This policy supersedes all previous policies for Policy on Consent to Examination or to Treatment.
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<th>Date</th>
<th>Author</th>
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<td>DRAFT</td>
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<td>Consultant Nurse</td>
<td>Existing Policy transferred to new format and reviewed</td>
<td>Sent to Quality and Safety Committee for ratification. Further consultation undertaken.</td>
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<td>2.1</td>
<td>27th August 2015</td>
<td>Consultant Nurse and Safeguarding Adult Nurse</td>
<td>Draft revision</td>
<td>Reviewed document to ensure web links etc. are up to date and amended as necessary</td>
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<td>3.0</td>
<td>December 2015</td>
<td>Kate Wilkins</td>
<td>Final</td>
<td>Minor changes made following PRG ratification. Ensured compliance with Deprivation of Liberty Safeguards (re consent to care and treatment)</td>
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<td>4.0</td>
<td>December 2017</td>
<td>Sandie Cox</td>
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<td>Reviewed document and amended as necessary</td>
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<td>5.0</td>
<td>March 2018</td>
<td>Cathy Withycombe (for PRG)</td>
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<td>Minor amendments following ratification by PRG on 22 March 2018</td>
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For guidance on version control please see policy on procedural documents.
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1. Introduction

Patients and users of our services have a fundamental legal and ethical right to determine what happens to their own bodies and how information about them is used. The Mental Capacity Act 2005 states that adults are presumed to have capacity to decide on their own healthcare and treatment, unless there is evidence to suggest otherwise.

Valid consent to examination, assessment, treatment or therapy is therefore a legal requirement for all forms of healthcare and social care delivery, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health and social care professionals and patients/users of services.

If a patient/service user is harmed as a result of treatment without obtaining proper consent, then this may be a factor in a claim of negligence. Poor handling of the consent procedures may also result in the patient/service user making complaints to the service or to professional bodies (DH, 2009)

The Department of Health has issued a range of guidance documents on consent, and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in Hounslow and Richmond Community Healthcare NHS Trust (HRCH), which aim to ensure that health and social care professionals are compliant with the DH 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. This policy takes into account the Mental Capacity Act 2005 which came into force in 2007.

In general, each patient or service user has the right to accept or refuse treatment, and in this document the term ‘treatment’ is taken to include assessment, examination, investigation, therapy and treatment. This is not only a legal right, but is recognized as a basic tenet of ethical health care. The fundamental principle on which consent rests is that of ‘self-determination’, a principle implicit since the time of St. Thomas Aquinas, and expressed in judicial writing as long ago as 1914:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body…” ¹

The Trust seeks to ensure that relevant information is provided to all patients, in ways that each patient or client can understand, about proposed treatments, including any alternatives. This information should contain an estimate of the relative risks and benefits of proposed treatments, and should be sufficiently detailed to enable patients or clients to arrive at a balanced judgment, having had the opportunity to put their own value on the relative risks and benefits described. Where there are concerns about an adult’s capacity to make a valid informed decision / give valid informed consent, the principles of the Mental Capacity Act 2005 must be used.

2. Aims and objectives

This policy applies to all employed health and social care staff, registered and unregistered, bank, sessional or honorarium staff who are required to work in clinical areas across the Trust (HRCH), who provide care or treatment to patients or service users; whether they be adults or children, with or without capacity to make their own treatment decision. This includes, but is not limited to medical personnel, nurses, health care assistants, allied health professionals or social care professionals.

Note: Practitioner includes any health or social care professional who delivers any aspect of health or social care in any environment.

As a healthcare and social care provider, the policy is applicable to care given in all service delivery areas and includes care given by Trust staff in Nursing Homes, Residential Care, Primary Care Premises, Hospitals, Urgent Care Centre, Walk in Centres, Family Planning Clinics, Community Clinics, Co-located service areas, Schools and Patient/Service Users homes.
The policy sets out the standards and procedures for obtaining valid consent from patients and service users. Where a patient or service user does not have the capacity to consent, the policy provides guidance to staff on their legal obligations under the Mental Capacity Act 2005.

It also covers the Mental Capacity Act Deprivation of Liberty Safeguards, which apply to adults who lack capacity to give valid consent to care or treatment that deprives them of their liberty.

It is intended that this policy can be used by independent contractors working in partnership with HRCH services if no such policy exists or as a reference when developing their own policies.

3. Definitions and explanation of any terms used.

<table>
<thead>
<tr>
<th>Acronym- Definition:</th>
<th>Explanation:</th>
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<tbody>
<tr>
<td>HRCH or the Trust</td>
<td>Hounslow and Richmond Community Healthcare NHS Trust</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>Practitioner</td>
<td>Includes any health or social care professional (registered or unregistered) who works for the organisation</td>
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<tr>
<td>MCA</td>
<td>Mental Capacity Act</td>
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<td>DoLS</td>
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4. Policy

4.1 What consent is – and isn’t

“Consent” is a patient's/service users informed agreement for a health or social care professional to provide care or wider input. Patients/service users may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. The type of consent must be proportionate to the care / treatment needed. For the consent to be valid, the patient/service user must:

- Be competent (have capacity) to take the particular decision;
- Have received sufficient information to take it; and
- Not be acting under duress

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

In some cases, the health or social care professional will suggest a particular form of treatment or investigation and after discussion the patient or service user may agree to accept it. In others, there may be a number of ways of managing the case or treating a condition, and the health or social care professional will help the patient/service user to decide between them.

Some patients/service users, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments or therapies. In many cases, ‘seeking consent’ is better described as ‘joint decision-making’: the patient/service user and health or social care professional need to come to an agreement on the best way forward, based on the patient’s/service users values and preferences and the health professional’s clinical knowledge.
Where an adult patient/service user lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no-one else can give consent on their behalf (although a deputy or attorney with health and welfare decision making powers may have the legal authority to make decisions on their behalf).

However, treatment or therapy may be given if it is in their best interests, as long the principles of the Mental Capacity Act are followed and this treatment has not been refused in advance in a valid and applicable **Advance Decision to Refuse Treatment (ADRT)**. In certain cases (significant decisions and no suitable advocate available) it may also be appropriate to instruct an Independent Mental Capacity Advocate (IMCA) for the patient/service user and the local arrangements should be followed if this is required.

### 4.2 Guidance on consent for HRCH staff

The Department of Health has published guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health and social care professionals must also be aware of any guidance on consent that is issued by their own regulatory bodies.

<table>
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<tr>
<th>Guidance:</th>
<th>Available at:</th>
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HRCH has also produced a short training film available on the HRCH Youtube channel. An accompanying booklet for staff, patients and carers can also be found on the HRCH intranet.

### 4.3 Guidance for Patients/Service Users, Families and Carers

Information can be sought from a variety of Government and other non-Government websites. Patients, Service Users, Families and Carer’s can be sign posted (as required) to access additional materials from the following sources:

<table>
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<th>Guidance:</th>
<th>Available at:</th>
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### 4.4 Documentation

For significant procedures, it is essential for health professionals to document clearly both a patient’s/service users agreement to the intervention and the discussions which led to that agreement.

This may be done either through the use of a consent form (with further detail in the patient’s/service users notes if necessary), or through documenting in the patient’s/service users notes (written or electronic) that they have given verbal consent. HRCH has produced guidance on recording which is on the intranet.
4.5 Evidence of agreement reached
Consent is often wrongly equated with a patient's/service users signature on a consent form. A signature on a form is evidence that the patient/service user has given consent, but is not proof of valid consent. If a patient/service user 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/service user has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to examination, treatment or therapy. Patients/service users may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

It is rarely a legal requirement to seek written consent, 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 or social care 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 professional who takes the consent is responsible for this consent. Using the principles of the MCA protects competent practitioners from liability for providing healthcare to people who lack capacity to consent.

Completed forms should be kept with the patient's/service users notes. Any changes to a form, made after the form has been signed by the patient/service user, should be initialled and dated by both patient/service user and health or social care professional.

It will not usually be necessary to document a patient's/service users 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/service user (for example if they have declined, or become very distressed about, similar care in the past); it would be helpful to do so.

4.6 Procedures to follow when patients/service users lack capacity to give or withhold consent

4.6.1 Adults without capacity
The Mental Capacity Act 2005 (MCA), which came into force in 2007, enshrines in statute best practice and common law principles concerning people who lack mental capacity and those who can lawfully take decisions on their behalf.

4.6.2 Assessing capacity
Staff should always start from the assumption that the person has capacity to make the decision in question. Under the MCA, staff will be required to make an assessment of capacity before carrying out any care, treatment, therapy or intervention. The more serious the decision, the more formal and detailed the assessment of capacity and the recording will need to be. See HRCH guidance on recording.

4.6.3 When should capacity be assessed?
It is important to remember that capacity is time and decision specific, which means that;
• The assessment of capacity must be about the particular decision that has to be made at a particular time.

• If someone cannot make complex decisions this does not mean that they cannot make simple decisions. For example, it is possible that someone with learning disabilities could make a decision about having a blood test but not to select a form of cancer treatment.

• Staff cannot decide that someone lacks capacity based upon their age, appearance, condition or behaviour alone.

