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Portsmouth Hospitals NHS Trust

# CONSENT TO EXAMINATION OR TREATMENT POLICY

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|---|---|---|---|
| 10.3 | 19/07/2021 | 3 month Extension | - |
| 10.2 | 01/02/2021 | Due to the second wave of the Coronavirus pandemic and continuing exceptional circumstances, the Trust Board have agreed to further extend all policies currently over their review date to 1st July 2021 | - |
| 10.1 | 25/03/2020 | Due to the current Coronavirus pandemic the Trust Board have agreed that all policies which are currently within review date will have their review date extended by six months from the review date stated on the currently published policy | - |
| 10 | 11/06/2019 | No changes. Policy review date reduced from 2yr to 1yr to facilitate timely incorporation of relevant issues arising from revised GMC guidance on consent, due for publication end 2019. | |
| 9.1 | 28/11/18 | Extension to review date | - |
| 9 | 13/12/2016 | 6.5 - Provision of Information: Reference to the Montgomery v Lanarkshire Health Board (2015) case | |

**CONTENTS**

# QUICK REFERENCE GUIDE

## 12 KEY POINTS ON CONSENT: THE LAW IN ENGLAND

**When do health professionals need consent from patients?**

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

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

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

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

**Can children give consent for themselves?**

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

**Who is the right person to seek consent?**

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

**What information should be provided?**

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

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

**Does it matter how the patient gives consent?**

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place. Trusts or organisations may have a policy setting out when you need to obtain written consent.

**Refusal of treatment**

10. Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the fetus.

**Adults who are not competent to give consent**

11. **No-one** can give consent on behalf of an incompetent adult. However, a patient may still be treated if this would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to provide information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and if these circumstances arise, this refusal must be abided by.

**This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment,* available from the NHS Response Line 08701 555 455 and at www.dh.gov.uk/consent.**

## 1. INTRODUCTION

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. A healthcare professional (or other healthcare staff) who does not respect this principle may be liable both to legal action by the patient and to action by their professional body. Employing bodies may also be liable for the actions of their staff.

While there is no English statute setting out the general principles of consent, case law ('common law') has established that touching a patient without valid consent may constitute the civil or criminal offence of battery. Further, if healthcare professionals (or other healthcare staff) fail to obtain proper consent and the patient subsequently suffers harm as a result of treatment, this may be a factor in a claim of negligence against the healthcare professional involved. Poor handling of the consent process may also result in complaints from patients through the NHS complaints procedure or to professional bodies.

## 2. PURPOSE

This document provides guidance on English law concerning consent to physical interventions on patients – from major surgery and the administration or prescription of drugs to assistance with dressing – and is relevant to all healthcare practitioners (including students) who carry out interventions of this nature. It updates the previous policy in order to reflect recent legislative changes. Guidance is provided on the legal requirements for obtaining valid consent and on the situations where the law recognises exceptions to the requirement to obtain consent.

## 3. SCOPE

This policy applies to all permanent, locum, agency and bank staff who carry out physical interventions on living patients. Therefore, the following areas are not included:

- Participation in observational studies
- The use of personal information
- The use of organs or tissue after death

*'In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety'*

## 4. DEFINITIONS

**Consent** is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing.

**Mental Capacity**: The Mental Capacity Act 2005 defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. It does not matter if the impairment or disturbance is permanent or temporary.

## 5. DUTIES AND RESPONSIBILITIES

**Consultants** responsible for a patient's care have a duty to ensure that:

- The consent process specific to their specialty interventions has been appropriately developed

- All participating staff are fully informed on the process, and that regular updates are provided when any changes / amendments have been required.

- Members of their team who are appropriately trained for the process and, therefore, can be allocated responsibility for completing consent, escalate any concerns or questions with which they do not feel able to deal with adequately to the consultant or nominated deputy

- Prior to the commencement of a procedure, and to the initiation of any form of sedation or anaesthesia the person who will perform the procedure has ensured that the consent process has been fully completed.

**Staff taking Consent/Performing the Procedure** must ensure that:

- The consent process and the procedure have been appropriately explained and that all questions have been answered.

- Any questions which they cannot answer are escalated to the Consultant or, in his/her absence another senior colleague

**Nurse Specialist**
Nurse specialists who have been appropriately trained may be allocated responsibility for explaining the intended procedures to the patients, and ensuring that they are comfortable to sign the consent form. In any circumstances where the patient has either concerns that they cannot answer, or if for some reason they have concerns about the patient's condition, they should contact a medical colleague to help address these issues. In complex circumstances this may mean that the consultant or a senior member of the medical team must become engaged in the process.

**Staff involved in the patient care pathway** all staff who are involved in the admission, assessment, preparation, explanation and transfer have a responsibility for ensuring that:

- The consent process has been fully followed and that patients have been informed of any risks/benefits

- The consent process had been completed before a patient's transfer is undertaken or any sedative medication is administered

- Should they have any concern about a patient's competency they should formally raise this for assessment before consent or any procedure is undertaken.

**Multi-Disciplinary Teams (MDTs)**
The teams are responsible for:

- Participating in the consent process for more complex patients
- Developing processes/procedures when participation from a number of specialist areas is required.
- Ensuring there is a consensus on the intended processes/procedure and that staff are fully aware of any changes together with the potential implications

**Clinical Directors' Forum** is responsible for:

- Providing expert advice on any aspect of the consent process

- Receiving the results of the annual audit of consent and ensuring appropriate dissemination through the divisional structures; to encourage organisational learning
- Ensuring this policy and any associated guidance or protocols are in line with current legislation

**Clinical Service Centre Governance Committees** are responsible for ensuring that the results of the annual consent audit is received from the Clinical Director's Forum and that any required changes or risks are appropriately addressed.

