Livewell Southwest

Consent To Treatment Policy

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Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

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Consent to Treatment Policy

Chapter One - Introduction

1. Introduction

1.1 This policy provides a guide in relation to consent for all treatment, care and physical interventions with a patient.

1.2 In doing so, it considers the components of valid consent, who is able to consent, how to deal with refusals of consent and specific examples of situations requiring consent.

2. Purpose

2.1 The purpose of this policy is to provide practical assistance to those working in and with situations where consent is required, whilst also explaining the legal background. The content of this document is in line with the professional standards of the General Medical Council, British Medical Association, Nursing & Midwifery Council and the Health & Care Professions Council.

3. Duties

3.1 The Chief Executive is ultimately responsible for the content of all policies and their implementation.

3.2 Directors and Locality Managers are responsible for identifying, producing and for implementing Livewell Southwest (LSW) policies relevant to their area.

3.3 Matrons and clinical managers are responsible for ensuring staff are working to the guidance of the policy and monitoring the implementation.

3.4 Clinical staff are responsible for ensuring they work within the guidance of the policy.

4. Definitions

4.1 "Healthcare Professionals" means any and all persons involved in the provision of care and treatment to a patient.

IMCA – Independent Mental Capacity Advisor
MCA – Mental Capacity Act 2007
MHA – Mental Health Act 1983
GMC – General Medical Council
BMA – British Medical Association
NMC – Nursing & Midwifery Council
HCPC – Health & Care Professions Council
GDC –General Dental Council

5. Why is Consent Required?

5.1 As a matter of law, consent must be obtained for every treatment and physical intervention. This includes everything from major surgery and the administration or prescription of drugs to assistance with dressing and eating.

5.2 This principle reflects the legal right of patients to determine what happens to their own bodies, and is a fundamental part of good practice.

5.3 This policy is relevant to all Healthcare Professionals (including students) who carry out actions of this nature.

5.4 Any Healthcare Professional providing treatment or any physical intervention in the face of a capable refusal, however irrational, may be liable to criminal and/or civil proceedings and possibly subject to a referral to their professional body. Employing bodies may also be liable for the actions of their staff.

5.5 Further, if Healthcare Professionals 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.

5.6 Finally, poor handling of the consent process may also result in complaints from patients through the NHS complaints procedure or to professional bodies.

5.7 It should be noted that this policy specifically applies to consent for all treatment, care and physical interventions involving living patients.

5.8 If the Healthcare Professional has any queries regarding capacity, consent and refusal the LSW solicitors can be contacted via Customer Services Manager, and out of hours via the duty manager.

6. Relevant Law

6.1 Case Law

6.1.1 There is no legislation in England and Wales that sets out the general principles and requirements of valid consent. Instead, these are embodied in a plethora of case law, which has evolved significantly over recent years. Further legal developments may occur after this policy has been issued, and all Healthcare Professionals must remember their duty to keep themselves informed of legal developments that may have a bearing on their practice. Whilst much of the case law refers specifically to doctors, the same principles will apply to other Healthcare Professionals involved in examining, treating and caring for patients.

6.1.2 Legal advice should always be sought if there is any doubt about the legal validity of a proposed intervention, via Complaints and Litigation Manager, and out of hours via the duty manager.

6.2 Human Rights Act 1998

6.2.1 The Human Rights Act 1998 came into force in October 2000, giving further effect in England and Wales to the rights enshrined in the European Convention on Human Rights. All public authorities are required to act in accordance with the rights set out in the Act, and all other statutes must be interpreted by the courts, so far as possible, in accordance with those rights.

6.2.2 Compliance with the Act is largely reflected in existing good ethical practice, but all Healthcare Professionals should be aware of it and ensure that they act in accordance with it.

6.3 Mental Capacity Act 2005

6.3.1 The Mental Capacity Act 2005, which came fully into force on 1 October 2007, sets out a statutory framework for making decisions for people who lack the capacity to make such decisions themselves in their "best interests." The Act establishes overarching statutory principles governing these decisions, setting out who can make them, how they should be made and when they should be made. It also sets out the legal test for assessing whether or not a person lacks the capacity to make a decision.

6.3.2 In addition, the Act introduced the role of the Independent Mental Capacity Advocate to assist unbefriended patients who lack capacity and lasting powers of attorney for personal welfare decisions. Also, the Act codified the position in relation to advance decisions to refuse treatment.

6.3.3 Further guidance to the Act can be found in the Mental Capacity Act Code of Practice. All staff employed in the provision of patient care must have access to the Code of Practice. The latest version can be accessed via the Department of Constitutional Affairs' website.

6.3.4 The Code itself is not legally binding, but it is considered as a standard of good practice. Healthcare Professionals should only depart from it with valid and justifiable reasons born out by the particular circumstances of each case.

6.3.5 If the Healthcare Professional has any queries regarding the Act and the accompanying Code, the LSW solicitors can be contacted via Complaints and Litigation Manager, and out of hours via the duty manager.

Chapter Two – Components of Valid Consent

Patients are entitled to receive sufficient information, in a way they can understand about the proposed treatment, the possible alternatives, and any substantial risks in order that they can make a balanced judgment. Patients must be allowed to decide whether they will agree to the treatment, and they may refuse treatment or withdraw consent at any time.

1. Form

1.1 Consent can be given verbally, can be in writing or can be implied through conduct. Implied consent is where the patient in effect provides consent by acquiescing to the procedure –for example, in the form of the patient offering out their arm to receive an injection.

1.2 All of the above are equally valid in law, but only written consent has the benefit of proof. It is best practice to receive written consent, but it is not a legal requirement (save for a in a few limited circumstances). Nor is it a legal requirement for consent to be recorded in the presence of a witness.

1.3 Written consent should be required for any invasive procedures, all surgery, general or regional anaesthesia and any treatment that carries substantial risks or side effects. Verbal consent must always be recorded in the patient's notes and should be limited to those procedures where there is little risk.

