capacity unless proven otherwise;
- **Right for individuals to be supported to make their own decisions**;
- **Best interests**: anything done for or on behalf of individuals without capacity must be in their best interests;
- **Leave restrictive intervention**: anything done for or on behalf of individuals without capacity should be the least restrictive of their basic rights and freedoms.

Fundamental to the Act is the principle that adults with incapacity retain the right to be fully involved in decisions regarding their care.

Adults might fall within the definition or ‘cognitively or mentally impaired’, whilst retaining mental capacity to make their own decisions. Vulnerable or cognitively/mentally impaired adults with capacity are entitled to make their own choices despite apparent risk. They also have the right to refuse care.

**Where it is unclear whether an individual has capacity, a formal assessment must be undertaken.**

**Legal presumption of capacity.**

All adults are presumed to have legal capacity unless they are:

- Unable by reason of mental disability, to make a decision for himself or herself on the matter in question and/or
- Unable to communicate their decision on that matter because they are unconscious or for any other reason

Evidence of incapacity must be gathered before decisions can be made and actions taken on the grounds of best interests. In many cases such evidence will be easily obtained, for example the patient is unconscious. Necessary urgent treatment should not be delayed in situations where it is obvious that the individual lacks capacity.

**Guidance of the test of Mental Capacity**

The person who needs to take a decision on behalf of a possible incapacitated patient should be the one to assess the capacity of the patient. This may be a Social Worker or doctor or any other individual involved.
A second opinion assessment of mental capacity may be required in complex cases. This might include:

- Lack of consensus among the multi-disciplinary team
- Where the assessment is unable to determine capacity
- Where there is dispute about capacity with family or significant others
- Where litigation or court proceedings are anticipated

The Act sets out a 2-stage test of capacity:

**Stage 1** - Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

**Stage 2** - Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

Assessment of capacity:

- Is task or decision specific, i.e. relating to one decision only
- May require several visits
- Should respect consistently held views
- Should respect privacy
- Should be undertaken in a manner the person can understand whether written, signed or using an interpreter
- Should not be rushed
- Must be carefully documented

In assessing mental capacity, the individual should be taken through the following four stages, all of which must be passed.

**An individual with capacity must have the ability to:**

1. Understand the information relevant to the decision
2. Retain the information (for long enough to process it and make an effective decision)
3. Use and weigh information as part of the decision making process
4. Communicate their decision (whether by talking, sign language or any other means)

The first 3 should be applied together. If a person cannot do any of these 3 things, they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way.

**Best Interests**

Decisions made on behalf of adults with incapacity must be on the grounds of best interests. This includes consideration of all relevant circumstances and
participating of the incapacitated individual as fully as possible. There can be no discrimination of age, condition or appearance. In considering the individual, it is necessary to take into account:

- Past and present wishes and feelings;
- Values likely to influence the decision if they had capacity;
- Any other factors the individual would have considered important

The assessor must also where practicable and appropriate, consult with:

- Anyone named by the patient as someone to be consulted on the matter in question
- Anyone engaged in caring for the patient or interested in his/her welfare including the IMCA service (see below)
- Any person to whom a lasting power of attorney has been granted by the patient
- Any deputy appointed for the patient by court

In assessing what is in the patient’s best interests, the views of the multi-professional team should be taken into account. A best interests decision should be the least restrictive of the persons rights and freedom. Professionals must always act in a manner that respects the individual, minimizes distress and supports him/her throughout any actions that need to be taken.

**Advance Decisions**

If the individual lacks capacity and the decision concerns the provision of medical treatment, the practitioner should ascertain whether there is a valid and applicable advance decision made by that person.

Advance decisions state specific medical treatment that is to be refused in specific circumstances and cannot demand specific treatment to be given. If the advance decision refuses life-sustaining treatment it must be in writing, signed and witnessed and clearly state that the decision applies even if life is at risk.

**Lasting Power of Attorney**

A Lasting Power of Attorney (LPA) is a legal document where a patient can say who they want to make certain decisions for them if they cannot make them for themselves. This can include decisions regarding health, welfare, property and money.

The LPA must act in the best interests of the person lacking mental capacity.

If a health professional considers that the LPA is not acting in the person’s best interests, then a referral to an Independent Mental Capacity Advocate can be made.
Referral to an independent Mental Capacity Advocate (IMCA)

Referral to the Independent Mental Capacity Advocate Service (IMCA service) should be made where there is concern over an individual’s capacity and when that person has no family or friends to represent them.