## 6. PROCESS

### 6.1 What consent is and isn't

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

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

Consent is not valid if obtained by fraudulent means.

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

In general, where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves **no one else can give consent on someone else's behalf.** However treatment may be given if it is in their best interests, as long as the requirements of the Mental Capacity Act 2005 are adhered to and it has not been refused in advance in a valid and applicable advance directive or advance decision. See section 6.7 and 6.8 for more information).

### 6.2 Guidance on consent

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

**Reference guide to consent for examination or treatment** provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies may be accessed on the internet at www.dh.gov.uk/consent and clicking on 'Consent Key Documents'.

**12 key points on consent: the law in England** has been distributed widely to health professionals working in England. This one-page document summarises those aspects of the law on consent which arise on a daily basis. Further copies are available from www.dh.gov.uk/consent

Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available on the internet at www.dh.gov.uk/consent and clicking on 'Consent Key Documents'

### 6.3 When should consent be sought?

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

#### 6.3.1 Single stage process

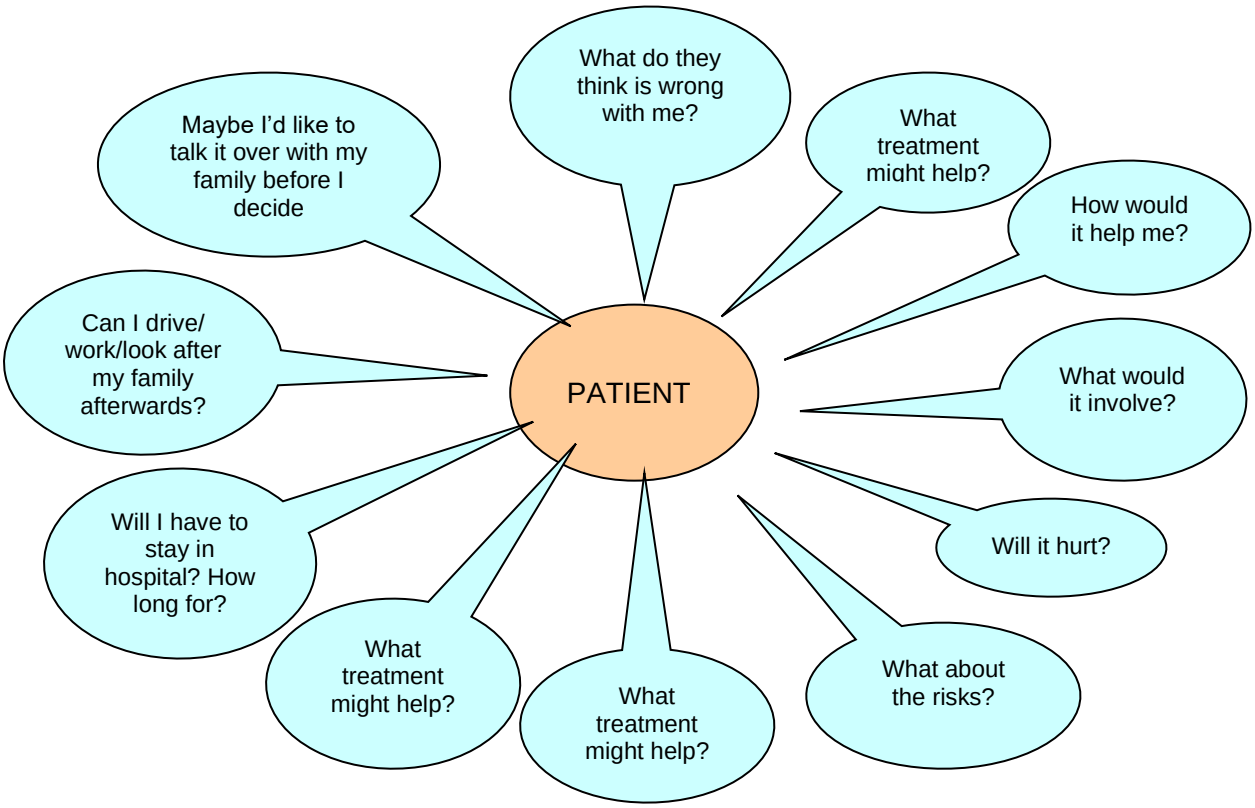
In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition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

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

#### 6.3.2 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), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages

**The first** being the provision of information, discussion of options and initial (oral) decision, and
**The second** being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting information stage(s), as well as the confirmation stage.




**Seeking consent: remembering the patient's perspective**

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

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

### 6.3.3 Seeking consent for anaesthesia and sedation

Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks. However, in elective treatment it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient will not be in a position genuinely to

make a decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in out-patients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient's notes or on the consent form. Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that procedure.

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

### 6.3.4 Emergencies

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

### 6.3.5 Additional procedures

During an operation it may become evident that the person could benefit from an additional procedure that was not within the scope of the original consent. If it would be unreasonable to delay the procedure until the person regains consciousness (for example because there is a threat to the person's life) it may be justified to perform the procedure on the grounds that it is in the person's best interests. However, the procedure should not be performed merely because it is convenient. For example, a hysterectomy should never be performed during an operation without explicit consent, unless it is necessary to do so to save life.