• Staff may involve family, friends, and/or carers or an independent Mental Capacity Advocate (IMCA) if one has been appointed in making an assessment of capacity. This will depend on the situation and the decision that needs to be made.

4.6.4 Who should assess capacity?
The most suitable person to obtain informed consent is responsible for assessing capacity. Where consent to medical treatment is required, the health professional proposing the treatment needs to decide whether the patient has the capacity to consent. The reasons for concerns about the person’s capacity for that decision at that time should be recorded in the patient/clients notes/records, as should details of the assessment process and its findings. The more significant the decision, the more formal the assessment process of capacity is likely to be, and, where appropriate, it can be helpful to refer to relevant professionals for support (e.g. speech and language professional, psychiatrist or psychologist).

4.6.5 How do you assess capacity?
Although the MCA contains a single clear ‘functional test’ for assessing whether a person has capacity to take a particular decision at a particular time, the reality of clinical practice is likely to be slightly more complex. Under the MCA, a person is regarded as being able to make decision if, at the time the decision needs to be made, he or she is able:

• To understand the information relevant to the decision
• To retain the information relevant to the decision
• To use or weigh the information, or
• To communicate the decision (by any means)

Where an individual fails one or more parts of the test, then you have shown they do not have the relevant capacity for this decision at this time.

Clearly difficult judgements will still need to be made, particularly where there is fluctuating capacity or where some capacity is demonstrable but its extent is uncertain. This four stage functional test is nevertheless well established, and more detailed advice on practical procedures for assessing capacity is available from other sources. The MCA requires that any decision that a person lacks capacity must be based on a ‘reasonable belief’ backed by recorded objective reasons as above.

Where there are disputes about whether a person lacks capacity for a significant decision that cannot be resolved using more informal methods, the Court of Protection can be asked for a judgement.

4.6.6 Concerns about capacity
In order to decide whether a person has the mental capacity to make a particular decision, staff must first decide whether there is an impairment of, or disturbance in, the functioning of the person’s mind or brain (either permanent or temporary). If so, the second question is whether the impairment or disturbance makes the person unable to make the particular decision. The person will be unable to make the particular decision if after all appropriate help and support to make the decision has been given to them, they cannot:

• Understand the information relevant to that decision, including understanding the likely consequences of making, or not making the decision
• Retain that information
• Use or weigh that information as part of the process of making the decision
• Communicate their decision (whether by talking, using sign language or any other means).

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties or lack of engagement, rather than genuine incapacity. You should involve appropriate colleagues in making assessments of capacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient/clients situation prevents this.

A patient/clients capacity to understand may be temporarily affected by factors such as confusion, panic, shock, fatigue, pain or medication. However, the existence of such factors should not be assumed automatically to render the patient incapable of consenting. Staff should be able to show in the records why they have come to the conclusion that the person lacks capacity to make the particular decision at the relevant time. A decision should be delayed if this would give the person a better chance of making their own decision and it is safe to do so. This is considered a reasonable adjustment.

NB: It is discrimination if you expect more of a patient or service user than another person without health needs. Your recording should satisfy you and others that you have taken an objective approach.

People are entitled to make decisions considered by others to be ‘unwise’ without being judged to lack capacity for that decision.

4.7 Consent forms
Standard consent forms and forms for adults who are assessed as unable to consent for themselves are reproduced in Appendix A, B, C, D, E are available on the Trusts intranet site. There are five standard consent forms:

Form 1 for adults or competent children – particularly when general anaesthetic may be used
Form 2 for parental consent for a child or young person and
Form 3 for patient/parental agreement for procedures where consciousness is unlikely to be impaired
Form 4 for adults who are unable to consent for investigation or treatment (includes assessment)
Form 5 Consent to photography, conventional or digital video, audio recordings

The use of form 3 may be thought more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.

All consent forms are available on the Trusts intranet site for staff to download and complete as required.

4.8 Seeking consent - When should consent be sought?
When a patient/service user 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.

4.9 Single stage process
In many cases, it will be appropriate for a health or social professional to initiate a procedure immediately after discussing it with the patient/service user. 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/service users condition and whether there are any significant risks. If the patient/service user 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 verbally.

If a proposed procedure carries significant risks, it may be appropriate to seek written consent and health and social professionals must take into consideration whether the patient/service
user 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.

4.10 Two or more stage process
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 out-patient clinic/home or other setting), or it might be over a whole series of consultations with a number of different health or social care 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/service user still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

Patients and service users 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 health or social care team must check with the patient/service user 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/service users consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient/service user: for example beginning with “tell me what you’re expecting to happen”, rather than “is everything all right?”

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

4.11 Seeking consent for anaesthesia
Where an anaesthetist is involved in a patient’s or service users 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/service user to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient/service user will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia.

Patients/service users 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/service users and their consent is documented in the anaesthetic record, in the patient’s/service users notes or on the consent form. Where the health professional 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/service user has given consent to that form of anaesthesia.

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

4.13 Children and young people

4.13.1 Children without capacity to consent
Where a person under 18 lacks capacity to consent to healthcare, consent can be given on their behalf by any one person with parental responsibility or by the court. As is the case where patient/clients are giving consent for themselves, those giving consent on behalf of child patients must have the capacity to consent to the intervention in question, be acting voluntarily, and be appropriately informed. The power to consent must be exercised according to the “welfare principle”: that child “welfare” or “best interests” must be paramount.

When babies or young children are being cared for in a clinic, it will not usually seem practicable to seek their parents’ consent on every occasion for every routine intervention such as blood or urine tests or x-rays. However, you should remember that, in law, such consent is required. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child’s health at risk.

Only people with “parental responsibility” are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children (for example, unmarried do not automatically have such responsibility although can acquire it). If you are in doubt about whether the person with the child has parental responsibility for that child, please contact the Assistant Director of Quality and Clinical Excellence.

Even where a child lacks capacity to consent on their own behalf, it is good practice to involve the child as much as possible in the decision-making process.

4.13.2 Children under 16 – the concept of “Gillick competence”
Following the case of Gillick v West Norfolk and Wisbech AHA (1986), the courts have ruled that children who have sufficient understanding and maturity to enable them to understand fully what is involved in a proposed intervention will have the capacity to consent to the intervention. This is sometimes described and documented as being “Gillick competent” (also sometimes referred to as “Fraser competent” although Fraser guidelines actually refer specifically to contraception) and may apply to consent for treatment, research or tissue donation.

As the understanding required for different interventions will vary considerably, a child under 16 may therefore have the capacity consent to some interventions but not others. As with adults, assumptions that a child with a learning disability may not be able to understand the issues should never be made automatically. If the child is Gillick/Fraser competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. However where the decision will have on-going implications, such as long-term use of contraception, it is good practice to encourage the child to inform his or her parents unless it would clearly not be in the child’s best interest to do so.

4.13.3 Young people aged 16-17
Young people aged 16-17 are entitled to consent their own medical treatment, and any ancillary procedures involved in that treatment, such as anaesthetic. As with adults, consent will be valid only if it is given voluntarily by an appropriately informed patient capable of consenting to the particular intervention. However, unlike adults, the refusal of healthcare of a competent person aged 16-17 may in certain circumstances be over-ridden by either a person with parental responsibility or a Court.

In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults should be used. The MCA applies from the 16th birthday. If the requirements for valid consent are met, it is not legally necessary to obtain consent from a person with parental responsibility for the young person on addition to that of the young person. It is, however, good practice to involve the young person’s family in the decision-making process, unless the young person specifically wishes to exclude them.
4.13.4 Child or young person with capacity refusing treatment
Where a competent child, or young person of 16 or 17 refuses treatment, such a refusal can in some situations be over-ruled either by a person with parental responsibility for the child or by the court. If more than one person has parental responsibility for the young person, consent by any one such person is sufficient, irrespective of the refusal of any other individual. This power to over-rule must be exercised on the basis that welfare of the child/ young person is paramount.

4.14.1.1 The Independent Mental Capacity Advocate (IMCA)
Where an adult (16+) lacks capacity to make a decision about serious medical treatment or long term care moves and has no family or friends to support them the MCA requires an Independent Mental Capacity Advocate (IMCA) to be appointed to represent and support them.

For Patients / Service Users residing in London Borough of Hounslow, contact

<table>
<thead>
<tr>
<th>KEY CONTACT</th>
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<tbody>
<tr>
<td>IMCA Service provider:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Email:</td>
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<tr>
<td>Webpage:</td>
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</tbody>
</table>

For Patients / Service Users residing in London Borough of Richmond upon Thames, contact

<table>
<thead>
<tr>
<th>KEY CONTACT</th>
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<tbody>
<tr>
<td>IMCA Service provider:</td>
</tr>
<tr>
<td>Telephone:</td>
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<td>Fax:</td>
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<td>Email:</td>
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4.14.1 Duties of an IMCA
The duty of an IMCA is to support the person who lacks capacity and represent their views, interests and to obtain and evaluate information and ascertain (as far as possible) the person’s wishes, feelings, beliefs and values, discuss alternative courses of action and to obtain a further medical opinion if necessary and prepare a report that the decision-maker must consider.