The IMCA will have the right to challenge or assist in challenging decisions made regarding serious medical treatment and accommodation. It is a statutory requirement to refer to this service.

At the time when the referral is made it must be evident that:

- A person lacks the capacity to make the particular decision
- The decision is:
  ~ either serious medical treatment
  ~ discharge to a different address from which the patient was admitted
  ~ probability of hospitalization of more than 28 days
  ~ a care review or an adult protection case
- There is nobody who can appropriately support and represent the person (does not apply to adult protection)

Advice regarding an IMCA referral can be sought from Sandra Crompton, Lead Nurse for Safeguarding Adults Ext 4176 or Richard Sachs, Head of Governance Ext 5292.
## Appendix E

### Useful Contact details

<table>
<thead>
<tr>
<th></th>
<th>Ext</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deputy Director of Nursing – Bev Tabernacle</td>
<td>5983</td>
</tr>
<tr>
<td>Head of Governance – Richard Sachs</td>
<td>5292</td>
</tr>
<tr>
<td><strong>Heads of Divisions</strong></td>
<td></td>
</tr>
<tr>
<td>Acute Adult Care Division – Dr Bharaj/Dr Bradley</td>
<td>5973</td>
</tr>
<tr>
<td>Elective Care Division – Dr J Wood</td>
<td>5343</td>
</tr>
<tr>
<td>Families Division – Miss K Bancroft</td>
<td>5279</td>
</tr>
<tr>
<td>Post Graduate Tutor – Dr L Holt</td>
<td>5426</td>
</tr>
<tr>
<td>Post Graduate Centre Manager – Joanne Warburton</td>
<td>5426</td>
</tr>
<tr>
<td>Medical Director – Mr S Hodgson</td>
<td>5367</td>
</tr>
</tbody>
</table>
Appendix F

How to seek a court declaration
Should legal assistance be required for any matter, this should be sought as far as possible, through the Legal Services Manager.

Only in exceptional circumstances should Trust solicitors be contacted direct.

Office Hours
During office hours contact the Legal Services Dept on Ext 5111. Appropriate advice and legal support will then be obtained from the Trust’s legal advisors.

Outside of normal office hours
Should assistance be required out of hours, you should contact the first on call manager who will decide upon the appropriate action and, if necessary will seek legal assistance from the Trust’s legal advisors:-

Hempsons Solicitors
Portland Tower
Portland Street
Manchester
M1 3LF

Normal working hours
0161 228 0011

Out of office hours, emergency number
0845 630 7718

Should legal assistance be required for any matter, this should be sought as far as possible, through the Legal Services Department.

Only in exceptional circumstances should Trust solicitors be contacted direct
Appendix G

Seeking consent: remembering the patient’s perspective

PATIENT

What do they think is wrong with me?

What treatment might help?

How would it help me?

What would it involve?

Will it hurt?

What about the risks?

Are there any alternatives?

What are the risks and benefits of the alternatives?

Can I drive/work or look after my family afterwards?

Will I have to stay in hospital? How long for?

Maybe I’d like to talk it over with my family before I decide.
Appendix H

DELEGATED CONSENT TRAINING PROFORMA

NAME OF LEARNER:.................................................................................................

SIGNATURE OF LEARNER...........................................................................................

SPECIALTY..................................................................................................................

GRADE.......................................................................................................................  

THE ABOVE HEALTH PROFESSIONAL HAS RECEIVED TRAINING IN DELEGATED
CONSENT FOR THE FOLLOWING PROCEDURES

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Signature of trainer</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
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<tr>
<td>g.</td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td></td>
</tr>
<tr>
<td>j.</td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td></td>
</tr>
</tbody>
</table>

Please return complete and signed proformas to the Post Graduate Centre Manager based in
the Education Centre. These proformas will be used as part of our audit arrangements.
Appendix I

Direct Observation of Procedural Skills (DOPS)
Guidance for Assessors

What is DOPS?
This is a structured checklist for assessing the foundation doctor’s interaction with the patient when performing a practical procedure. Although DOPS was developed to assess procedural skills, its primary purpose in the Foundation Programme is to assess the doctor/patient interaction.

The logbook of procedural skills should be used to assess the 15 core procedural skills listed in the Foundation Programme Curriculum. Foundation doctors can use DOPS to assess doctor/patient interactions while undertaking procedures not listed in the logbook.