If a person has refused certain additional procedures before the anaesthetic (for example, specifying that a mastectomy should not be carried out after a frozen section biopsy result), then this must be respected if the refusal is applicable to the circumstances (see section 6.8 for more details on advance decisions). The GMC guidance states that it is good practice to seek the views of the patient on possible additional procedures when seeking consent for the original intervention.

### 6.3.6 Treatment of young children

Where a child is admitted, you should discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. When babies or young children are being cared for in hospital, it may not 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. Parental responsibility is defined in the Children Act (1989) as:

> "All the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to a child and his property" (Children Act 1989, section 3 (1)).

You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers will have such responsibility if jointly registered with the mother on the birth certificate, but not otherwise). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

### 6.3.7 Duration of consent

In general, when a person gives valid consent to an intervention that consent remains valid for an indefinite duration, unless it is withdrawn by the person. However, if new information becomes available regarding the proposed intervention (for example new evidence of risks or new treatment options) between the time when consent was sought and when the intervention is undertaken, the General Medical Council (GMC) guidance states that a doctor or member of the healthcare team should inform the patient and reconfirm their consent.

The clinician should consider whether the new information should be drawn to the attention of the patient and the process of seeking consent repeated on the basis of this information. Similarly, if the patient's condition has changed significantly in the intervening time it may be necessary to seek consent again, on the basis that the likely benefits and/or risks of the intervention may also have changed.

If consent has been obtained a significant time before undertaking the intervention, it is good practice to confirm that the person who has given consent (assuming that they retain capacity) still wishes the intervention to proceed, even if no new information needs to be provided or further questions answered.

## 6.4 Documentation

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

### 6.4.1 Written consent

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

Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

It is rarely a legal requirement to seek written consent (The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances), but it is good practice to do so if any of the following circumstances apply:

- The treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- The procedure involves general/regional anaesthesia or sedation

- Providing clinical care is not the primary purpose of the procedure, *e.g. research trials, student observation*
- There may be significant consequences for the patient's employment, social or personal life, *e.g. HIV and Hepatitis B testing, pregnancy testing, stress testing.*
- The treatment is part of a project or programme of research approved by this Trust

Attending for a procedure and proffering an arm or removing clothing implies consent for the majority of the population. However, there are times when people may be directed or instructed what to do, without fully understanding why, or what is happening.

In the case of people with a learning disability, who present as inpatient, at out-patient clinics, the Emergency Department, community clinics and surgeries, they may not always arrive fully understanding why or what they are there for.

In these cases it is important to establish a person's preference regarding treatment and their capacity to consent. This should include their level of understanding, their ability to retain the information and their ability to express their choice. This is important even in the most common procedures, (such as the taking of blood pressure, an injection, taking of blood and cytology).

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

It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past); it would be helpful to do so.
In the case of a patient who is illiterate it is advisable to obtain a countersignature from an independent witness, confirming the actual details of the proposed procedure and any associated risks that have been discussed and documented on the consent form.

### 6.4.2 Availability of forms

Standard consent forms and forms for adults (Appendix A) who are unable to consent for themselves are available to order through the electronic ordering system: SBS. There are four versions of the consent form:

**Form 1:** for adults or competent children,
**Form 2:** for parental consent for a child or young person
**Form 3:** for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care. The use of form 3 is optional but may be thought more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.
**Form 4:** for adults who are unable to consent to investigation or treatment.

### 6.5 Provision of Information

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

Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgment in determining what information should be given. However, the *presumption* must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented in their health record. If a hazard that should have been mentioned is not mentioned, the law will impose an obligation to compensate if that hazard occurs.

Recent court judgements (e.g. Chester vs Afshar [2002]) have reinforced the importance of identifying serious risk to the patient, even if that risk is relatively rare. This applies especially if the patient may choose an alternative treatment or no treatment at all if made aware of the risk.

More recently in the case of Montgomery v Lanarkshire Health Board (2015), the Supreme Court judgment found for the mother involved, who had argued that she had not been told of significant risks surrounding the mode of her son's birth. Had she been appraised of the material risks in her case in advance of delivery she would have requested a caesarian section rather than accepting a natural birth, which had resulted in her son suffering a severe hypoxic brain injury secondary to shoulder dystocia.

The GMC had intervened in this case to explain the development and content of its publications "Good medical practice" and "Consent: patients and doctors making decisions together". The Court endorsed the approach advocated in the guidance and the judgment brings the law up-to-date with good medical practice. Central to this is the principle that the relationship between a doctor and a patient should be a partnership based on openness, trust and communication.

To illustrate the ramifications of the Montgomery case, discussing risk with a patient shouldn't be reduced to simplistic percentages; it should be part of a dialogue. The key is to understand what actually matters – or is likely to matter – to the individual patient. The judgment describes this in terms of 'materiality': "A material risk is one that a reasonable person in the patient's position is likely to attach significance to, or if the doctor is or should reasonably be aware that their patient would be likely to attach significance to it." You should do your best to understand the patient's views and preferences and the adverse outcomes they are most concerned about.

