group policies and procedures

# patient consent policy

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| Date of issue | September 2016 |
| next review date | September 2025 |
| Document ref & version | Patient Consent Policy V1 |

**Related policies and guidance**

**Document revision and approval history**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Version | Date | Author | Approved by | Comments |
| V1 | Jul 2016 |  |  | Reviewed by DH - references, edits updated |
| Final | Sep 2016 |  | DH |  |
|  | Apr 2018 |  |  | Reviewed by JL |
|  | Aug 2019 |  |  | Reviewed by JL |
|  | Sep 2021 |  |  | Reviewed by DH |
|  | Sep 2023 |  |  | Reviewed by DH |

# why consent is crucial

Patients have a fundamental legal and ethical right to determine what happens to them. Valid consent to treatment is therefore absolutely central in all forms of health care, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health care professionals and patients (Department of Health, 2009).

# aim of policy

The Department of Health (DH) issued range of guidance documents on consent[[1]](#footnote-1) and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures for Castleman Healthcare Ltd which aim to ensure that health professionals are able to comply with the guidance.

# what consent is, or 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:

1. be competent to take the particular decision;
2. have received sufficient information to take it;
3. not be acting under duress.

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

Where an adult lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no-one else can give consent on their behalf. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable

advance directive. For further details on advance directives see the Department of Health, *Social Services and Public Safety’s Reference Guide to Consent for Examination, Treatment or Care (chapter 1, paragraph 16).*

# consent to treatment

If you give your consent to something, it means you give your permission, or you agree. All people aged 16 years or over have the right to make their own decisions about their health. They are deemed to have enough maturity and understanding to consent to medical treatment.

There are instances where young people under 16 years old can give their consent for their own medical treatment without parent/ guardian/carer involvement. This is called being ‘Fraser competent’[[2]](#footnote-2). There is no set age for being ‘Fraser competent’- it depends on each individual young person. The doctor or nurse will decide if a young person is ‘Fraser competent’, by having a chat to them about how they are feeling and what they want.

We hope that working in this way, young people will be encouraged to seek medical care and advice, and to give the full facts needed in order to provide good care.

Patients can give consent orally or in writing, or they may imply consent by complying with the proposed examination or treatment, for example, by rolling up their sleeve to have their blood pressure taken.

Before accepting a persons’ (patients) consent, a nurse or doctor must consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed. This is more important than how their consent is expressed or recorded.

In cases of minor or routine investigations or treatments, if the doctor or nurse are satisfied that the patient understands what you propose to do and why, it is usually enough to have oral or implied consent.

In cases that involve higher risk, it is important that the healthcare professional gets the persons (patients) written consent. This is so that everyone involved understands what was explained and agreed.

**The doctor or nurse should always get written consent from a patient, if:**

1. The investigation or treatment is complex or involves significant risks.
2. There may be significant consequences for the persons’ (patient) employment, or social or personal life.
3. If providing clinical care is not the primary purpose of the investigation or treatment.
4. The treatment is part of a research programme or is an innovative treatment designed specifically for their benefit.
5. Fertility treatment and organ donation, must by law, be only undertaken with written consent. Codes of practice govern these situations.

If it is not possible to get written consent, for example, in an emergency situation or if the person requires the treatment to relieve pain or distress, you can rely on oral consent (if possible).

Castleman Healthcare will request written consent from the parents of children under five years of age will always be obtained prior to childhood immunisations being administered. We will also ask for written consent before undertaking any minor surgery procedure. The person will be asked to sign the practice consent form and this will be held in the patients’ records.

**Documentation**

For significant 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.