An IMCA will not be the decision-maker, but the decision-maker will have a duty to take into account the information given by the IMCA. It is the duty of the decision-maker to instruct the IMCA before making the decision (apart from emergency situations). Referrals are made / directed to the above IMCA Services, based on where the patient / service user is living.

4.15 Lasting Powers of Attorney (LPA)
The Mental Capacity Act introduced a new form of power of attorney from October 2007 which allows people over the age of 18 to formally appoint one or more people to look after their health and welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves.
The LPA will give the attorney authority to make decisions on behalf of the donor. There will be 2 different types of LPA:

- A personal welfare LPA is for decisions about both health and personal welfare
- A property and affairs LPA is for decisions about financial matters.

An LPA must be registered with the Office of the Public Guardian before it takes effect. A personal welfare LPA will only take effect when the donor of the LPA no longer has capacity. Where a person lacks capacity and has created a personal welfare LPA, the attorney will be the decision-maker on all matters relating to the person’s care and treatment. Unless the LPA specifies limits to the attorney’s authority the attorney will have the authority to make personal welfare decisions and consent to or refuse treatment on the donor’s behalf.

The attorney will have a duty to make decisions in the best interests of the person who has made the LPA.

- If there is a dispute that cannot be resolved, e.g. between the attorney and a doctor, the matter may have to be referred to the Court of Protection
- If the decision is about life-sustaining treatment, the attorney will have the authority to make the decision only if the LPA specifies this.

It is important to read the individual LPA to understand the extent of the attorney’s power for the patient including whether they have been given the authority to refuse life-sustaining treatment. A copy of the LPA should be kept in the patient records particularly where an attorney is making treatment decisions on behalf of a patient. This is to ensure HRCH has appropriate evidence of their authority.

4.16 Best Interests
If a person has been assessed as lacking capacity for a specific decision at a relevant time, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests. The person who leads on making a decision is known as the ‘decision-maker’ and normally will be the carer responsible for the day to day care, or a professional such as a doctor, nurse or social worker/care manager where decisions about treatment, care managements or accommodation have to be made. This action/intervention must also be the ‘less restrictive option’ of those available to that person at that time. The decision should be constructed taking full account of what the person would decide IF they were able to do so.

The MCA provides a checklist of key factors which staff must consider when working out what is in the best interests of a person who lacks capacity. For more information about assessing capacity and best interest, staff should refer to the MCA Code of Practice.

4.16.1 Form 4
Where an adult patient/client does not have the capacity to give or withhold consent to some significant intervention, this fact should be documented in Form 4 (form for adults who lack the capacity to consent to investigation or treatment) along with the assessment of the patient/clients capacity for this decision at the relevant time, why the health professional believes the treatment to be in the patient/clients best interests, and the involvement of people close to the individual concerned. For more minor interventions, this information should be entered in the patient/client’s notes.

4.17 Seeking a Court Declaration
If you are involved in a case and need to seek a Court Declaration (in the first instance), speak with your line manager (if this is not possible) then please make contact with the Assistant Director of Quality and Clinical Excellence (in the first instance) or the Director of Nursing and Non-Medical Professionals and advise them accordingly.
4.18 Provision of information

The provision of information is central to the consent process. Before patients/service users can come to a decision about any treatment, intervention or therapy, they need comprehensive information about their condition and about possible options available to them, in addition to the risks and benefits of such a course of action (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue.

Once a decision to have a particular treatment or investigation has been made, patients/service users need information about what will happen: where to go, how long they will be restricted, how they will feel afterwards and so on.

Patients and service users 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 or social care professionals to make decisions for them. There will always be an element of clinical and professional judgement in determining what information should be given. However, the presumption must be that the patient/service user wishes to be well informed about the risks and benefits of the various options. Where the patient/service users makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

All information that is given to patients/users of services will be:-

- documented in the clinical records
- where HRCH leaflets are provided, the title of patient information given will be listed as well as its version number or date recorded
- provided in a timely manner (e.g. given at that appointment or by the next appointment) and (where appropriate) sign posted to where additional information can be obtained.
For external leaflets (for example from the DH) or other organizations, the title, date, version control and organization providing the leaflet will be documented.

A sample of each of the versions of HRCH patient information will be held by the QCE team concerned and will be archived by the team in accordance with the archiving standard operating procedure.

4.18.1 Provision for patients and service users whose first language is not English

The Trust is committed to ensuring that patients and service users whose first language is not English receive the information they need and are able to communicate appropriately with health and social care staff. It is not appropriate to use children to interpret for family members who do not speak English. It is also not appropriate to use other patients/service users for such support.

If an appointed interpreter has been used as part of the communication and wider consent process, it is important that the interpreter ‘confirms’ what was discussed between the patient and the health professional. This will be entered in the clinical record as an accurate account of what occurred during the consultation. The health professional should write the account and ask the interpreter to confirm the account by asking them to:

- print name
- state role and
- language and
- to sign the record.

Translation and interpretation services are provided by the London Borough of Hounslow on behalf of all residents that reside in both boroughs.

Patient/service users who are hearing impaired should receive support from sign language interpreters who can also be booked through this service. These services must be paid for using the Departmental cost code (available from your line manager)

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<thead>
<tr>
<th>Residents:</th>
<th>Service name:</th>
<th>Contact details:</th>
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</table>
| Hounslow and Richmond residents | Translation and Interpretation Service | Translation and Interpretation Service, London Borough of Hounslow, Civic Centre, Lampton Road, Hounslow, TW3 4DN  
020 8583 2299  
www.hounslow.gov.uk/translation  
(access and complete the online E form) |

4.18.2 Discussion and provision of information relating to risks, benefits and alternative treatment, intervention and therapy

All clinical staff has a general duty to patients and service users to warn them (in general terms) of what the treatment, therapy or intervention will entail, including possible risks (particularly serious risks) involved in the procedure. In modern law, medical paternalism no longer rules and a patient has a right to be informed by the health professional of small, but well established risks relating to the proposed treatment, therapy or intervention. It is the responsibility of the health professional to discuss in full:

- known or potential risks
- known or potential serious risks
- benefits, health gains and outcomes
- alternative treatment, therapy or intervention options
- risks of declining of refusing treatment, therapy or intervention options
All information (discussion and provision of information) that is given to patients/users of services will documented in the clinical records

### 4.18.3 Access to more detailed or specialist information

Patients/service users may sometimes request more detailed information about their condition or about a proposed treatment, therapy or intervention than that is provided in general leaflets. The Trust has made the following arrangements to assist people to obtain such information:

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<tr>
<td><strong>Officer:</strong> Patient Experience and Involvement Manager</td>
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### 4.18.4 Access to health professionals between formal appointments

After an appointment with a health or social care professional, whether in the person’s home, primary care or outpatients setting, patient/service users 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/service user to contact the service 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 person’s choice). Contact details of the health or social care professional should be given at the initial appointment.

### 4.18.5 Open access clinics

Where patient/clients 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 to gain consent for an investigation, treatment or therapy. This will be provided directly from the clinic and the practitioner providing the service. If a health professional has concerns about a patient’s capacity to consent, then a capacity assessment needs to made and recorded.

### 4.18.6 Sharing of Information

Information is essential for the delivery of high quality evidence based care. The primary purpose for keeping personal records is to support the *assessment, management, planning, delivery* and *continuation of safe care* to that individual.

The public expects that service providers respond effectively to their needs and understands that this often requires their information to be shared between the different agencies. Whilst it is vital for the proper care of individuals that those concerned with that care have ready access to the information they need, it is also important that service users can trust that personal information will be kept confidential, secure and that their privacy is respected.

In order to be confident that sharing is justified, both the requestor and the provider should be clear about the purpose of exchanging personal identifiable information and only the minimal identifiable information necessary to satisfy that purpose should be made available.

Staff should only access personal information on a justifiable *need to know* basis in order to perform their duties in connection with the care they are employed to deliver. Information sharing should be done with the consent of the individual patient/service user concerned.

It is neither practicable nor necessary to seek an individual’s specific consent each time information needs to be shared, but this is contingent upon the individual being previously informed that the sharing of their personal information would be likely and they understand the uses to which their information may be put. This is addressed in SystmOne via consent for a patient’s information to be shared in and out.
If an individual wishes information about them to be withheld from someone who might otherwise have received it, the individual's wishes should be respected unless there are exceptional circumstances where a breach of confidentiality can be justified. Every effort should be made to explain to the individual the consequences for their care and planning their decision may have, including risks, but the individual's final decision should be honoured.

The exceptional circumstances which may override the need for the individual's consent include:

- When it is necessary to fulfil a statutory obligation or court order
- Where there is a serious public health risk or risk of harm to an individual or others e.g. children protection or adults at risk
- For the prevention and detection of serious crime

The decision to release information in these or any other circumstances without consent must be made by the Consultant or G.P or Health or Social Care Professional in charge of the individual's care or a person of similar authority within Social Care Services. Advice from the organisation's Caldicott Guardian should be sought where necessary.