This judgment makes clear that the "Bolam" test (the consensus of a responsible body of medical opinion) should no longer be applied to discussing risks with patients. It confirms beyond doubt that – in law as well as in good practice – patient views and shared decision-making are key to a valid consent process (i.e. the consensus of a body of patient opinion – the "prudent patient" is what matters).

https://gmcuk.wordpress.com/2015/05/29/making-decisions-together-the-implications-of-the-montgomery-judgment/

https://www.supremecourt.uk/cases/docs/uksc-2013-0136-press-summary.pdf

### 6.5.1 Patient Information Leaflets

Patient information leaflets/fact sheets are a useful means of providing information on the procedure and the risks, benefits, alternatives and sources of information, as they can take them away with them and consider the implications of the required treatment. Most departments have leaflets but they can also be obtained from the Health Information Manager in the foyer of Queen Alexandra Hospital (7700 6757).

Information leaflets/fact sheets do not negate the clinician's responsibility to provide a verbal explanation of much of the same information. For example, the clinician will clearly need to explain why one procedure has been suggested over the alternatives in a particular client's specific case.

When providing patient information as part of the consent process, the use and provision of the relevant leaflet must be clearly documented in the patient's health record.

All patient information leaflets used must be developed as per the Patient Information Policy. All patient information regarding research projects must be reviewed by the Research and Development Department before being made available.

### 6.5.2 Provision for patients whose first language is not English

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

Leaflets translated into alternative languages are available on request.

Interpreter services are available at three levels

1) Written translation service
2) 24/7 access to telephone translation service
3) Face-to-face translation service

In addition, specific provision (such as tapes, pictorial materials etc.) is made for those who, for reasons of disability or otherwise, would not find printed information particularly easy to use, together with details of local independent advocacy groups who can assist.

Further information and advice can be obtained from the Voluntary and Inclusion Manager on 7700 6401.

### 6.5.3 Provision for patients with hearing or sight loss

This Trust is committed to ensuring that patients with hearing or sight loss receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to rely on children or family members to interpret or communicate to patients.

British Sign Language is available for deaf patients and written information can be provided in “easy read”, large print or Braille for those with sight loss.

Further information and advice can be obtained from the Voluntary and Inclusion Manager on 7700 6401.

#### 6.5.4 Provision for patients with cognitive impairment

For concerns about the ability of a patient with cognitive impairment to understand the information being given, advice can be obtained from the Voluntary and Inclusion Manager on 7700 6401.

#### 6.5.5 Access to more detailed or specialist information

Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. The treating clinician should be prepared to provide more detailed information on request.

The Health Information Manager may be contacted to assist with accessing more detailed information. 7700 6757

#### 6.5.6 Access to health professionals between formal appointments

After an appointment with a health professional in primary care or in out-patients, patients will often think of further questions which they would like answered before they take their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or to wait until the date of an elective procedure (by which time it is too late for the information genuinely to affect the patient’s choice). To ensure patients can easily follow up any queries, there is a section on the Form 1 and Form 2 consent forms for the health professional to fill in their contact details.

PALS may also be able to assist with more general enquiries.

In compliance with cancer treatment guidelines, all patients are given contact details, including the number of the appropriate health professional, prior to treatment.

#### 6.5.7 Open access clinics

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

### 6.6 Who is responsible for taking consent?

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

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

#### 6.6.1 Delegated consent

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

they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit. This is known as delegated consent; the clinician has been given delegated authority to obtain consent.

Each specialty wishing to delegate the responsibility for obtaining informed consent for specific procedures must:

- Have a Standard Operating Procedure (SOP) which outlines to whom training for delegated consent will be provided and recorded
- Identify the procedures for which delegated consent is undertaken by those who are not capable of performing that procedure
- Develop a procedure specific training package for undertaking delegated consent for that particular procedure.

The delegating clinician must remember that they retain accountability for the information provided to the patient at all times, even if they have not personally provided it.

Where the healthcare professional 'confirming' consent is unable to answer specific patient queries, they should contact the healthcare professional carrying out the procedure (or where not possible a colleague competent to undertake such a procedure) to ensure the information is provided in a timely manner.

Procedures are in place to ensure that the health professionals ‘confirming’ the patient’s consent have access to appropriate colleagues where they are personally not able to answer any remaining questions. All Consultants carry a pager or mobile phone, the numbers for which are registered with the Trust's Main Switchboard and made known to delegates for immediate advice. Where the Consultant is away from the Trust site, the team must have a nominated second Consultant, within the specialty or a closely related specialty, agreed as a proxy, to provide advice on the patients Consultant's behalf.

### 6.6.2 Responsibility of health professionals

It is a health professional’s own responsibility to:

- Ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent and trained to do so; and
- Work within their own competence and not to agree to perform tasks which are outside their competence levels or that they are untrained to do.

If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), there is a further opportunity to confirm that the patient still wishes to go ahead on the day of admission. It is expected that clinicians will obtain verbal confirmation of this. The requirement for formal written reconfirmation of consent will be at the discretion of the clinicians involved and will be based upon current GMC guidance. Factors to take into consideration include the length of time since the original consent was obtained, the complexity of the surgery proposed and further questions the patient may have. Any new treatment options that may be available or significant developments in other clinical factors, including patient co-morbidity must also influence the need for written reconfirmation of consent. In exceptional cases the consent form may need to be rewritten.

If you feel that you are being pressurised to seek consent when you do not feel competent to do so contact the Director of Education on 7700 5837

If you are taking consent for research please contact the Research and Development Manager 7700 4271

### 6.7 Refusal of Treatment

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983*. The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults. For the young patient who is not deemed to be "Gillick competent", under the Fraser guidelines, refer to the parent/carer.