# written consent

1. Consent is often wrongly equated with a patient’s signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.
2. It is rarely a legal requirement to seek written consent,[[3]](#footnote-3) but it is good practice to do so if any of the following circumstances apply:
   1. 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’);
   2. The procedure involves general/regional anaesthesia or sedation;
   3. Providing clinical care is not the primary purpose of the procedure;
   4. There may be significant consequences for the patient’s employment, social or personal life
   5. The treatment is part of a project or programme of research approved by this company.
3. If the individual is illiterate, the individual may be able to make their mark on the form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the clinician/practitioner seeking consent, and for the fact that the individual has chosen to make their

mark in this way to be recorded in the case notes. Similarly, if the individual has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes, or on the consent form.

1. Completed forms should be scanned into 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.
2. 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.

# 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.

**Single stage process**

1. 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.
2. 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.

**Two or more stage process**

1. 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 the information stage(s), as well as the confirmation stage.
2. Patients receiving elective treatment, intervention 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?”
3. 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.

# seeking consent for local anaesthesia

Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia. Information for patients’ relatives and friends on anaesthesia have been produced by the Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland.

# 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.

# treatment of young children

When babies or young children are being cared for in hospital, 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, the Healthcare professional should remember that, in law, such consent is required. The Healthcare professional (HCP) should therefore discuss with the child’s parent(s) what routine procedures will be necessary, and ensure that the HCP have the parents’ consent for these interventions in advance. 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.

Please see previous paragraphs regarding childhood immunisations by health care professionals.

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 fathers do not automatically have such responsibility although they can acquire it). If the HCP is in any doubt about whether the person with the child has parental responsibility for that child, the HCP must check.

# responsibility of health professionals

It is a health care professional’s own responsibility:

1. to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
2. to work within their own competence and not to agree to perform tasks which exceed that competence.

If you feel that you are being pressurised to seek consent when you do not feel competent patients are advised to contact the clinical governance director for advice and information for reporting.

# Other types of consent

1. Medical records – If the patient puts in a claim to an insurance company, the HCP may ask the person (patient) to sign a form to consent or agree that the company may have access to their medical records.
2. Viewing patient’s own medical records: when the patient is requesting this facility, the person (patient) consents to the surgery releasing the records to the patient only. The patient must also agree that they have read the information about using the records responsibly.
3. Sharing patient medical records with the Clinical Commissioning Group - General Practice is inspected every year for both organisational and clinical aspects of the care it provides, although this is mainly done anonymously, there may be occasion to request fuller note -sharing, this will be done only with the person’s (patient) consent.
4. Contacting the patient (person) by text messaging and on-line booking. All patients will be asked to consent to this type of contact.

# Conclusion

The legal and practical issues of consent are not exhaustive in a primary care setting. It is far better to ‘err’ on the side of caution and complete written consent forms if in doubt, rather than not to do so, and these should always be added in the patient’s notes.

All qualified health care providers would be expected to adhere to their ‘Codes of Professional Conduct’ (GMC and GNC, etc) at all times. For the non- qualified clinical staff, advice should always be sought from ‘senior’ qualified staff, if uncertain, and this should be documented in the patient’s notes.

# References

The DH Reference guide to consent for examination, treatment or care are available at [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk).

1. Consent –what you have a right to expect (versions for adults, children/young people, people with learning difficulties, parents and relatives/carers)
2. Seeking consent: working with children
3. Seeking consent: working with older people
4. Seeking consent: working with people with learning disabilities.

1. *Social Services and Public Safety’s Reference Guide to Consent for Examination, Treatment or Care (chapter 1, paragraph 16).* [↑](#footnote-ref-1)
2. Gillick Competent, Fraser Guidelines - see [https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines](https://www.dropbox.com/referrer_cleansing_redirect?url=https%3A%2F%2Fwww.nspcc.org.uk%2Fpreventing-abuse%2Fchild-protection-system%2Flegal-definition-child-rights-law%2Fgillick-competency-fraser-guidelines&hmac=qgBxxBWjXsFDB4RjkrSdjPR8VtLBBlu3zc7e%2FN9A%2BFg%3D)/ [↑](#footnote-ref-2)
3. The Mental Health (Northern Ireland) Order 1986 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances [↑](#footnote-ref-3)