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<tr>
<td>Caldicott Guardian:</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing and Non-Medical Professionals</td>
<td>Hounslow and Richmond Community Healthcare NHS Trust, Thames House, 180-194 High Street, Teddington, TW1 8HU 020 8973 3000</td>
</tr>
</tbody>
</table>

4.19 Who is responsible for seeking consent?
The professional carrying out the procedure is ultimately responsible for ensuring that the patient/service user is genuinely consenting to what is being done; it is they who will be held responsible in law if this is challenged later. However team work is essential in the NHS and where written consent is being sought, in some cases, it may be appropriate for other health professionals who are capable of carrying out the procedure to seek consent.

The Trust does not authorise ‘delegated consent’ whereby another health professional seeks consent but where they are not capable of carrying out the procedure themselves.

Where verbal or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the health professional responsible for undertaking the procedure. They will be responsible for ensuring that the consent to treatment is valid and that discussions are recorded in the patient's record.

4.19.1 Completing consent forms
The standard consent form provides space for health professionals to provide information to patients / service users and to sign confirming that they have done so. The health professional providing the information must be competent to do so because they themselves are able to carry out the procedure.

4.19.2 How the organisation follows up where an individual has obtained consent without authorisation to do so.
Staff must complete incident forms if aware that consent is being obtained outside the standards as set out in this policy. The incident will be managed in line with the incident reporting policy. If a complaint or concern is expressed by a patient or carer or their representative an investigation would follow as per the complaints policy.

Anyone taking consent who is not authorised to do so will be managed by their manager via their line manager through the relevant procedure including the disciplinary procedure or via their professional body as appropriate.
4.19.3 How the organisation notifies the GMC of any individual who has obtained consent without the authorisation to do so.

If concerns about improper consent-taking by a doctor have been identified staff may submit information on the steps they have taken to prevent recurrence using the form that can be found on the web page https://www.gmc-uk.org/about/contactus/comments_and_complaints.asp. Individuals should not be identified.

4.19.4 Responsibility of health professionals

It is the health and social care professional’s own responsibility to work according to their own professional organisations standards and HRCH policy. Staff should:-

- 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. If you do not feel competent to seek consent you should contact your line manager

- If you feel that you are being pressurised to seek consent when you do not feel competent to do so you should contact your clinical/professional lead and/or line manager for further advice

4.20 Refusal of treatment

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient or service users’ options. An adult patient/service user with capacity in relation to that decision at that time is entitled to refuse any treatment, investigation or therapy, except in circumstances governed by the Mental Health Act 1983 (amended 2007). The situation for children is more complex: see the Department of Health’s Reference guide to consent for examination or treatment.

The following paragraphs apply primarily to adults.

If, after discussion of possible treatment options, a patient or service user refuses all treatment, intervention or therapy, this fact should be clearly documented in their notes together with evidence that the risks have been explained to them.

If they have already signed a consent form, but then change their mind, you (and where possible the patient/service user) should note this on the form.

Where a patient/service user 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/service user realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

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

Tattoos which refuse life sustaining treatment are not a valid form of advance decision as it cannot be evidenced that they were freely obtained and they are not personally signed. They may, however give an indication of the person’s previous wishes to be discussed.
4.20 Jehovah's witnesses
Patients or service users (18+) who are Jehovah’s Witnesses may carry an Advance decision to refuse treatment card setting out their choices. If valid, decisions to refuse blood transfusions or blood products must be respected provided the adult has acknowledged in writing within the document that their life is at risk.

4.21 Tissue
The Human Tissue Act 2004 came fully into force on 1 September 2006. It sets out the legal framework for the storage and use of tissue from the living and for the removal, storage and use of tissues and organs from the dead, including ‘residual’ tissue following clinical and diagnostic procedures. The Human Tissue Act makes consent a legal requirement for the removal, storage and use of human tissue or organs and sets out whose consent is needed in which circumstances. The Act also established the Human Tissue Authority (HTA). The HTA is also responsible for approving the transplantation of organs from living donors and bone marrow and peripheral blood stem cells from adults who lack capacity to consent and children who lack the competence to consent. Further guidance and HTA Code of Practice is available from HTA’s website www.hta.gov.uk

4.21.1 Public Health Surveillance
Explicit consent is not necessary for public health surveillance using the unlinked anonymous method, but a well-publicised opt-out policy must apply. This does not currently apply to HRCH but should the organisation undertake such surveillance in the future an appropriate opt-out policy will be developed and publicised.

4.21.2 Tissue Samples - Quality Assurance
The Department of Health believes that tissue samples may be used for quality assurance purposes without requiring specific patient consent provided there is an active policy of informing patients of such use. This is essential to ensure the high quality of service which all patients have the right to expect. Wherever possible, samples of tissue used in this way should be anonymised or pseudonymised. In instances where pathology and haematology samples are submitted from primary and community care the whole of the sample is used for investigation.

4.22 Clinical photography and conventional or digital video and audio recordings
Photographic and video recordings made for clinical, treatment or care purposes form part of a patient/service user’s record. Although consent to certain recordings, such as X-rays, is implicit in the patient/service users consent to the procedure, professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

Photographic and video recordings which are made for treating or assessing a patient/service user and from which there is no possibility that the patient/service user might be recognised, may be used within the clinical setting for education or research purposes without express consent from the person, as long as this policy is well publicised. However, express consent must be sought for any form of publication.

4.22.1 Recordings for education, publication or research purposes
If you wish to make a photographic or video recording of a patient/service user 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/clients 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/client decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients/clients 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.

4.22.2 Patients who are temporarily unable to give consent
The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient/service user 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/service user regains capacity. You must not use the recording until you have received consent for its use, and if the patient/service user does not consent to any form of use, the recording must be destroyed.

4.22.3 Seeking agreement from a third party
If the patient/service user 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/service user. You must not make any use of the recording, which might be against the interests of that person. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients/service users who are able to give or withhold consent.

4.23 Information security
- All staff are responsible for ensuring that recordings (images / video etc.) of patients/service users are always stored on Trust/Service premises. All recordings should be stored securely on the Trust’s server / network. Recordings can be stored temporarily on Trust laptops / USB Sticks / CDs / DVDs / mobile working devices endorsed by the Trust provided that the devices have been encrypted.
- Images may also be stored temporarily on Trust digital cameras before being uploaded to a secure area of the network. All digital images should be uploaded as soon as possible and deleted from the camera either at the end of each day, in the patient/service user’s home or immediately upon return to base. Once the data has been transferred, all traces of the data should be immediately removed from the removable storage device.
- Staff are responsible for ensuring that digital cameras are stored securely when removed from Trust premises.
- Any personally owned storage devices USB sticks, mobile phones, personal digital cameras or MP3 players must never be used to store images or recordings.
- Data in transit on removable media must be encrypted, handled and stored appropriately and afforded the utmost security and protection at all times. An exception to this applies to images held on digital cameras during transit - the Trust accepts this risk as there is currently no encryption solution to digital cameras.
- Any image or recordings should be named with the patient/service users NHS Number using the recommended format of 3 3 4 e.g. 123 456 7890 (NPSA Safer Practice Notice: Sep 2008 No NPSA/2008/SPN001) and the date the image or recording was made. It is noted that some electronic systems are only set up to record a full 10 digit number with no spaces.
- In the case of a digital picture file, the original file must be written to encrypted disc and stored securely with appropriate measures taken to back up the images. Each image should be saved under the patient’s NHS number and the date of the recording.
- The Department of Health’s ‘Records Management: NHS Code of Practice’ ‘Part 2, Annex D1: Health Records Retention Schedule’ must be referred to for retention periods of Digital Photography and Video Recordings. The Records Management NHS Code of Practice must also be referred to when archiving information given to patients to support their decision making.
Further specific advice can be sought from:-

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<tr>
<td>Officer:</td>
<td></td>
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<tr>
<td>Information Governance and</td>
<td>Hounslow and Richmond Community Healthcare NHS Trust,</td>
</tr>
<tr>
<td>Freedom of Information Manager</td>
<td>Thames House, 180-194 High Street, Teddington, TW1 8HU</td>
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<td>020 8973 3000</td>
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4.24 Seeking informed consent for research

The gaining of informed consent for research is an important starting point for all studies involving human subjects. There is a clear distinction between informed consent to research and informed consent to a clinical or therapeutic procedure. Most of the activities performed in the health care setting have a beneficial aim, even if the outcome is not proven. The aim of research is very much the same but with one main difference. The individual involved in research may not benefit personally and may even be inconvenienced. This is the main reason why there is greater emphasis placed on the strict guidelines for informed consent for research.

The provision of information is a fundamental requirement if potential research subjects are to be able to make meaningful decisions. Information provided to research subjects essentially takes two forms. Firstly, the researcher will talk to the potential subject and provide verbal information. It is important, however, that this is backed-up by the second category which is written information (accessible to that person). It is through the process of providing verbal information that potential research subjects are able to ask questions and clarify points that will influence their decision.

The process is initiated when information is relayed from the researcher to the prospective subject. The quality and content of that information will influence the subject’s decision so that the researcher has an obligation to ensure that the potential subject has sufficient information to make that decision.