#### 6.7.1 Advance decisions to refuse treatment

A person may have made an advance decision to refuse particular treatment in anticipation of future incapacity (sometimes previously referred to as a 'living will' or 'advance directive'). A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment. This is a well-established rule of common law, and the Mental Capacity Act 2005 now puts advance decisions on a statutory basis. The Act sets out the requirements that such a decision must meet to be valid and applicable. Further details are available in chapter 9 of the Mental Capacity Act (2005) Code of Practice.

Healthcare professionals **must follow** an advance decision if it is valid and applicable, even if it may result in the person's death. If they do not, they could face criminal prosecution or civil liability. The Mental Capacity Act 2005 protects a health professional from liability for treating or continuing to treat a person in the person's best interests if they are not satisfied that an advance decision exists which is valid and applicable. The Act also protects healthcare professionals from liability for the consequences of withholding or withdrawing a treatment if at the time they reasonably believe that there is a valid and applicable advance decision. If there is genuine doubt or disagreement about an advance decision's existence, validity or applicability, the case should be referred to the Court of Protection. The court does not have the power to overturn a valid and applicable advance decision. While a decision is awaited from the courts, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration in the patient's condition.

If an advance decision is not valid or applicable to current circumstances, healthcare professionals must consider the advance decision as part of their assessment of the person's best interests. Advance decisions made before the Mental Capacity Act came into force may still be valid if they meet the provisions of the Act. There are transitional arrangements for advance decisions to refuse life-sustaining treatment made before 1 October 2007. Further information is available on the Department of Health website.

Some healthcare professionals may disagree in principle with a person's right to refuse life-sustaining treatment. The Mental Capacity Act does not change the current legal position. Healthcare professionals do not have to act in a way that goes against their beliefs. However, they must not simply abandon patients or cause their care to suffer. A patient should have the option of transferring their care to another healthcare professional or, if the patient lacks capacity, arrangements should be made for the management of the patient's care to be transferred to another healthcare professional.

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

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

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

### 6.8 Mental Capacity

The Mental Capacity Act 2005 defines a person who lacks capacity as a person who **is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.** It does not matter if the impairment or disturbance is permanent or temporary

A person is unable to make a decision for himself if he is unable to:

- Understand the information relevant to the decision
- Retain that information
- Use or weigh the information as part of the process of making the decision
- Communicate the decision

The assessment of capacity should be made by the practitioner in charge of the patient's medical treatment. Although a psychiatric opinion may be helpful, it should not in itself be regarded as conclusive. Guidance is provided in chapter 4 of the Mental Capacity Act (2005) Code of Practice.

*NOTE: Every adult is assumed to be capable. The default position, therefore, is that all adults have capacity until they are proven otherwise*

#### 6.8.1 Third party consent and advanced decisions

As a general rule, one adult may not provide consent for the medical treatment of another adult. There are two exceptions under the Mental Capacity Act 2005:

- Lasting Power of Attorney (LPA): the person is instructed under an LPA, validly made by the patient while they were still capable and which relates to their health and social care.
- Court of Protection: the person is a Deputy appointed to make decisions on behalf of the patient.

An advance decision (AD) is a refusal of healthcare treatment made when the person is capable. It will only apply when the person lacks capacity. If it is valid and applicable (i.e. it mentions the proposed treatment and circumstances), it will

take precedence over consent given by an LPA appointed prior to the AD or Court of Protection Appointed Deputy. It need not be in writing unless it is refusing life-sustaining treatment, in which case it must be signed and witnessed. An AD that otherwise would be valid and applicable will not be so if:

- The patient has withdrawn the AD
- There are reasonable grounds for believing that circumstances exist that the person did not anticipate when the AD was made and that would have affected the decision.
- A LPA has been appointed since the AD
- Since making the AD, the patient has done something inconsistent with it.

Existing Advance Directives (from before the Mental Capacity Act 2005 came into force) are still valid unless they have subsequently been withdrawn.

**6.8.2 Advocacy – Independent Mental Capacity Advocacy (IMCA)**

In some circumstances, an advocate will have to be appointed for a patient who lacks capacity:

- The patient is to have 'serious medical treatment' (see below);
- The patient is to be in hospital for more than 28 days or in a care home for more than 8 weeks; or
- The local authority is to arrange for the patient to be accommodated for more than 8 weeks.

A 'serious medical treatment' will involve providing, withdrawing, or withholding treatment in circumstances where:

- A single treatment is proposed and there is a fine balance between its benefits and burdens (and risks);
- There is a choice of treatments but a decision as to which one to use is finely balanced; or
- What is proposed would be likely to involve serious consequences for the patient.

**6.8.3 Procedures to follow when patients lack capacity to give or withhold consent**

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in form 4 (form for adults who are unable to consent to investigation or treatment), along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient. The standard consent forms should never be used for adult patients unable to consent for themselves. For more minor interventions, this information should be entered in the patient's notes.

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

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having, or not

having, the treatment are potentially serious, a court declaration may be sought. See Appendix B for further information on how to do this

#### 6.8.4 Referral to court

The Mental Capacity Act established the Court of Protection to deal with decision-making for adults (and children in a few cases) who may lack the capacity to make specific decisions for themselves. The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court. In cases of serious dispute, where there is no other way of finding a solution or when the authority of the court is needed in order to make a particular decision or take a particular action, the court can be asked to make a decision.