1.4 If the patient has capacity, but is unable to read or write, they may be able to make their mark on the form to indicate consent. It would be good practice (but not a legal requirement) for the mark to be witnessed by a person other than the Healthcare Professional seeking the consent, and for the fact that the patient has chosen to make their mark in this way to be recorded in the case notes. Similarly, if the person has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes.

1.5 Consent forms cannot be signed on behalf of a patient who lacks capacity, unless the signatory is acting under a valid and applicable lasting power of attorney for personal welfare, or is a court appointed deputy. It is good practice to record who is signing on behalf of the patient and under what authority their signature is given.

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

1.7 All Healthcare Professionals should ensure that the consent procedure is robustly captured in the medical records.

2. Duress

2.1 To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the patient either to accept or refuse treatment. There is of course a difficulty in identifying what is simply family concern, and what is true duress. It is therefore often useful to speak to the patient alone without family members present.

2.2 When patients are seen and treated in environments where involuntary detention may be an issue, such as prisons and mental inpatient facilities, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent, and care must be taken to ensure that the patient makes decisions freely. Coercion should be distinguished from providing the patient with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for the patient's health. However, threats such as withdrawal of any privileges, loss of remission of sentence for refusing consent or using such matters to induce consent may well invalidate the consent given, and are not acceptable.

2.3 Children and young people, in particular, may be subject to undue influence by their parent(s), other carers or a sexual partner (current or potential). However, specific issues should be considered in relation to children, young persons and consent. Please see page 20 for further details.

3. Information

3.1 To give valid consent, the patient needs to understand the nature and purpose of the procedure. The risks and benefits should be discussed with every patient to the extent that it is reasonable to do so. It is advisable to inform the patient of any ‘material,’ ‘significant’ or unavoidable risks, however small, in the proposed treatment; any alternatives to it; and the risks incurred by doing nothing. If the patient asks questions, these should always be answered fully.

3.2 The GMC provides guidance on the type of information that patients may need to know before making a decision, and recommends that doctors should do their best to find out about patients’ individual needs and priorities. It advises that discussions should focus on the patient’s ‘individual situation and risk to them and sets out the importance of providing the information about the procedure and associated risks in a balanced way and checking that patients have understood the information given. Where relevant, information about anaesthesia should be given alongside information about the procedure itself.

3.3 It is particularly important that a person is aware of the situation when students or trainees carry out procedures to further their own education. Where the procedure will further the person’s care – for example taking a blood sample for testing – then, on the basis that the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the person that the Healthcare Professional is a student, although it would always be good practice to do so. In contrast, where a student proposes to conduct a physical examination that is not part of the patient's care, but in

furtherance of their own education, then it is essential to explain that the purpose of the examination is to further the student's training, and to seek consent for that to take place.

3.4 If a patient is not offered as much information as they may reasonably require in making their decision, or information is misrepresented in any way, their consent may be invalid. In addition, this may be a factor in any action for negligence if a patient subsequently suffers harm as a result of the treatment received.

3.5 However, it is important to gauge the patient's level of understanding and not to raise expectations unnecessarily. Some patients may wish to know very little about the treatment that is being proposed. If information is offered and declined, it is essential to record this fact in the notes. However, it is possible that patient's wishes may change over time, and it is important to provide opportunities for them to express this. Regulatory professional bodies such as the GMC, BMA, NMC and HCPC provide guidance which encourages Healthcare Professionals to explain to patients the importance of knowing the options open to them whilst respecting a patient's wish not to know, and states that basic information should always be provided about what the treatment aims to achieve and what it will involve.

3.6 In the very rare event that the Healthcare Professional feels that providing the patient with this information will cause the patient significant harm and/or suffering, the Healthcare Professional should discuss their concerns within the multi-disciplinary team caring for the patient. The Healthcare Professional's view, and the reasons for it, should be carefully recorded in the patient's notes. In individual cases the court may accept such a justification for the withholding of information, but reasons would be examined with great care. The mere fact that the patient might become upset by hearing the information, or might refuse the treatment, is not in itself sufficient justification for withholding the information.

3.7 If the Healthcare Professional is in any doubt about the information to be given to a patient, the LSW solicitors can be contacted via Complaints and Litigation Manager, and out of hours via the duty manager.

4. Who should seek consent?

4.1 The Healthcare Professional providing the treatment, care or physical intervention is responsible for ensuring that the patient has given valid consent before that action begins. However, the consultant responsible for the patient's care will remain ultimately responsible for the quality of medical care provided.

4.2 Consent must be taken by a Healthcare Professional who is both capable of performing the procedure and is able to explain the risks and benefits and answer any questions the patient might have.

4.3 Inappropriate delegation (for example where the Healthcare Professional seeking consent has inadequate knowledge of the procedure) may mean that the 'consent' obtained is not valid. Healthcare Professionals are responsible for knowing the limits of their own competence, and should seek the advice of appropriate colleagues when

necessary. However, where inappropriate delegation has occurred, the Healthcare Professional who has so delegated the task will also be held to account should any claim or adverse consequence arise.

5. When should consent be sought?

5.1 Consent must be given prior to the action requiring consent. That said, the seeking and giving of consent is usually a process, rather than a one-off event, and should be obtained not just at the outset of any action, but also as and/or when any circumstances change.

5.2 For major interventions, it is good practice, where possible, to seek the patient's consent to the proposed action well in advance, when there is time to respond to the patient's questions and provide adequate information. Healthcare Professionals should then check, before the procedure starts, that the patient still consents. If a patient is not asked to signify their consent until just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, there may be real doubt as to its validity. In no circumstances should a patient be given routine pre-operative medication before being asked for their consent to proceed with the treatment.

6. Duration

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

6.2 However, if new information becomes available regarding the proposed treatment, care or physical intervention (for example new evidence of risks or new treatment options) between the time when consent was sought and when the action is undertaken, the GMC guidance states that the Healthcare Professional should inform the patient and reconfirm their consent.

6.3 The Healthcare Professional 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.

6.4 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 action to proceed, even if no new information needs to be provided or further questions answered.

Chapter Three – Who can Validly Provide Consent?