Once potential research subjects have received comprehensive information, which they understand, they should then be free to decide whether to participate in the research or not. That decision should be their decision without any coercion from any other party. It should also be clear that their decision will not affect the care, treatment or therapies they are receiving from the organisation or other investigating body, and that they are free to withdraw from the study at any time.

4.25 Deprivation of Liberty Safeguards (MCA DOLS)

The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS) uphold people’s universal right to liberty and prevent deprivations of this liberty without proper safeguards including independent consideration and authorisation. Deprivations of liberty in hospitals or care homes, (administrative deprivations) other than under the Mental Health Act, should follow the MCA DOLS process. For HRCH, this primarily applies to inpatients who lack capacity to consent to their care and treatment at Teddington Memorial Hospital.

This will apply to people who lack capacity to consent to a care plan which includes continuous supervision and means they are not free to leave. Application and outcome forms are within clinical care records on SystmOne. Guidance is available on the HRCH intranet.

Judicial deprivations may apply to people deprived of their liberty in community environments (whose care is funded by the State i.e. the local authority or CCG) following the Supreme Court judgment of 19 March 2014 making case law relating to Cheshire West and clarifying an “acid test” for what constitutes a “deprivation of liberty”.

The HRCH coterminous Local Authorities act as Supervisory Bodies for DOLS and have the following functions:

• Assess any person for whom the Managing Authorities (i.e. providers of care and treatment including HRCH) request an authorisation to deprive someone of their liberty.
• Authorise a deprivation if it is proportionate to the risk and in the best interests of a person to whom the Safeguards apply.
• Set any necessary conditions to make sure the person’s care/treatment meets their needs in their best interests.
• Set a timescale for how long a deprivation can last.
• Keep records of who is being deprived of their liberty.

HRCH staff who believe a patient may be deprived of their liberty by a publically funded care plan to which they are unable to consent should seek advice from the Safeguarding team.

4.26 Advance Care Planning
Advance Care Planning is one way to take account of a person’s wishes in relation to future care and treatment decisions. Well informed consent needs to be sensitively gained and staff needs to be prepared for and supported to have potentially difficult conversations with people who may have been diagnosed with a long term or life limiting condition. The principles of the Mental Capacity Act apply. Health professionals should be led by the individual and recognise different needs and preferences. If the person has given consent for carers, family, or friends to be involved in discussions (or if this has been agreed as in their best interests) health professionals should take reasonable steps to involve them, keeping the patient at the centre. The patient (and / or advocate must be provided with an accessible document that records their preferences for key issues such as treatment, support, accommodation and place of death. Consent should be sought for appropriate sharing of this plan between agencies that have a legitimate need to know.

5. Duties

Chief Executive:
The Chief Executive of Hounslow and Richmond Community Healthcare NHS Trust is the accountable officer for ensuring high quality, safe care provision and they in turn reports to the Trust Board. He / she is ultimately responsible for the implementation of this policy. Delegated responsibility of operational management of care to named executive directors is described below.

Director of Operations:
The Director of Operations is the Board level lead for the operational management of services within the Trust and is the designated lead for the organisation’s Health and Safety. They are also responsible for ensuring processes for patient/client safety and delivery of care is in place.

Director of Quality and Clinical Effectiveness:
The Director of Quality and Clinical Excellence is the Board level lead (as the clinical lead within the organisation), to facilitate, develop and provide monitoring processes for the identification, assessment, reporting and management of risk within community care.

Director of Human Resources and Organisational Development:
The Director of Human Resources and Organisational Development is the Board level lead for the relevant training programmes for consent are made available.

Service Leads and Managers:
It is the responsibility of all service leads and managers to:-

- Ensure staff are informed of the policy and competent to provide a quality service.
- Support staff by ensuring appropriate training, counselling and clinical supervision is available to ensure full compliance with the implications of this policy.
- Investigate adverse or Serious Untoward Incidents and complaints as per the Trust policy, ensuring learning outcomes are disseminated.
- To monitor and audit the use of the policy.
- To ensure regular reviews are undertaken.
All Staff:
The health or social care professional carrying out a procedure is ultimately responsible for ensuring that the patient/client is genuinely consenting to what is being done; it is they who will be held responsible in law if this is challenged later. It is the responsibility of all Trust staff engaged in the provision of clinical and social care to:-

- Accept the overall responsibility for providing accurate information to the patient/client for informed consent to be made. The decision should be made after consultation and consideration of all aspects of the patient’s condition.
- Ensure consent, appropriate to the procedure is obtained from the patient/client prior to the procedure
- It is the professionals own responsibility to work according to their own professional organisations’ standards and respective codes of practice.
- To ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so
- To work within their own competence and not to agree to perform tasks which exceed that competence. If you do not feel competent to seek consent you should contact your line manager and discuss this in your clinical, peer and 1 to 1 supervision.
- Work as part of the multidisciplinary and multi-agency teams
- Fully understand the policy and the implications for practice, undertaking training where relevant.
- Ensure clear communication lines within the team/service and with all relevant professionals in primary, secondary, tertiary or other social care settings.
- Ensure clear record keeping of all decisions and reasons for those decisions in the patient/client’s records with full regard given to confidentiality.
- 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 professional responsible. However, team work is a crucial part of the way the NHS, Local Authorities and 3rd Sector partners operate, and where written consent is being sought it may be appropriate for other members of the wider team/service or agency to participate in the process of seeking consent, this is especially true when integrated care is being delivered.

Responsible Committees – Quality Governance Committee and Safeguarding Committee:

This policy has been reviewed by the Safeguarding Committee which reports to the Quality Governance Committee (QGC). The QGC has overarching responsibility for risk management, which includes consent, delegated by the Trust Board. The Committee’s role is to ensure actions are taken as a result of trend analysis of incidents and complaints, and the cascading of the information throughout the organisation. The responsibility for monitoring the completion of the action plans and the subsequent effectiveness of any risk reduction measures introduced are included within this remit. This is reflected in the Terms of Reference (TOR) for this committee which are reviewed annually and is available upon request.

6. Consultation Process

The consultation and engagement process regarding the original consent policy included the following and comments incorporated as appropriate:-

- Hounslow and Richmond HealthWatch have had an opportunity to review the policy from a Patient/Service Users perspective
- Trust staff and managers (including the Patient Experience and Involvement Manager)
- Trust Lead for Equalities
- Quality and Safety Committee
- Safeguarding Committee
7. Approval and Ratification Process
This revised and updated policy was approved by the Safeguarding Committee on 5 February 2018 and was ratified by the Policy Ratification Group on 22 March 2018.

8. Dissemination and Implementation
This document will be placed on the intranet by the QCE Team.

It will therefore be available to all staff via the HRCH NHS intranet. Furthermore the document will be circulated to all managers who will be required to cascade the information to members of their teams and to confirm receipt of the procedure and destruction of previous procedures/policies which this supersedes. Managers will ensure that all staff is briefed on its contents and on what it means to them in relation to their practice. The policy will be part of the induction programme for all new staff when joining the Trust.

9. Archiving
The overarching archiving arrangements for clinical records are contained within the clinical records management policy.
All information given to patients/users of services will be:
- documented in the clinical records at the time of the consultation/clinical interaction
- version control (title of patient information given and version number or date) recorded

10. Training requirements

10.1 Staff and Service lines (within their sphere of clinical practice) capable of performing and authorised to obtain consent for a procedure, treatment or intervention

Note: Consent can only be obtained by health professionals that are capable of undertaking the procedure themselves.

<table>
<thead>
<tr>
<th>Staff and Service Lines – Consent Training Required</th>
<th>Yes:</th>
<th>No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Registered Specialist Community Public Health Nurses</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Speech and Language Therapists</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Podiatrists</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Audiologists/Audiology</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dieticians</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Phlebotomists/Phlebotomy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Clerical and Administration staff</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Board and Executive Directors</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Senior Managers</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

10.2 Frequency of consent training or consent ‘learning activity’
The Trust requires its ‘patient facing’ staff to have consent training (or related consent learning activity) at least every three years in line with the training needs analysis and training and development policy. Furthermore health professionals who are capable of obtaining consent are required to familiarize themselves with the contents of this policy and identify any further training requirements.

10.3 Identification of training or learning needs
Training needs are identified by individual practitioners (themselves), managers and the Organisational Development team. This will be achieved through:

- Clinical, peer and 1 to 1 supervision
- PDP and annual appraisal process
- Individual applications for specific courses
- Training needs analysis

10.4 Types of learning available to staff
The following are 'types' of learning activity made available by the Trust (the list is not exhaustive, but may include):

- Mental Capacity and Consent training
- Record Keeping
- Information Governance training
- Practice Briefing Notes (mental capacity)
- Individual learning (protected learning time as identified by PDP process)

11. Monitoring and Auditing Compliance with the Procedural Document

See compliance monitoring tables Appendix F
Standard 5.2 Patient Information and Consent
Standard 5.3 Consent Training

12. Review

The policy will be reviewed in 2 years' time (by December 2019) by the policy author or designated other.

13. References

- OPG (2009): Making Decisions: about your health, welfare or finances. Who decides when you can’t?