#### 6.8.5 Research

The Mental Capacity Act sets out a legal framework for involving people who lack the capacity to consent to taking part in research. Anyone setting up or carrying out such research will need to make sure that the research complies with the provisions set out in the Act and will need to follow the guidance given in chapter 11 of the Mental Capacity Act (2005) Code of Practice. The Act does not include clinical trials, which are covered by the Medicines for Human Use (Clinical Trial Regulations) 2004

### 6.9 Subsequent Removal of Tissue

#### 6.9.1 The Human Tissue Act 2004

The 2004 Act repeals and replaces the Human Tissue Act 1961, the Anatomy Act 1984 and the Human Organ Transplants Act 1989 as they relate to England and Wales. It also repeals and replaces the Human Tissue Act (Northern Ireland) 1962, the Human Organ Transplants (Northern Ireland) Order 1989 and the Anatomy (Northern Ireland) Order 1992.

The 2004 Act makes consent the fundamental principle underpinning the lawful retention and use of body parts, organs and tissue from the living or the deceased for specified health-related purposes and public display. It also covers the **removal** of such material from the deceased. (It does not cover removal of such material from living patients – this continues to be dealt with under the common law and the Mental Capacity Act 2005.)

The 2004 Act regulates removal, storage and use of human tissue. This is referred to in the Act as 'relevant material' and is defined as material that has come from a human body and consists of, or includes, human cells. Cell lines are excluded, as is hair and nail from living people. Live gametes and embryos are excluded as they are already regulated under the Human Fertilisation and Embryology Act 1990 as amended by the Human Fertilisation and Embryology Act 2008

Human Tissue Act 2004 lists the purposes for which consent is required in Schedule 1, and they are referred to as 'scheduled purposes'. The consent required under the Act is called 'appropriate consent', which means consent from the appropriate person, as identified in the Act. Where there has been a failure to obtain or misuse of consent, penalties of up to three years imprisonment or a fine, or both, are provided for in the Act.

Full details on the requirements of the Human Tissue Act 2004 and the Human Tissue Authority's codes of practice can be found at www.hta.gov.uk

#### 6.9.2 Post mortems

Attitudes towards post mortem examination, in particular the removal of organs and tissue and the use of tissue after death, differ greatly. When death has

occurred unexpectedly or as a potential consequence of procedures / interventions undertaken, referral should be made to the Coroner who has responsibility for deciding whether a post mortem should be performed. Although a full explanation should be provided to the relatives and consent should be requested for such procedures, post mortems in appropriate circumstances are a legal requirement they can be undertaken without consent.

It may also occasionally be relevant to discuss the potential of a post mortem (and even agree consent if this is their preference) with a patient who is known to be terminally ill if there is knowledge that they would wish this to be performed for the benefits of others.

If a family refuses consent for a post mortem for religious or other reasons and there are reservations / concerns about whether death may have been influenced by procedures or interventions the doctor responsible for the patient's previous care should consult with the Coroner

For religious or other reasons, it may be essential that the funeral takes place as soon as possible and therefore the post mortem needs to be undertaken as promptly as possible. The implications of this should be discussed sensitively and openly, with every effort made to meet the family's requirements without compromising the outcome. If the post mortem is to be a 'coroner's' post mortem the issues should be discussed with them. Appendix C gives guidance on religion-specific post mortems.

In cases where consent is being sought for hospital post mortems further guidance and assistance may be obtained directly from the cellular pathology department manager in the hospital mortuary (*phone: 023 9228 6718*). They will be able to both facilitate the process and provide specific consent forms.

### 6.10 Clinical Photography and Conventional or Digital Video Recordings

Consent should be obtained for any visual or audio recording, including photographs or other visual images. The purpose and possible future use of the recording must be clearly explained to the person before their consent is sought for the recording to be made. If it is to be used for teaching, audit or research, people must be aware that they can refuse without their care being compromised and that when required or appropriate it can be anonymised. GMC guidance gives more detailed advice, including situations when permission is not required and about obtaining consent to use recordings as part of the assessment or treatment of patients and for training and research

## 7. TRAINING REQUIREMENTS

### 7.1 Generic consent

- Receive training on the principles of informed consent as part of induction, as identified in the Trust's TNA
- Receive training on the medico-legal aspects of consent, as part of induction
- Have access to additional e-learning

### 7.2 Procedure specific training

Clinicians seeking to delegate the role of obtaining consent to junior staff have a responsibility to ensure that those to whom they wish to delegate are competent in the general principles of consent and in the specific details of the proposed procedures for which that consent is to be taken.

Each consultant or specialty wishing to devolve the responsibility for obtaining informed consent for specific procedures must develop a procedure specific training package for

consent to that particular procedure. The delegating clinician must remember that they retain accountability for the information provided to the patient at all times; even if they have not personally provided it. However, the primary responsibility for ensuring that knowledge of consent principles and law is possessed by an individual clinician lies with the clinician themselves.

Nurses are authorised to undertake specific procedures for which consent is required. In this instance, they must demonstrate the appropriate level of competency (Appendix D)

### 7.3 Identifying staff who are not capable of performing the procedure but are authorised to take consent

Each consultant/specialty wishing to delegate consent to junior staff who are not capable of performing the procedure, must have in place a standard operating protocol (SOP). The contents of the SOP will vary from specialty to specialty but should include: the types of procedure for which delegated consent is appropriate; the level/staff group to which delegation is given; and the training that is provided.