The ability to consent to treatment, care and physical interventions differs between adults, young people and children.

1. Adults

1.1 A capable adult is able to validly consent to any treatment, care or physical intervention for themselves. A refusal of treatment by a capable adult must be respected, even if the consequences of that refusal may lead to serious injury or death.

1.2 In England and Wales, no one is able to consent on behalf of an adult with capacity.

1.3 Does the adult patient have capacity?

1.4 In assessing whether an adult patient is capable, the test is whether that adult has capacity for that **particular decision**, i.e. whether to accept or refuse that particular treatment, care or physical intervention. It is irrelevant whether the patient has capacity in other circumstances. Therefore a patient may not have capacity in relation to one decision, they may in relation to another.

1.5 In accordance with the Mental Capacity Act 2005, the starting presumption is always that a patient has capacity to make a decision unless they can be shown to lack capacity. The burden lies with the Healthcare Professional to provide evidence of why and how the patient lacks capacity using the framework in the Act.

1.6 The Act defines a person who lacks capacity as a person who:

1. has an impairment or disturbance (for example a disability, condition or trauma or the effect of drugs or alcohol) that affects the way their mind or brain works, and

2. on the balance of probabilities, that impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

1.7 The following factors are imperative for the Healthcare Professional to consider when determining whether the patient has capacity. Is the patient able to:

- understand the information about the decision to be made;
- retain that information long enough to be able to make the decision;
- use or weigh up the information as part of the decision-making process;
- communicate their decision – this could be by talking or using sign language or other personalised forms of augmentative and alternative forms of communication (AAC) and includes simple muscle movements such as blinking an eye or squeezing a hand.

NB. This consideration is only prohibitive where a patient is unable to communicate their decision in any format.

1.8 A patient's capacity to consent may be temporarily affected by factors such as confusion, panic, shock, fatigue, pain or medication. However, the existence of such factors should not lead to an automatic assumption that the patient does not have the capacity to consent. The Healthcare Professional should consider whether it is possible to defer the decision, or to make a temporary decision to be reviewed once the patient regains capacity.

1.9 In addition, it is important to note that when determining capacity, a decision must never be based upon a patient's age, appearance or assumptions about their condition or any aspect of their behaviour.

1.10 Capacity should not be confused with a Healthcare Professional's assessment of the reasonableness of the patient's decision. A patient should not to be treated as unable to make a decision merely because they make an unwise decision. A patient is entitled to make a decision which may be perceived by others to be unwise or irrational, as long as they have the capacity to do so.

1.11 The Mental Capacity Act 2005 also requires that all appropriate and reasonable steps should be taken to enable a patient to make the decision themselves. Examples of such steps include the following:

- Communicating in an appropriate manner for the patient. For example, could the information be explained or presented in a way that is easier for the patient to understand?

- Making the patient feel at ease. For example, are there particular times of the day when a patient's understanding is better?

- Supporting the patient. For example, can anyone else help or support the patient to understand information and to make a choice?

1.12 Guidance on how patients should be helped to make their own decisions is given in Chapter 3 of the Mental Capacity Act Code of Practice.

1.13 An accurate record of all discussions and reasons for decisions regarding capacity should be made in the patient's medical records.

1.14 Guidance on assessing capacity is given in Chapter 4 of the Mental Capacity Act Code of Practice.

1.15 Acting in the Best Interests of an Adult Patient who Lacks Capacity.

1.15.1 If an adult patient is found to lack capacity, the Healthcare Professional must base decisions and actions on what is in the patient's best interests. In most cases, parents, relatives or carers cannot consent on behalf of an incapacitated adult.

1.15.2 The Mental Capacity Act 2005 sets out a checklist of common principles that should be considered when determining what action/decision is in the best interests of the patient:

1 What are the reasonably ascertainable past and present feelings and wishes of the patient? It is important to involve the patient in all decisions and to the maximum extent possible.

2 Does the patient have any beliefs and values that may influence the decision?

3 Is there a valid and applicable Advance Decision? (please refer to page 23 for further information).

3.1 In general, the refusal to a treatment, care or physical intervention made by a patient when they had capacity cannot be overridden if the advance decision is valid and applicable to the situation. There are certain statutory exceptions to this principle, including treatment for mental disorder under the Mental Health Act 1983.

4 Is there a valid and applicable Lasting Power of Attorney?

4.1 If there is, the Healthcare Professional should consider the guidance set out in this document in relation to Lasting Powers of Attorney.

5 Has the patient made a written statement of their wishes and feelings?

5.1 If the Healthcare Professional's decision is different to a written statement, a Healthcare Professional should keep a record of this and be prepared to justify the decision if challenged. There is an important legal distinction between a written statement expressing treatment preferences, which a Healthcare Professional must take into account when making a best interests decision, and a valid and applicable advance decision to refuse treatment which Healthcare Professionals must follow.

6 What are the views of other relevant people who are close to the patient?

7 Is the proposed decision/action the least restrictive of basic rights and freedoms?

8 Are there any alternative ways of meeting the patient's care needs?

9 Is the patient likely to regain capacity?

9.1 Is it possible to defer the decision, or make a temporary decision to be reviewed once the patient regains capacity?

9.2 It is possible for capacity to fluctuate. In such cases, it is good practice to establish, whilst the patient has capacity, their views about any treatment, care or physical intervention that may be necessary in any period of incapacity. The patient may wish to make an Advance Decision to refuse treatment or a lasting power of attorney for personal welfare.

10 Is the patient unbefriended?

10.1 If so, the Healthcare Professional should consider the guidance set out in this document in relation to Independent Mental Capacity Advocates.

10.1.2 In the case of conflicting views, whilst a consensus may be desirable, it does not necessarily reflect what is in the patient's best interest – this decision still lies with the leading treating consultant or professional. In cases of serious doubt or dispute about an individual's mental capacity or best interests, an application can be made to the Court of Protection for a ruling.