Who can be a DOPS assessor?
Assessors must be trained in assessment and feedback methodology. You must be able to competently perform the interaction including the procedure yourself. Assessors should be consultants, GPs, doctors in core or higher training (ST3 or above/SpR), or specialty doctors/staff grade or associate specialists. If possible, different assessors should be used for each encounter wherever possible.

How does it work?
The process is led by the foundation doctor. Each DOPS should represent a different procedure and may be specific to the specialty. The observed process typically takes around 20 minutes and immediate feedback around 5 minutes. It may be necessary to allocate more time.

What specific competences does the DOPS assess?
DOPS includes 11 rated question areas and provides free-text space for you to identify strengths and areas for development. These question areas are self-explanatory and may vary depending on the procedure. However, positive indicators for three of these question areas are given below: post-procedure management, communication skills and consideration of patient/professionalism. Not all elements need be assessed on each occasion.

<table>
<thead>
<tr>
<th>Question area</th>
<th>Positive indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-procedure management</td>
<td>Safely disposes of equipment; documents the procedure, including labelling samples and giving instructions for monitoring, arranges appropriate aftercare/monitoring</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Explores patient’s perspective; jargon free; open and honest; empathetic; agrees management plan with patient</td>
</tr>
<tr>
<td>Consideration of patient / professionalism</td>
<td>Shows respect, compassion, empathy, establishes trust; attends to patient’s needs of comfort; respects confidentiality; behaves in an ethical manner; awareness of legal frameworks; aware of own limitations.</td>
</tr>
</tbody>
</table>

What is the reference standard?
You should assess F1 doctors against the standard expected at satisfactory completion of F1. You should assess F2 doctors against the standard expected at satisfactory completion of the Foundation Programme (F2). The Curriculum provides a detailed description of the relevant competences expected of a doctor completing F1 and F2.

Feedback
In order to maximise the educational impact of using DOPS, you and the foundation doctor need to identify strengths and areas for development. This should be done sensitively and in a suitable environment.
**Appendix J**

**EQUALITY IMPACT ASSESSMENT TOOL**

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

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the document/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Nationality</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Gender (including gender reassignment)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Culture</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Religion or belief</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Sexual orientation</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>Yes</td>
</tr>
<tr>
<td>2.</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>Yes</td>
</tr>
<tr>
<td>3.</td>
<td>If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?</td>
<td>No</td>
</tr>
<tr>
<td>4.</td>
<td>Is the impact of the document/guidance likely to be negative?</td>
<td>N/A</td>
</tr>
<tr>
<td>5.</td>
<td>If so, can the impact be avoided?</td>
<td>N/A</td>
</tr>
<tr>
<td>6.</td>
<td>What alternative is there to achieving the document/guidance without the impact?</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>Can we reduce the impact by taking different action?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If you have identified a potential discriminatory impact of this procedural document, please refer it to your divisional E and D lead together with any suggestions as to the action required to avoid/reduce this impact.
**Appendix K**

**Document Control Tracking**
To be completed and attached to documents submitted for consideration and approval. After ratification to be included within appendices.

<table>
<thead>
<tr>
<th><strong>Document Title:</strong></th>
<th>Consent to Examination or Treatment Policy</th>
</tr>
</thead>
</table>
| **Author:**         | Steve Hodgson, Medical Director  
|                     | Bev Tabernacle, Deputy Director of Nursing |
| **New/revised:**    | Revised |
| **Summary:**        | If new please indicate reason document needed and summary of purpose; if revised state if minor or significant revisions and summarise  
|                     | Changes made in line with national guidance regarding consent |
| **Keywords:**       | Include keywords that staff may use to search for the policy on the intranet  
|                     | Consent, examination, guidance |
| **Staff/Stakeholders Consulted:** | Consultants, Divisional Nurse Directors, Practitioners |

**Section below to be completed by ratifying committee**

<table>
<thead>
<tr>
<th><strong>Ratifying Committee:</strong></th>
<th>Executive Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date presented for Ratification:</strong></td>
<td>10th March 2015</td>
</tr>
</tbody>
</table>
| **Outcome:**             | Ratified ☑  
|                          | Ratified subject to minor amendments  
|                          | Not ratified |

<table>
<thead>
<tr>
<th><strong>Comments:</strong></th>
</tr>
</thead>
</table>