### 7.4 Training records

#### 7.4.1 Induction

As identified in the induction and training policy, the Learning and Development Team will maintain records of completed induction training, via the Electronic Staff Record

#### 7.4.2 Specialty consent training

Details of specialty consent training is recorded and retained in the individual's e-passport. This allows the individual to transport their consent training details from specialty to specialty within the Trust but also to other organisations, when moving on as part of further development and training. E-passports also allow for monitoring to ensure all those taking consent are authorized to do so.

## 8. REFERENCES AND ASSOCIATED DOCUMENTATION

**External**

Department of Health (2001) *Good Practice in Consent Implementation Guide* www.dh.gov.uk

Department of Health (2001) *Reference Guide to Consent for Examination or Treatment* *www.dh.gov.uk*

GMC (2008) Consent: patients and doctors making decisions together. London: GMC

GMC (2002) *Making and Using Visual and Audio Recordings of Patients*. London: GMC www.gmc-uk.org/guidance/current/library/making_audiovisual.asp

BMA (2004) Medical Ethics Today: The BMA's Handbook of Ethics and Law (second edition). Update to chapter 2. London: BMJ Group. www.bma.org.uk/ethics/MET2007updates.jsp

*Mental Capacity Act 2005 (Lasting Powers of Attorney, Enduring Powers of Attorney and Public Guardian) Regulations 2007*, SI 2007, 2161 and www.publicguardian.gov.uk/forms/Making-an-LPA.htm

*The Human Tissue Act 2004.* London The Stationery Office www.opsi.gov.uk
*The Mental Capacity Act 2005.* London: The Stationery Office www.opsi.gov.uk

**Internal**

- Patient Information Policy

## 9. EQUALITY IMPACT STATEMENT

Portsmouth Hospitals NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly

Our values are the core of what Portsmouth Hospitals NHS Trust is and what we cherish. They are beliefs that manifest in the behaviours our employees display in the workplace.
Our Values were developed after listening to our staff. They bring the Trust closer to its vision to be the best hospital, providing the best care by the best people and ensure that our patients are at the centre of all we do.
We are committed to promoting a culture founded on these values which form the 'heart' of our Trust:

**Respect and dignity**
**Quality of care**
**Working together**
**Efficiency**

This policy should be read and implemented with the Trust Values in mind at all times.

## 10. MONITORING COMPLIANCE

As a minimum the following elements will be monitored

| Minimum requirement to be monitored | Lead | Tool | Frequency of Report of Compliance | Reporting arrangements | Lead(s) for acting on recommendations |
|---|---|---|---|---|---|
| 100% of junior doctors will receive consent training on induction | Learning and Development Team | Learning and Development database | Annually | Policy audit report to:<br>• Clinical Directors Forum | Director of Education |
| 100% of staff who are not capable of performing the procedure are authorized to obtain consent | Learning and Development Team | Random audit of 25 e-passports | Annually | Policy audit report to:<br>• Clinical Directors Forum | Director of Education |
| 100% of staff to whom consent is delegated but who are not capable of performing the procedure receive procedure specific training for staff | Learning and Development Team | Random audit of 25 e-passports | Annually | Policy audit report to:<br>• Clinical Directors Forum | Director of Education |
| Process for following up those who have obtained consent for a procedure without being authorized to do so | Learning and Development Team | Random audit of 25 consent forms v e-passports | Annually | Policy audit report to:<br>• Clinical Directors Forum | Director of Education |
| The provision of information to patients is documented in 100% of cases | Clinical Audit Department | Random audit of 50 consent forms | Annually | Policy audit report to:<br>• Clinical Directors Forum | Medical Director |

## APPENDIX A

### CONSENT FORMS

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent (also available at **www.doh.gov.uk/consent.**

**Consent Form 1 - Patient agreement to investigation or treatment**.
This form deals with people who have the capacity to consent to treatment. It should not be used if the patient is 18 years or over and lacks the capacity to give consent.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019034.pdf

**Consent Form 2** -Parental agreement to investigation or treatment for a child or young person.
This form is to be used when a parent (or person who has parental responsibility) is providing consent.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019040.pdf

**Consent Form 3** - Patient/parental agreement to investigation or treatment
(Procedures where consciousness not impaired)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019143.pdf

**Consent Form 4** - Form for adults who are unable to consent to investigation or treatment
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019148.pdf

Consent Forms are produced by Harlow Printing (0191 4554286) and are available to order through the electronic ordering system SBS.

## APPENDIX B

### HOW TO SEEK LEGAL ADVICE /A COURT DECLARATION

### HOW TO SEEK A COURT DECLARATION OR LEGAL ADVICE

In the first instance (within hours) please contact the Legal Services Manager (ext 7700 6527) or the Head of Risk Management and Legal Services (ext 7700 6388). Either of these people may be able to offer the appropriate advice or, alternatively, will contact the Trust solicitors direct. Out of hours the Hospital Duty Manager should be contacted via the switchboard. The Hospital Duty Manager will inform the Duty Manager or Duty Executive