10.1.3 Healthcare Professionals should demonstrate in their record-keeping that the decision has been based on all available evidence and has taken into account any conflicting views. What is in a patient's best interests may well change over time. This means that even where similar actions need to be taken repeatedly in connection with the patient's care or treatment, the patient's best interests should be reviewed regularly.

10.1.4 The Mental Capacity Act provides Healthcare Professionals with protection from civil and criminal legal liability for those acting in a reasonable belief, in all the circumstances, that they are acting in a patient's best interest. There is still no legal protection for negligent actions however.

10.1.5 If the Healthcare Professional has any queries regarding acting in a patient's best interests, LSW solicitors can be contacted via Complaints and Litigation Manager, and out of hours via the duty manager.

10.2 Lasting Powers of Attorney

10.2.1 The Mental Capacity Act enables a person aged 18 or over to appoint an attorney to look after their health and welfare decisions if they should lack the capacity to make such decisions in the future. Under a personal welfare LPA, the attorney – if they have the authority to do so – can make decisions that are as valid as those made by the patient themselves. The LPA must be made in the form and meet the criteria set out in the Mental Capacity Act 2005, and it must be registered with the Office of the Public Guardian before it can be used.

10.2.2 The LPA may specify limits to the attorney's authority, and the LPA must **specifically specify whether or not the attorney has the authority to make decisions about life-sustaining treatment**. Healthcare Professionals directly involved in the care or treatment of a patient who lacks capacity should not agree to act as that patient's attorney other than in exceptional circumstances (for example if they are the only close relative of the person). If the patient lacks capacity and has created a personal welfare

LPA, the attorney will have the authority to make decisions and consent to or refuse treatment as set out in the LPA. Healthcare Professionals should read the LPA if it is available, in order to understand the extent of the attorney's power.

10.2.3 An important safeguard with LPAs, is that the attorney must be acting in the best interests of the patient when taking any decision. The Healthcare Professional should ensure that they are satisfied that any attorney is acting in the patient's best interests; if they are not so satisfied, the Healthcare Professional can challenge the decision of the attorney in the Court of Protection. This is to try to ensure that no-one is unjustly motivated by a desire to bring about death.

10.2.4 Further guidance about LPAs is given in Chapter 7 of the Code of Practice for the Mental Capacity Act. If the Healthcare Professional has any queries regarding lasting powers of attorney, the LSW solicitors can be contacted via Complaints and Litigation Manager, and out of hours via the duty manager.

10.3 Independent Mental Capacity Advocates

10.3.1 If a patient, who lacks capacity, is "unbefriended" then they have a right to an IMCA. A patient is unbefriended if they have no other person, other than paid staff, to support or represent them.

10.3.2 The Healthcare Professional must instruct an IMCA where:

- serious medical treatment decisions are being taken;
- the patient is to be placed in hospital or moved to another hospital for longer than 28 days;
- the patient is moving into long term accommodation for periods longer than 8 weeks or there is a change of long term accommodation

10.3.3 Serious medical treatment is:

- Where there is a fine balance between the benefits of a proposed treatment and the burdens and risks likely to entail for the patient; or
- Where there is a choice of treatments and there is a fine balance between each; or
- Where the treatment proposed is likely to involve serious consequences for the patient.

10.3.4 The Healthcare Professional may instruct an IMCA in cases of adult protection even where the patient is not unbefriended.

The duties of an IMCA are to:

- Support the person who lacks capacity and represent their views and interests to the decision-maker;
- Obtain and evaluate information, both through interviewing the person and through examining relevant records and documents. IMCAs have the right to information about a patient and can see relevant healthcare records;

- Obtain the views of professionals providing treatment for the person who lacks capacity;
- Identify alternative courses of action;
- Obtain a further medical opinion, if required, and prepare a report (that the decision-maker must consider).

10.3.5 IMCAs are not decision-makers for the patient who lacks capacity. They are there to support and represent that patient and to ensure that decision-making for the person who lacks capacity is done appropriately and in accordance with the Mental Capacity Act.

10.3.6 Further information is given at www.dh.gov.uk/imca and in Chapter 10 of the Mental Capacity Act Code of Practice. The Plymouth IMCA Service can be contacted via the Plymouth Highbury Trust on 01752 753718.

11. Court Appointed Deputies

11.1 If a patient lacks capacity to make a decision relating to their personal welfare, then the Court of Protection can make an order making a decision on their behalf.

11.2 On rare occasions, the Court of Protection can appoint a deputy to make decisions on behalf of the patient who lacks capacity. The Mental Capacity Act 2005 makes it clear that in such situations it is preferable for the Court of Protection to make the decision if at all possible, and that if a deputy is appointed, then their powers should be limited in scope to what is absolutely necessary.

11.3 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 as a one off declaration or where there is no other way of settling the matter in the best interests of the patient who lacks capacity. For example, a deputy could be appointed to make ongoing decisions, having consulted all relevant parties. This could be useful where there is a history of family disputes.

11.4 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 Healthcare Professional who consents to the treatment decision. However, a deputy cannot override a decision of an attorney under an LPA made before the person lacked capacity. Deputies must follow the Mental Capacity Act's statutory principles and must make decisions in the patient's best interests.

11.5 Further information about the powers of the Court of Protection and the role of deputies is given in Chapter 8 of the Code of Practice.

12. Young People and Children

12.1 The legal position concerning consent and refusal of treatment by those under the age of 18 is different from that of adults. The law splits children into two categories, each

with its own separate legal position. "Children" are those aged 0-15 years of age, whereas those aged 16-17 are classified as "Young Persons."

12.2 Where a child is a ward of court, no important step may be taken in the life of the child without the prior consent of the court. This is likely to include more significant medical interventions but not treatment for minor injuries or common diseases of childhood.

13. Parental Responsibility

13.1 Parental responsibility is a legal concept, and refers to those with authority to potentially make decisions on a child or young person's behalf. Its definition in the Children Act 1989 is "*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."*

13.2 The mother of the child will always have parental responsibility. If the child's biological father is married to the mother at the time of the birth, he will also have parental responsibility. Since December 2003, unmarried fathers will have parental responsibility where both parents register the birth together and the father's name appears on the birth certificate. Evidence by way of a copy of the birth certificate is usually sufficient.