14. Associated Documentation

- Clinical Records Management Policy
- Training and Development Policy
- Policy for the Management of Complaints and Concerns
- Policy for the Investigation of Incidents, Complaints and Claims

15. Appendices
Appendix A: Form 1 for adults or competent children – patient agreement to investigation treatment or procedure

Appendix B: Form 2 for parental consent for a child or young person and

Appendix C: Form 3 for patient/parental agreement for procedures where consciousness not impaired

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

Appendix E: Form 5 for Photography, conventional or digital video, audio recordings

Appendix F: Monitoring and compliance Table

Appendix G: Audit document

Appendix H: Equality Impact Assessment
Hounslow and Richmond Community Healthcare NHS Trust

Consent form 1

Patient/Client agreement to investigation, treatment or therapy

Patient/Client details (or pre-printed label)

Patient/Clients surname/family name…………………………

Patient/Clients first names……………………………………

Date of birth …………………………………………………

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

Job title ………………………………………………………

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

☐ Male ☐ Female

Special requirements ………………………………………
(E.g. other language/other communication method)

To be retained in patient/client notes
Patient/Client identifier/label

Name of proposed procedure or course of treatment (include brief explanation if medical, nursing or therapy term is 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/client. In particular, I have explained:

The intended benefits ………………………………………………………………………………………
…………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………
Significant, 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/information has been provided
…………………………………………………………………………………………………………………………

This procedure will involve:
☐ General and/or regional anesthesia ☐ local anesthesia ☐ sedation

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

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

Statement of interpreter (where appropriate)

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

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

Top copy accepted by patient: yes/no (please ring)
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, course of treatment, therapy or care described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

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

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

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

Patient/Client’s signature ........................................Date..........................
Name (PRINT) ..................................................................................

A witness should sign below if the patient/client is unable to sign but has indicated his or her consent. Young people/children may also like a parent (or those with parental responsibility) 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/client, I have confirmed with the patient/client that s/he has no further questions and wishes the procedure to go ahead.

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

Important notes: (tick if applicable)

☐ See also advance decision to refuse treatment /living will (e.g. Jehovah’s Witness form)
☐ Patient/Client 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/client’s agreement to go ahead with the investigation, treatment or therapy you have proposed. It is not a legal waiver – if patients/clients, 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. Patient/clients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patient/clients, 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/client be regarded as a substitute for face-to-face discussions with the person concerned.

The law on consent

See the Department of Health’s (2009) Reference guide to consent for examination or treatment (2nd edition) for a comprehensive summary of the law on consent (available at www.doh.gov.uk)

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”, then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child’s care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient/client is 18 or over and lacks the capacity 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/client 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 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/client in making their own decision, 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 themselves, unless they have been given the authority to so under a Lasting Power of Attorney or as a court appointed deputy.”

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. Following the Chester v Afshar judgement, the courts have stated that patients/clients should be told about ‘significant, unavoidable and frequently occurring risks which would affect the judgement of a reasonable patient’. ‘Significant’ has not been legally defined, but the GMC requires doctors to tell patient/clients about ‘serious or frequently occurring’ risks. In addition if patient/clients make clear they have particular concerns about certain kinds of risk, you should make
sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patient/clients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient/client receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient/clients notes.
Hounslow and Richmond Community Healthcare NHS Trust

Consent form 2

Parent (or person who has parental responsibility) agreement to investigation, treatment or therapy for a child or young person

Patient/Client details (or pre-printed label)

Patient/Clients surname/family name………………………………

Patient/Clients first names…………………………………………

Date of birth ………………………………………………………

Age …………………………………………………………………

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

Job title …………………………………………………………………

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

☐ Male              ☐ Female

Special requirements ………………………………………
(E.g. other language/other communication method)

To be retained in patient/clients notes
Patient/Client identifier/label

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear) ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………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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/therapy described on this form and I confirm that I have ‘parental responsibility’ for this child.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

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

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

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

Signature ………………………………………….. Date…………………………
Name (PRINT) ………………………..Relationship to child…………………………..

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

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

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

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

On behalf of the team treating the patient/client, I have confirmed with the child and his or her parent(s)/(or those with parental responsibility) that they have no further questions and wish the procedure to go ahead.

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

Important notes: (tick if applicable)

☐ See also advance decision to refuse treatment /living will (e.g. Jehovah’s Witness form)
☐ Parent has withdrawn consent (ask parent to sign /date here) …………………………
Guidance to health professionals (to be read in conjunction with consent policy)

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

Who can give consent
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. The courts have stated that if a child under the age of 16 has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”, then he or she will be competent to give consent for his 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, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child’s treatment. In law, health professionals only need the consent of one appropriate person before providing treatment.

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-rulled 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. (Gillick v West Norfolk and Wisbech AHA (1986) AC 112).

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.

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

Information
Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for children and their parents when making up their minds about treatment. The courts have stated that patients should be told about ‘significant risks which would affect the judgement of a reasonable patient’. ‘Significant’ has not been legally defined, but the GMC requires doctors to tell patients about ‘serious or frequently occurring’ risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

Guidance on the law on consent
# Consent form 3

## Patient/Parental agreement to investigation or treatment for a child or young person

<table>
<thead>
<tr>
<th>Patient details (or pre-printed label)</th>
</tr>
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<tbody>
<tr>
<td>Patient/Clients surname/family name...</td>
</tr>
<tr>
<td>Patient/Clients first names...</td>
</tr>
<tr>
<td>Date of birth</td>
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<tr>
<td>Age</td>
</tr>
<tr>
<td>Responsible health professional...</td>
</tr>
<tr>
<td>Job title</td>
</tr>
<tr>
<td>NHS number (or other identifier)...</td>
</tr>
</tbody>
</table>

- **Male**  
- **Female**

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

To be retained in patient/client notes
Patient/Client identifier/label

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

Name of procedure (include brief explanation if medical/treatment/therapy 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/information has been provided

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

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

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

Statement of patient/person with parental responsibility for patient
I agree to the procedure described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure, treatment, intervention or therapy. 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………………………

37 of 63
Confirmation of consent (to be completed by a health professional when the patient is admitted/arrives for the procedure, if the patient/parent has signed the form in advance)

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

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

Top copy accepted by patient: yes/no (please ring)
Guidance to health professionals (to be read in conjunction with consent policy)

This form
This form documents the patient’s agreement (or that of a person with parental responsibility for the patient) to go ahead with the investigation or treatment you have proposed. It is only designed for procedures where the patient is expected to remain alert throughout and where an anaesthetist is not involved in their care: for example for drug therapy where written consent is deemed appropriate. In other circumstances you should use either form 1 (for adults/competent children) or form 2 (parental consent for children/young people) as appropriate.

Consent forms are not legal waivers – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients also have every right to change their mind after signing the form.

Who can give consent
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”, then he or she will be competent to give consent for his or herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this form for themselves, if they wish. If the child is not able to give consent for his or herself, some-one with parental responsibility may do so on their behalf. Even where a child is able to give consent for his 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/client is 18 or over and lacks the capacity 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/client 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 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/client in making their own decision, 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 themselves, unless they have been given the authority to so under a Lasting Power of Attorney or as a court appointed deputy.

Information
Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds about treatment. The courts have stated that patients should be told about ‘significant risks which would affect the judgement of a reasonable patient’. ‘Significant’ has not been legally defined, but the GMC requires doctors to tell patients about ‘serious or frequently occurring’ risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to
have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this overleaf or in the patient’s notes.

The law on consent

HRCH have produced a ‘Show How to Know How’ training film to guide use of the Mental Capacity Act and recording in community healthcare.
It is available on our website here
There is also an accompanying booklet attached above aimed at those who don’t use Youtube.
Hounslow and Richmond Community Healthcare NHS Trust

Consent form 4

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

Patient details (or pre-printed label)

Patient’s surname/family name…………………………………..
Patient’s first names ......................................................
Date of birth .....................................................................
Responsible health professional........................................
Job title ...........................................................................
NHS number (or other identifier)........................................

☐ Male  ☐ Female

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

To be retained in patient/clients notes
A Details of procedure or course of treatment proposed

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

B Assessment of patient’s capacity

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

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

☐ The patient is unable to use and weigh this information in the decision-making process; or communicate their decision (by talking, using sign language or any other means)

☐ The patient is unconscious

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

C Assessment of patient’s best interests

I am satisfied that the patient has not refused this procedure in a valid advance decision. As far as is reasonably possible, I have considered the person’s past and present wishes and feelings (in particular if they have been written down) any beliefs and values that would be likely to influence the decision in question. As far as possible, I have consulted 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 patient’s best interests in accordance with the requirements of the mental capacity Act and believe the procedure to be in the best interests because:

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

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

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

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

Any other comments (including any concerns about decision)

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

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

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

☐ Yes      ☐ No

Details:

Independent Mental Capacity Advocate (IMCA)
For decisions about serious medical treatment or intervention, where there is no one appropriate to consult other than paid staff, has the IMCA been instructed?

☐ Yes      ☐ No

Details: Name: Address: Contact:

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

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

I have/have not sought a second opinion.

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

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

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

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 authorised 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.