**Appendix C**

### RELIGION-SPECIFIC POST MORTEM REQUIREMENTS

| RELIGION | REQUIREMENTS |
|---|---|
| Ba'hai | No specific objections or requirements |
| Buddhist | No specific objections or requirements |
| Christian Scientists | Only if required by coroner |
| Christians | No specific objections or requirements |
| Hindhu | Considered distasteful, so only if required by Coroner |
| Islam | Only if required by Coroner. The family of the deceased may request that an Iman (religious leader) be present during the post mortem. In this instance time **must** be allowed for the Iman to arrive before commencing the post mortem. This may have a potential conflict with the religious preference of burial being undertaken within a time limit and should be discussed / agreed with family members.<br>The family may request that any organs removed should be returned to the body after examination |
| Jehovah's witness | Usually only if required by Coroner, |
| Judaism | Only if required by coroner. |
| Mormon | No specific objections or requirements |
| Rastafarianism | Only if required by coroner |
| Sikhism | No specific objections or requirements |

## APPENDIX D

### Competency Statement: Gaining Consent

Informal/formal non-invasive procedures: level 1 & 2
Written consent minimum level 3

| Competency Indicators 1st Level | Achieved Assessor Signature | Competency Indicators 2nd Level | Achieved Assessor Signature | Competency Indicators 3rd Level | Achieved Assessor Signature | Competency Indicators 4th Level | Achieved Assessor Signature |
|---|---|---|---|---|---|---|---|
| | | **All of level 1 plus** | | **All of level 1 and 2 plus** | | **All of level 1,2,3 plus** | |
| a. Can demonstrate current knowledge of<br>• Consent Policy<br>• Related guidelines<br>• Thorough knowledge of the procedure<br>• Knowledge of alternatives<br>b. Is able to communicate fully with patients giving and receiving all relevant information re proposed procedure<br>c. When appropriate, involves the patient's relatives / carers<br>d. Is able to assess a patient's ability to consent<br>e. Can demonstrate knowledge of legal aspects related to consent<br>f. Understands the specific risks and benefits for the | | a. Is able to use diverse methods of communication and is perceptive to the patient's understanding of the proposed surgical procedure<br>b. Can demonstrate a wide knowledge of available patient information | | <u>Nurse specific</u><br>a. Can demonstrate a background clinical working experience of 2 years within the specialty related to the proposed surgical procedure<br>b. Is able to demonstrate 6 months clinical work relating to a specialty specific role<br>c. Evidence of delegated authority from accountable consultant to take part in the written consent process for the proposed surgical procedure<br><br><u>Doctor specific</u><br>Demonstrates 3 observed patient consenting events prior to unsupervised consent<br>a. Is able to tailor information to meet | | a. Utilises expert judgment to facilitate the timely referral to the clinicians responsible for the procedure / operation when further clarification is required to agree consent<br>b. Takes part in yearly review of consent competency<br>c. Able to assess others to achieve competency<br>d. Evidence of yearly review of delegated authority from accountable consultant | |

| Competency Indicators 1st Level | Achieved Assessor Signature | Competency Indicators 2nd Level | Achieved Assessor Signature | Competency Indicators 3rd Level | Achieved Assessor Signature | Competency Indicators 4th Level | Achieved Assessor Signature |
|---|---|---|---|---|---|---|---|
| proposed procedure<br>g. Is current with all documentation related to consent | | | | individual patient's needs<br>b. Can demonstrate appropriate referral when own scope of knowledge and experience is exceeded<br>c. Ensures the patient is offered a copy of the consent form<br>d. Accurately records formal consent on appropriate consent form and in health records, if necessary | | | |
| **Education Resources to Support your Development** | | | | | | | |
| Pre-reg governance sessions<br>CE gaining consent<br>In-house training | | Department of Health: Reference Guide to Consent for Examination or Treatment www.dh.gov.uk/consent | | In-house pre-operative assessment training programme: consent included | | | |
| **Record of Achievement:** To verify competence, ensure you have the appropriate level signed as a record of your achievement. | | | | | | | |

# EQUALITY IMPACT SCREENING TOOL

**To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval for service and policy changes/amendments.**

| **Stage 1 - Screening** | | | |
|---|---|---|---|
| **Title of Procedural Document:** Consent to Examination or Treatment Policy | | | |
| **Date of assessment** | 12/01/2017 | **Responsible Department** | Patient Safety Steering Committee |
| **Name of person completing assessment** | Dr James Vincent | **Job Title** | Consultant Anaesthetist |

| **Does the policy/function affect one group less or more favourably than another on the basis of** : | **Yes/No** | **Comments** |
|---|---|---|
| • Age | No | |
| • Disability<br>Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia | No | |
| • Ethnic Origin (including gypsies and travellers) | No | |
| • Gender reassignment | No | |
| • Pregnancy or Maternity | No | |
| • Race | No | |
| • Sex | No | |
| • Religion and Belief | No | |
| • Sexual Orientation | No | |
| **If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2** | | |
| More Information can be found be following the link below<br><br>www.legislation.gov.uk/ukpga/2010/15/contents | | |

| Stage 2 – Full Impact Assessment | | | |
|---|---|---|---|
| **What is the impact** | **Level of Impact** | **Mitigating Actions** (what needs to be done to minimise / remove the impact) | **Responsible Officer** |
| | | | |

**Monitoring of Actions**

The monitoring of actions to mitigate any impact will be undertaken at the appropriate level

Specialty Procedural Document: Specialty Governance Committee
Clinical Service Centre Procedural Document: Clinical Service Centre Governance Committee
Corporate Procedural Document: Relevant Corporate Committee

All actions will be further monitored as part of reporting schedule to the Equality and Diversity Committee