13.3 In all other circumstances a court order or formal agreement will be required to grant a person parental responsibility. Examples of other people who might have parental responsibility through a court order of formal agreement include unmarried fathers who are not registered on the birth certificate (or who were registered prior to the December 2003), adoptive parents, guardians, the local authority or someone with an emergency protection order in favour of the child. Foster parents do not automatically have parental responsibility.

13.4 It is important to note that the burden is placed upon the Healthcare Professional to satisfy himself/herself that those pertaining to have parental responsibility do in fact have such responsibility legally. As only a person exercising parental responsibility can potentially give valid consent for a child. In the event of any doubt then specific enquiry should be made.

14. Emergency Treatment

14.1 An emergency is classed as an imminent threat to life or irreversible serious deterioration in condition. In these circumstances, children and young people can be treated without consent until the state of emergency has ceased. If they do not have capacity, the Healthcare Professional must act in the best interests of the patient. In determining what is in the best interests of the patient, the Healthcare Professional should refer to the considerations set out above for adults who lack capacity. Although it is important to note that the Act only strictly applies to those over 16 years of age, it is applied in spirit to children and reinforced by case law.

15. Non-Emergency Treatment Young Persons (age 16-17years)

15.1 A refusal of treatment by a capable young person (aged 16 or 17 years) must be respected, even if the consequences of that refusal may lead to serious injury or death. The Mental Capacity Act 2005 applies to those over the age of 16, and therefore includes young persons. It should be used to assess whether the young person has capacity in all the circumstances to take a decision and provide or refuse consent. Healthcare Professionals should refer to the section above discussing whether an adult patient has capacity. This ties in with the Family Law Reform Act 1969 which entitles young people to consent to medical treatment as if they were an adult.

15.2 If however, the young person is unable to make the decision for some other reason, for example because they are overwhelmed by the implications of the decision, the legality of any treatment should be considered in line with the advice below in relation to children.

16. Young Persons with Capacity – Consenting to Treatment

16.1 The consent of a young person with capacity is sufficient even in the face of a refusal from a person with parental responsibility.

16.2 If the Healthcare Professional considers that the young person may suffer serious or significant harm in keeping information confidential then he/she may consider disclosure to appropriate relevant persons.

17. Young Persons with Capacity – Refusing Treatment

17.1 If the young person with capacity is refusing treatment, but the Healthcare Professional still believes that it is in their best interests to have the treatment then the Healthcare Professional should contact the LSW's legal team. It is not considered good practice, in line with the human rights legislation, to rely upon the consent of a person with parental responsibility to overrule the refusal of a young person with capacity in all the circumstances.

17.2 The changes made to section 131 of the Mental Health Act 1983 by section 43 of the Mental Health Act 2007 mean that when a young person has capacity and does not consent to admission for treatment for mental disorder (either because they are overwhelmed, do not want to consent or refuse to consent), they cannot then be admitted informally on the basis of the consent of a person with parental responsibility (see chapter 36 of the Code of Practice to the Mental Health Act 1983, as amended 2008).

18. Young Persons without Capacity

18.1 If the young person does not have capacity in accordance with the test laid out in the Mental Capacity Act 2005, the Healthcare Professional should provide the treatment if

it is considered to be in the patient's best interests. This is the situation irrelevant of whether those with parental responsibility consent to the treatment. However the views of those with parental responsibility should be taken into account when determining whether the treatment is in the young person's best interests. The Healthcare Professional should refer to the section above discussing acting in the best interests of an adult who lacks capacity.

18.2 Please note that Lasting Powers of Attorney and Advance Decisions **do not** apply to those under the age of 18.

19. Non-Emergency Treatment Children (those under 16 years)

19.1 Strictly speaking the Act only applies to those over the age of 16, however its spirit is helpful and indicative of good practice in relation to children. Therefore, the Healthcare Professionals may wish to consider the test of capacity in the Mental Capacity Act outlined above.

19.2 However, the *Gillick* test of competence should be the Healthcare Professional's primary consideration in relation to children.

19.3 "Does the child have sufficient intelligence and maturity to understand the nature and implications of the treatment?"

19.4 The concept of *Gillick* competence is said to reflect a child's increasing development to maturity. The understanding required for different interventions will vary considerably. Thus a child may have the capacity to consent to some interventions but not to others. The child's capacity to consent should be assessed carefully in relation to each decision that needs to be made.

19.5 In some cases, for example because of a mental disorder, a child's mental state may fluctuate significantly, so that on some occasions the child appears *Gillick* competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given as to whether the child is truly *Gillick* competent at the time that they need to take a relevant decision.

19.6 In addition, please see set out below the British Medical Association and Law Society's Guidelines for assessing competence in children. Although these are not legally enforceable, they are good practice and expand upon the succinct *Gillick* test.

1. Ability to understand that there is a choice and that choices have consequences;
2. Willingness and ability to make a choice;
3. Understanding the nature and purpose of the proposed procedure;
4. Understanding the proposed procedure's risks and side effects;
5. Understanding of the alternatives to the procedure and the risks attached to them, and the consequences of no treatment; and
6. Freedom from pressure.

20. Competent Children – Consenting to Treatment

20.1 If the child is deemed competent (i.e. has capacity) to make decisions regarding his/her treatment or care, his/her consent to the treatment or care is sufficient, even in the face of a refusal from a person with parental responsibility. It is, however, good practice to involve the child's family in the decision-making process, if the child consents to their information being shared.

20.2 Where advice or treatment is provided, the Healthcare Professional should try to persuade the child to inform his or her parent(s), or allow the medical professional to do so. If however the child cannot be persuaded, advice and/or treatment should still be given if the Healthcare Professional considers that the child is *Gillick* competent and therefore able to consent.

20.3 If the Healthcare Professional considers that the child may suffer serious or significant harm in keeping information confidential then he/she may consider disclosure to appropriate relevant persons.