Signature of attorney or deputy
I have been authorised to make a decision about the procedure in question under a Lasting Power of Attorney / 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 patient’s best interests)

Signature ........................................................................... Date
Name (PRINT) ...................................................................Role.................................
Guidance to health professionals (to be read in conjunction with consent policy)

This form should only be used where it would be usual to seek written consent but an adult patient (18 or over) lacks capacity to give or withhold consent to treatment. If an adult has capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the Mental Health Act 1983 (Amended 2007), different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance decision to refuse treatment), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health’s Reference guide to consent for examination or treatment (www.doh.gov.uk).

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 Practice (www.publicguardian.gov.uk/mca/code-of-practice.htm) Treatment can be given to a patient who is unable to consent, only if the following apply:-

- the patient must lack the capacity (‘competence’) to give or withhold consent to this procedure AND
- the procedure must be in the patient’s best interests.

Capacity
A 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 effects 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 that the information given to them 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, and
- 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

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 therapists or learning disability teams, and independent advocates (as distinct from an IMCA as set out below) or supporters. Sometimes it may be necessary for a formal assessment to be carried out by a suitable 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 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 capacity.

Best Interests
The Mental Capacity requires that a health professional 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 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 including disability) 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 is appropriate to do so, and to take into account of their views as to what would be in the best interest of 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 authorised 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 no way of settling the matter in the best interests of the person lacking capacity. If a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity then it is the deputy rather than the health professional that makes the treatment decision and the deputy must make decisions in the patient’s best interests.

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 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.

**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 sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
- all other cases where there is a doubt or dispute about whether a particular treatment will be

in a person’s best interest (including 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 advanced decision to refuse treatment

09.12v
Hounslow and Richmond Community Healthcare NHS Trust

Consent form 5

Consent to photography, conventional or digital video, audio recordings that may be used for

- Teaching in the delivery of/or providing care
- Patient/Client care and support plans
- Education, publication or research

Patient/Client details (or pre-printed label)

Patient/Clients surname/family name…………………………
Patient/Clients first names……………………………………
Date of birth …………………………………………………
Responsible health professional……………………………
Job title ………………………………………………………
NHS number (or other identifier)……………………………

□ Male □ Female

Special requirements ………………………………………
(E.g. other language/other communication method)

To be retained in patient/client notes
Patient/Client identifier/label

A: Able to give consent
I have no objection to myself/child being photographed either conventional or digital video, audio recordings.

I give my consent for the photographs, digital video or audio recordings to be used for (please tick as appropriate):

☐ Teaching in the delivery of/or providing care
☐ Patient/Client care and support plans
☐ Education
☐ Publication
☐ Research

Specific reason for taking photographs, digital video or audio recordings for which consent has been given

…………………………………………………………………………………………………………
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Specific restrictions in the use of photographs, digital video or audio recordings for which consent has been given

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

Patients/Clients surname/family name .................................................................

Patients/Clients first name .................................................................................

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

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

Print name ..........................................................

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

Job title ..............................................................................................................

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

Print name ..........................................................
Patient/Client identifier/label

B Unable to give Consent

Patient unable to give consent and Best Interest
The patient lacks the capacity to give consent for the taking of photographs, conventional or digital video, audio recordings.

I/we are of the view that it is in the person’s best interest that the taking of photographs, conventional or digital video, audio recordings is in the person’s best interest in order for the:-

☐ Teaching of: care, treatment, intervention or therapy
☐ Patient/Client care and support plans

(Please tick appropriate box)

And/or

Specific reason for taking photographs, digital video or audio recordings for which consent has been given

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

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

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

Print name …………………………………………………

Names of others consulted in the best interest discussion

<table>
<thead>
<tr>
<th>Name</th>
<th>Role/Relationship</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Guidance to health professionals (to be read in conjunction with consent policy)
It is important that all health care professionals obtain consent in relation to the Trust’s Consent Policy and make specific reference to policy sections:-

- Best Interests
- Clinical photography and conventional or digital video and audio recordings
- Recordings for education, publication or research purposes
- Information security
- Seeking informed consent for research

When obtaining consent for the patient/client, parent (or those with parental responsibility) or those with LPA

If patient unable to give consent
If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests. The person who has to make a decision is known as the ‘decision-maker’ and normally will be the carer responsible for the day to day care, or a professional such as a doctor, nurse or social worker/care manager where decisions about treatment, care management or accommodation have to be made. As a health professional, you have a responsibility to ensure (and satisfy yourself) that the taking of photographs, conventional or digital video, audio recordings of the patient are in their best interest, that may be used for:-

- Teaching of: care, treatment, intervention or therapy
- Patient/Client care and support plans

09.12v
## Appendix F: Monitoring and Compliance Tool

### Patient Information and Consent - Monitoring and Compliance Tool

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>How Trust will monitor compliance (Data and audit)</th>
<th>Frequency of monitoring</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented process for obtaining consent</td>
<td>Sandie Cox Safeguarding Adults Lead</td>
<td>• Two service areas will conduct a ‘consent to treatment or therapy’ audit&lt;br&gt;• Head of Service/Service Manager will have responsibility to conduct audit in their area&lt;br&gt;• Consent Lead will work with Clinical Audit Dept in collating/producing an annual audit review to look at services audited</td>
<td>Quarterly Audit</td>
<td>Group Service Managers/Locality Managers/CEAG</td>
<td>Group Service Managers/Locality Managers</td>
<td>Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
</tr>
<tr>
<td>Documented process for how information is provided to patients to support their decision making, including risks, benefits and alternatives where appropriate</td>
<td>Sandie Cox Safeguarding Adults Lead</td>
<td>• Two service areas will conduct a ‘consent to treatment or therapy’ audit&lt;br&gt;• Head of Service/Service Manager will have responsibility to conduct audit in their area&lt;br&gt;• Consent Lead will work with Clinical Audit Dept in collating/producing an annual audit review to look at services audited</td>
<td>Quarterly Audit</td>
<td>Group Service Managers/Locality Managers/CEAG</td>
<td>Group Service Managers/Locality Managers</td>
<td>As above</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>How Trust will monitor compliance</th>
<th>Frequency of monitoring</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented process for how the discussion and provision of information to patients is recorded</td>
<td>Sandie Cox Safeguarding Adults Lead</td>
<td>Two service areas will conduct a ‘consent to treatment or therapy’ audit</td>
<td>Quarterly Audit</td>
<td>Group Service Managers/ Locality Managers</td>
<td>Group Service Managers/ Locality Managers/ CEAG</td>
<td>As above</td>
</tr>
<tr>
<td>Process for recording that consent has been given</td>
<td>Sandie Cox Safeguarding Adults Lead</td>
<td>Two service areas will conduct a ‘consent to treatment or therapy’ audit</td>
<td>Quarterly Audit</td>
<td>Group Service Managers/ Locality Managers</td>
<td>Group Service Managers/ Locality Managers/ CEAG</td>
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<tr>
<td></td>
<td></td>
<td>Head of Service/Service Manager will have responsibility to conduct audit in their area</td>
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<tr>
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<td></td>
<td>Consent Lead will work with Clinical Audit Dept in collating/producing an annual audit review to look at services audited</td>
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<tr>
<td>Element to be monitored</td>
<td>Lead</td>
<td>How Trust will monitor compliance (Data and audit)</td>
<td>Frequency of monitoring</td>
<td>Reporting arrangements</td>
<td>Acting on recommendations and Lead(s)</td>
<td>Change in practice and lessons to be shared</td>
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</tr>
<tr>
<td>Process for archiving arrangements for any information given to patients to support their decision making</td>
<td>Sandie Cox Safeguarding Adults Lead</td>
<td>• Two service areas will conduct a ‘consent to treatment or therapy’ audit</td>
<td>Quarterly Audit</td>
<td>Group Service Managers/Locality Managers</td>
<td>Group Service Managers/Locality Managers/CEAG</td>
<td>How will changes be implemented and lessons learnt/ shared</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Head of Service/Service Manager will have responsibility to conduct audit in their area</td>
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<tr>
<td></td>
<td></td>
<td>• Consent Lead will work with Clinical Audit Dept in collating/producing an annual audit review to look at services audited</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How the organisation monitors compliance with all of the above</td>
<td>Sandie Cox Safeguarding Adults Lead</td>
<td>Annual audit review to look at services audited</td>
<td>Annually</td>
<td>Clinical Effectiveness and Audit Group</td>
<td>Quality and Safety Committee/Integrated Governance Committee</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix F: Monitoring and Compliance Tool