21. Competent Children – Refusing Treatment

21.1 The Healthcare Professional should consider whether the treatment, care or physical intervention is in the child's best interests in light of his/her competent refusal. Although the Mental Capacity Act 2005 does not strictly apply, it is viewed as best practice to consider the factors to determine best interests in the Act as set out above. In addition, the views of the persons with parental responsibility for the child should be considered at this stage.

21.2 As the law in England and Wales currently stands, consent from a person with parental responsibility can override the refusal of a competent child. However, since the Human Rights Act 1998 this is no longer quite so certain and it may be unwise to rely upon an overriding consent of a person with parental responsibility, considering the trend in the European Court of Human Rights to respect greater autonomy in those under 18.

21.3 With this in mind, if the Healthcare Professional still considers the treatment to be in the best interests of the child, the next step is often to ensure that all reasonable attempts to persuade the child to have the treatment have been taken. To this extent, obtaining a second opinion on the proposed treatment, mediation and an opinion from an impartial organisation may be helpful. Also, it might be prudent to obtain a second opinion on whether the child is competent.

21.4 If the child continues to refuse to consent to treatment, and a second opinion confirms that he/she has capacity, the Healthcare Professional will need to consider whether the patient is likely to die or suffer imminent irreversible serious deterioration in his/her condition whilst a court order is obtained. If he/she is, treatment can be provided against his/her will as long as it is in the patient's best interests and consent is provided from those with parental responsibility. Reasonable force can be used to achieve this.

21.5 However, if it is not likely that the patient will die or suffer irreversible serious deterioration in her condition whilst a court order is obtained, the Healthcare Professional should contact the LSW's legal team to consider whether an application to court is required in all the circumstances.

21.6 It is important to note that usually a court order can be obtained in a matter of hours. However, this timeframe is longer over Bank Holidays and weekends.

22. Incompetent Children – Consent from a Person with Parental Responsibility

22.1 Under the Children Act 1989, consent is only required from one person with parental responsibility. However, the courts have stated that a 'small group of important decisions' should not be taken by one person with parental responsibility against the wishes of another, citing in particular non-therapeutic male circumcision and immunisation. Where persons with parental responsibility disagree as to whether these procedures are in the child's best interests, it is advisable to refer the decision to the courts.

22.2 In addition, it is important to note that any consent from a person with parental responsibility is only authoritative if the treatment decision is within their zone of parental control i.e. if it is the sort of decision it would be reasonable to expect a parent to take. Careful consideration will have to be given in the individual circumstances, but as a rule of thumb, the more invasive the treatment is and the greater the deprivation to patient's liberty, the less likely it is that the decision will fall within the zone of parental control. In these circumstances, it will be necessary to obtain a court order unless there is an imminent threat to the patient's life or he/she is likely to suffer irreversible serious deterioration in their condition.

22.3 Consent is required for each and every aspect of treatment given to the patient, and a "blanket" consent should not be considered sufficient.

22.4 As is the case where patients are giving consent for themselves, those giving consent on behalf of children 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 the child's 'welfare' or 'best interests' must be paramount. 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. Where there is doubt about whether a parent is acting in the interest of the child, then the Healthcare Professional would be unwise to rely on the parent's consent, for example if a child alleges abuse and the parent supports psychiatric treatment for the child. The Government's guidance Working Together to Safeguard Children covers situations involving parental consent where abuse or neglect is suspected.

22.5 It is recommended that certain important decisions, such as sterilisation for contraceptive purposes, should be referred to the courts for guidance, even if those with parental responsibility consent to the operation going ahead.

23. Incompetent Children – No Consent from a Person with Parental Responsibility

23.1 If the Healthcare Professional still considers that the treatment is in the best interests of the patient, even with the refusal of those with parental consent, all reasonable steps to persuade those with parental consent to consent should be explored. Again, a second opinion on the proposed treatment along with opinions from impartial organisations and mediation may be useful.

23.2 In such circumstances the Healthcare Professional will have to weigh up all of the evidence and determine whether to acquiesce to the view of the person with parental responsibility or to go to court for a best interests declaration.

Please also consider "Working Together to Safeguard Children" (2013)
http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children

24. Referrals to Court

24.1 The Mental Capacity Act 2005 established the Court of Protection to deal with decision-making for adults and young persons 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.

24.2 Where there is a dispute between the Healthcare Professional, the decision-maker and the patient as to what treatment or action is in the patient's best interests, a referral to the Court may be appropriate. All court referrals will come from the LSW, and the relevant Healthcare Professional should contact the LSW's legal department in the first instance.

24.3 In addition, where the Healthcare Professional wishes to provide treatment that is deemed in the patient's best interests, but will involve restraint and control, the LSW's legal team should be contacted to discuss the appropriateness of the restraint or whether a court declaration is required.

24.4 There are certain circumstances where a court referral is mandatory. These include:

- Decisions about the proposed withholding or withdrawal of Artificial Nutrition and Hydration from patients in a permanent vegetative state
- Cases involving organ, bone marrow or peripheral blood stem cell donation by an adult who lacks the capacity to consent
- Cases involving the proposed non-therapeutic sterilisation of a patient who lacks the 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 patient's best interests.

24.5 Other cases likely to be referred to the court include those involving ethical dilemmas in untested areas (such as innovative treatments for variant CJD), or where there are otherwise irresolvable conflicts between healthcare staff, or between staff and family members. More information about the powers of the Court of Protection and the cases that should be referred to the court is given in the Mental Capacity Act Code of Practice and in a Court of Protection Practice Directions.

24.6 If Court assistance is deemed necessary, the patient, and all those involved in the decision, should be notified as soon as possible of such intended action. This will enable the Court to hear both sides so as to weigh all factors before reaching a decision.

24.7 If the Healthcare Professional has any queries regarding referrals to court, the LSW solicitors can be contacted via Complaints and Litigation Manager, and out of hours via the duty manager.

Chapter Four – Refusal of Consent

1. When Consent is Refused

1.1 A refusal of treatment (whether contemporaneously or in advance) by a capable adult or young person must be respected, even if the consequences of that refusal may lead to serious injury or death (and/or the death of an unborn child, whatever the stage of the pregnancy). In relation to a refusal by a Gillick competent child, please see the section entitled "Refusal by a Competent Child" in Chapter 3. A capable refusal, however irrational, is valid and providing treatment in the face of such a refusal may lead to criminal and/or civil proceedings against the Healthcare Professional/the hospital and a possible referral to the General Medical Council or appropriate professional body.

1.2 It is important that all refusals of consent should be documented, preferably in the form of written assurance by the patient, and the following information should be included:

- that the refusal represents an informed and settled decision; and
- the reasons for the patient's refusal; and
- that the patient understands the following in relation to the proposed treatment; its nature;
- the reasons for it being recommended;
- the risks; and
- the likely prognosis involved in the decision to refuse it.

1.3 If the patient is not prepared to provide a written assurance, a careful record should be kept of the advice given to the patient about the need for treatment and the risks of refusing it, together with the patient's reasons for refusal.

2. Advance Decisions to Refuse Treatment

2.1 An adult patient is able to make an advance decision to refuse particular treatment in anticipation of future incapacity (also known as a 'living will' or an 'advance directive'). An existing, valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment and a Healthcare Professional acting contrary to it is open to liability. The Mental Capacity Act 2005 sets out the requirements for an advance decision to be valid and applicable. Further details are available in Chapter 9 of the Mental Capacity Act Code of Practice, but in summary these are:

- the patient must currently lack capacity;

- the patient must have been 18 or over when they made the advance decision;

- the patient must have had the capacity to make the advance decision when it was created;

- the patient must make clear which treatments they are refusing (a general desire not to be treated is insufficient) and in what specific circumstances they refuse them - the advance decision must apply to the proposed current treatment and in the current circumstances;

    - The patient must not have withdrawn the advance decision:
    - Expressly either verbally or in writing;
    - Since making the advance decision the patient has created a lasting power of attorney giving the attorney the authority to make decisions in the same areas covered by the advance decision;
    - The patient has done something that clearly goes against the advance decision.

2.2 There is no required format for an advance decision, unless it relates to life sustaining treatment in which case it must be in writing, signed by the patient, witnessed and must specifically state that it applies even if life is at risk.

2.3 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 can 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 Court, Healthcare Professionals can provide life-sustaining treatment or treatment to prevent a serious deterioration in the patient's condition.

2.4 If an advance decision is not valid or applicable to the current circumstances, Healthcare Professionals must consider the advance decision as part of their assessment of the patient's best interests. Advance decisions made before the Mental Capacity Act 2005 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. However, please note that it is unlikely that an advance decision made prior to the Act will be sufficient to meet the conditions of the Act and therefore be valid.

2.5 Patients cannot refuse measures that are essential to keeping them comfortable in an advance decision. This is sometimes referred to as 'basic' or 'essential' care, and includes warmth, shelter, actions to keep a person clean and free from distress and the offer of food and water by mouth. An advance decision can refuse artificial nutrition and hydration. However, the BMA's guidance advises that basic care should always be

provided unless it is actively resisted by a patient, and that ‘refusals of basic care by patients with capacity should be respected, although it should be continued to be offered’.

3. Withdrawal of Consent

3.1 A patient with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a patient does object during treatment, it is good practice for the Healthcare Professional, if at all possible, to stop the procedure, establish the patient's concerns and explain the consequences of not completing the procedure. At times, an apparent objection may in fact be a cry of pain rather than withdrawal of consent, and appropriate reassurance may enable the Healthcare Professional to continue with the patient's consent. If stopping the procedure at that point would genuinely put the life of the patient at risk, the Healthcare Professional may be entitled to continue until that risk no longer applies.

3.2 Assessing capacity during a procedure may be difficult and, as noted above, factors such as pain, panic and shock may diminish capacity to consent. The Healthcare Professional should try to establish whether at that time the patient has capacity to withdraw a previously given consent. If capacity is lacking, it may sometimes be justified to continue in the patient's best interests but this should not be used as an excuse to ignore distress.

4. Ability of Healthcare Professional to Refuse to Provide/Withdraw Treatment

4.1 A Healthcare Professional cannot be forced to provide or stop providing any form of treatment that goes against his/her beliefs. However, the Healthcare Professional cannot simply abandon their patient or cause their patient's care to suffer.

4.2 At the earliest opportunity the Healthcare Professional should make their views clear to the patient and the healthcare team. Arrangements should be made to transfer the care of the patient to a suitably qualified colleague who is prepared to consider the clinical circumstances and give effect to the patient's wishes where appropriate.

4.3 A patient (or a person entitled to provide consent on their behalf), cannot demand nor require treatment that the Healthcare Professional does not think is in the patient’s best interests.

Chapter Five – Specific Examples

1. Research and Innovative Treatment

1.1 Broadly speaking, the same legal principles apply when seeking consent from a patient for research purposes as when seeking consent for investigations or treatment. However, there are subtle differences and Healthcare Professionals involved in research should refer to the Medical Research Council's guidance, in particular in relation to adults lacking capacity and young people and children. The information set out below is only an overview and should not be substituted for review of the specific guidance and legislation applicable.

1.2 Types of Research

Legally, there are two types of research:

a) Clinical Trials – these are researches to ascertain the efficacy or safety of a medicinal product on human subjects. This type of research is governed by the Medicines for Human Use (Clinical Trials) Regulations 2004;
b) Other Research involving People – all other research is governed by a combination of the common law and the Mental Capacity Act 2005.

Healthcare Professionals should ensure that they are familiar with the particular legal provisions relating to the type of research and the patient.

1.3 Adults and Young Persons with Capacity

The same principles to consent as described above in Chapter Three apply.

GMC guidance advises that patients ‘should be told how the proposed treatment differs from the usual methods, why it is being offered, and if there are any additional risks or uncertainties’.