#### Standard 5.3 – Consent Training – Monitoring and Compliance Tool

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>How Trust will monitor compliance (Data and audit)</th>
<th>Frequency of monitoring</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Changes in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented process for how the organisation trains clinical staff on the consent process, in line with the training needs analysis</td>
<td>Rubi Gubarra-Sannie Organisational Development Manager</td>
<td>WIRED electronic training records Service Managers/Heads of Service can liaise with relevant staff member Training needs can be identified via the annual appraisal process</td>
<td>Quarterly</td>
<td>OD will provide information to relevant Service Managers/Heads of Service of staff that have not received Consent training</td>
<td>OD manager reports to Human Resources Committee</td>
<td>Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
</tr>
<tr>
<td>Documented process for how the organisation identifies clinical staff who are not capable of performing the procedure, but who are authorised to obtain consent for that procedure</td>
<td>NA Only those capable of performing procedure can take consent.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Element to be monitored</td>
<td>Lead</td>
<td>How Trust will monitor compliance (Data and audit)</td>
<td>Frequency of monitoring</td>
<td>Reporting arrangements</td>
<td>Acting on recommendations and Lead(s)</td>
<td>Changes in practice and lessons to be shared.</td>
</tr>
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</tr>
<tr>
<td>Documented process for how the organisation provides procedure specific training on consent for clinical staff who are not capable of performing the procedure, but who are authorised to obtain consent for that procedure</td>
<td>NA as above</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Process for how the organisation follows up where an individual has obtained consent without the authorisation to do so</td>
<td>AD of Q&amp;CE/Medical Director, AD or HR &amp; OD</td>
<td>Incident Reporting procedure, Formal capability or disciplinary procedure</td>
<td>Annual, Quarterly</td>
<td>AD QCE reviews operation of incident reporting, AD of HR &amp; OD produces quarterly report of employee relations issues</td>
<td>AD of QCE reports to Integrated Governance Committee, AD or HR &amp; OD reports to the HR Committee and Remuneration Committee</td>
<td>As above</td>
</tr>
<tr>
<td>Element to be monitored</td>
<td>Lead</td>
<td>How Trust will monitor compliance (Data and audit)</td>
<td>Frequency of monitoring</td>
<td>Reporting arrangements</td>
<td>Acting on recommendations and Lead(s)</td>
<td>Changes in practice and lessons to be shared.</td>
</tr>
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</tr>
<tr>
<td>Process for how the organisation notifies the GMC via the required form, of any individual who has obtained consent without the authorisation to do so</td>
<td>Medical Director/Consent Lead</td>
<td>From information provided to the NHSLA</td>
<td>Quarterly audit</td>
<td>Consent lead will notify the Medical Director of any breaches of the consent policy by doctors. The Medical Director will report to the Integrated Governance Committee on any breaches of the consent policy by doctors</td>
<td>IGC will recommend that a referral to the GMC is made where appropriate</td>
<td>As above</td>
</tr>
<tr>
<td>How the organisation monitors compliance with all of the above</td>
<td>AD of HR &amp; OD</td>
<td>Through the annual internal audit and policy review by HR Committee.</td>
<td>Annually</td>
<td>Audit to audit committee and HR Committee.</td>
<td>Audit Committee, HR Committee and Remuneration Committee/IGC</td>
<td>As above</td>
</tr>
</tbody>
</table>

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Appendix G: Consent to Examination, Treatment or Therapy Audit Tool

**Consent to Examination, Treatment or Therapy Audit Tool**

This audit tool monitors compliance against standards set in the trust consent to examination, treatment or therapy policy and CQC essential standards (Outcome 2): Consent to Care and Treatment. To complete this tool, review the notes in the patient/client records.

**Q1** What type of consent was required?
- Oral consent  □ Go to Q3
- Written consent □ Go to Q6
- Consent for research □ Go to Q10
- No consent required □ Go to End

*If no consent is required, do not continue to fill out this form.*

**Q2** If the patient/client is a child, do the notes identify who has parental responsibility?
- Yes .................................................. □
- No .................................................. □
- N/a .................................................. □

**Single Stage Process (Oral Consent)**

**Q3** If oral consent is given, was the following documented in the notes:
- Yes □
- No □
- N/a □
  - Risks
  - Condition explained
  - Treatment and Therapy given

**Q4** If the patient's/client's first language is not English, was it documented that an interpreter was used?
- Yes .................................................. □
- No .................................................. □
- N/a .................................................. □

**Q5** If the patient/client has withdrawn or declined consent, has this been recorded in the progress notes?
- Yes .................................................. □
- No .................................................. □
- N/a .................................................. □

**Two or more Stage Process (Written Consent)**

**Q6** If written consent is given, was the following documented in the notes:
- Yes □
- No □
- N/a □
  - Information given about treatment and therapy
  - Discussion of treatment therapy options
  - Confirmation of the patient's/client's consent
  - Consent form completed and signed

**Q7** If the patient/client first language is not English, was it documented that an interpreter was used?
- Yes .................................................. □
- No .................................................. □
- N/a .................................................. □

**Q8** If required, were reasonable adjustments made to support the consent process, (e.g. advocate, sign language, MAKATON, Loop Hearing System, etc)?

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Q9 If the patient/client has withdrawn or declined consent, has this been recorded in the progress notes?
Yes .................................. ☐    No .................................. ☐    N/a .................................. ☐

Consent for Research

Q10 Is the following documented in the patient/client notes?
Yes No N/a
Information given about the study.
Reason why the client has been asked to participate.
Risks and possible adverse consequences.
Potential benefits explained.
The participation in the study would not affect the care/treatment of the patient/client.
Patient is informed that they are free to withdraw at any stage, and do not have to give a reason.

Q11 If the patient/client has withdrawn or declined consent, has this been recorded in the progress notes.
Yes .................................. ☐    No .................................. ☐    N/a .................................. ☐

Information

Q12 Is it documented in the notes that:
Yes No N/a
Information is provided orally
Written information is given (e.g. leaflets, guidance sheets)

Q13 If the patient/client requires a reasonable adjustment, was the information provided in the appropriate format (e.g. brail, easy read, large print, sign posting)?
Yes .................................. ☐    No .................................. ☐    N/a .................................. ☐
If Yes, state what format
________________________________________________________________________
__________________________________

People Lacking Capacity

Q14 Does this person lack capacity?
Yes......................... ☐  Go to Q15     No ......................... ☐  Go to End

Q15 If a person lacks capacity, and treatment or therapy is/is not required, was a 'best interest' discussion/meeting held?
Yes ......................... ☐  No ......................... ☐  N/a ......................... ☐

Q16 Who was involved in the 'best interest' discussion/meeting of whether to or not to proceed with the treatment or therapy with the patient/client?
Yes No N/a
Patient's Family ☐ ☐ ☐
### Appendix H: Equalities Impact Assessment

#### Policy on Consent to Examination, Treatment or Therapy

<table>
<thead>
<tr>
<th>Manager’s name</th>
<th>Sandie Cox: Adult Safeguarding Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate</td>
<td>Adult Services</td>
</tr>
<tr>
<td>Date</td>
<td>28.09.12</td>
</tr>
<tr>
<td>Function, strategy, policy or service</td>
<td>Policy</td>
</tr>
<tr>
<td>Main aims, purpose and outcomes of the function, strategy, policy, service or work</td>
<td>To ensure that the Trust has a robust consent to examination, treatment or therapy policy that maximises patient/client involvement in the consent process, is compliant with legislation and guidance and provides a clear processes for staff to follow</td>
</tr>
<tr>
<td>How will these aims affect our statutory duty to: 1. Advance equality of opportunity? 2. Eliminate unlawful discrimination, harassment and victimisation? 3. Foster good relations between different groups? 4. Protect and promote human rights?</td>
<td>Demonstrate compliance</td>
</tr>
</tbody>
</table>
| Associated frameworks/NHS Operating Framework mention e.g. national targets NSFs | • NHSLA Risk Management Standards 2012/2013  
• CQC (2010) Essential Standards: Outcome 2: consent to care and treatment  
• Mental Capacity Act (2005) |
| Who does it affect? e.g. staff, patients, carers | All patients, clients, users of services, advocates, carers and staff |
| Engagement and consultation process carried out (state who was involved, how and when they were engaged and the key feedback) | Hounslow and Richmond HealthWatch have had an opportunity to review the policy from a Patient/Client’s perspective. **Nil comments made**  
HRCH Trust staff and managers (including the Patient Experience and Involvement Manager)  
HRCH Trust Lead for Equalities |
What aspects of the policy, including how it is delivered, or accessed, could contribute to inequality?
The policy is inclusive and outlines how it engages with patients, clients, users of services and their families, carer’s or advocates in the ‘consent process’

What different needs, experiences or attitudes are particular communities or groups likely to have in relation to this policy?
The policy is inclusive and outlines how it engages with patients, clients, users of services and their families, carer’s or advocates in the ‘consent process’

Please complete the screening assessment grid below for equality groups listed within the Equality Act (2010) and highlight the evidence underlying your assessment.

<table>
<thead>
<tr>
<th>Equality group</th>
<th>Positive impact</th>
<th>Neutral impact</th>
<th>Negative impact</th>
<th>Reason/comment/evidence/ necessary action planning following equality analysis screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Consider and detail (including any source of evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Consider and detail on attitudinal, physical and social barriers.</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td><em>Consider impact on transgender and transsexual people. This can include issues such as privacy of data and harassment.</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
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<tr>
<td>------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Consider and detail on working arrangements, part-time working, infant caring responsibilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider and detail on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Religion/belief (including lack of belief)</td>
<td>x</td>
<td></td>
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</tr>
<tr>
<td>Consider and detail) on people with different religions, beliefs or no belief.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (i.e. gender)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation Consider and detail) on heterosexual people as well as lesbian, gay and bi-sexual people</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (e.g. carers, homeless people, sex workers)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>