If the treatment being offered is of an experimental nature, but not actually part of a research trial, this fact must be clearly explained to a patient with capacity before their consent is sought, along with information about standard alternatives. It is good practice to give a patient information about the evidence to date of the effectiveness of the new treatment, both at national/international levels and in the Healthcare Professional’s own experience, including information about known possible side-effects.

1.4 Adults and Young Persons Lacking Capacity

For all types of research there are certain pre-requisites:

- The research protocol must have been approved by an independent research ethics committee;

- Any potential benefits must outweigh any risks or burdens that would be imposed on the patient. If there are no potential benefits to the patient, the risks should be negligible;

- Only research relating to the condition or impairment (and the treatment thereof) that affects the patient should be used;

- The views of those close to the patient should be obtained – if they indicate that the patient would not consent, the research should not be conducted;

- If possible, the research should be discussed with the patient themselves – if there are any indications that they are not in agreement, the research should not be conducted.

1.5 Clinical Trials

Consent should be obtained from the patient's legal representative. That is a person who is independent of the trial, who by virtue of their relationship with the patient is suitable to act as the legal representative for that trial, and who is available and willing to act. If there is no other suitable person, the doctor who is primarily responsible for the patient's care should be the legal representative.

1.6 Other Research

Either a personal consultee or a nominated consultee should consent to the research. The consultee should be a person involved in the patient's care, should be interested in the patient's welfare and be willing to act. They should not be a professional or paid consultee.

If a personal consultee cannot be identified, then the researcher must nominate a consultee who is independent of the research project to provide advice on the participation of the patient who lacks capacity in the research.

The consultee should be asked for advice about whether the patient who lacks capacity should participate in the research project and what, in their opinion, the patient's wishes and feelings about taking part would be likely to be if they had capacity. The patient's past or present wishes, feelings and values are most important in deciding whether they should take part in research or not.

NB. No patient should be involved in any research if it is contrary to their best interests.

1.7 Children

Clinical Trials

Those under the age of 16 require consent from someone with parental responsibility or a legal representative as described above.

1.8 Other Research

The Healthcare Professional should apply the principles of the common law as described above in Chapter Three. In addition, the Healthcare Professional should consider same considerations as described above in relation to Young Persons and Adults who Lack Capacity and other research.

2 Visual and Audio 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 patient before their consent is sought for the recording to be made. If it is to be used for teaching, audit or research, patients 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 or research.

3 Self-harm

3.1 Cases of self-harm present a particular difficulty for Healthcare Professionals. In an emergency situation, where the Healthcare Professional is unable to fully assess the patient's capacity, emergency treatment to preserve life or to prevent an irreversible and serious deterioration in condition should always be given. An assessment of the patient's mental capacity, in accordance with the appropriate test as set out above, should be undertaken as a matter of urgency as soon as the patient is through the state of emergency.

3.2 Making a decision which, if followed, may result in death does not necessarily mean that a patient is or feels suicidal. In addition, assumptions in relation to capacity should not be made just because a patient appears to have made a decision that will result in their death. Suicidal ideation is however, a consideration to be factored in the capacity assessment.

3.3 If the patient is judged to lack capacity, then they may be treated in their best interests. Consideration should be given as to whether the incapacity is temporary or permanent, and decision-making and action should be moulded accordingly.

3.4 Healthcare Professionals should consider any advance decisions or do not resuscitate orders if they are relevant. In addition, it may be appropriate to arrange an assessment under the Mental Health Act 1983 if mental disorder may be a factor.

3.5 If a patient has capacity, and mental disorder is not a factor, and they refuse treatment following an attempt at self harm, their refusal must be respected, even if this will result in their death.

4. Notifiable Infectious Diseases

4.1 The Public Health (Control of Disease) Act 1984, as amended by the Health and Social Care Act 2008, grants a Justice of the Peace authority to order health measures in relation to persons who are or may be infected or contaminated. Such health measures include things like submitting to a medical examination, removal and detention in hospital and isolation or quarantine. However, importantly, it does not impose a power to force treatment on contaminated or infected persons. Therefore, the principles of consent as set out in Chapter 2 above apply equally to persons detained under this legislation.

5. Mental Health Act 1983

5.1 Patients who are formally detained under the Mental Health Act 1983 require further consideration. Part 4 of the Mental Health Act 1983 sets out circumstances in which patients liable to be detained under the Act may be treated without consent for their mental disorder and manifestations and symptoms of their mental disorder. Part 4A sets out the requirements for treatment of patients who are in the community under supervised community treatment orders. Healthcare Professionals who work with patients detained under the Mental Health Act 1983 should refer to the Mental Health Act Code of Practice, which can be accessed electronically via the Department of Health's website.

5.2 The Mental Health Act 1983 has **no application** to treatment for physical disorders that are unrelated to the mental disorder. For such unrelated physical disorders, the requirements and considerations (such as capacity and valid consent) detailed in this policy prevail. It is important to note that, neither the existence of mental disorder nor the fact of detention under the Mental Health Act 1983 should give rise to an assumption of incapacity. The patient's capacity must be assessed in every case in relation to the particular decision being made.

5.3 The Mental Capacity Act 2005 Code of Practice provides information on the relationship between the Mental Capacity Act 2005 and the Mental Health Act 1983. Where there is any doubt as to whether treatment falls under the Mental Health Act 1983 or the Mental Capacity Act 2005, advice from the Mental Health Act Manager (Glenbourne) must be sought.

Chapter Six - Monitoring Compliance with the Document

The issue of consent and capacity must to be considered on an individual basis. Training should be available for all staff on induction, at a minimum of two years and following any changes in legislation. This should include training for staff to whom the consent process is delegated even though they may not be performing the procedure.

The Health records should contain evidence of informed consent and capacity, this should be audited annually via the Health Records Audit.

All consent forms should be audited via the Matrons and Service Managers on an annual basis.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Professional Practice Safety & Quality

Date: 4th April 2016

Appendix A

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, some one 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. Your Trust or organisation 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 foetus.

Adults who are not competent to give consent

11. **No-one** can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment 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 give you 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 the patient is lacks capacity and has no appropriate relative, friend or unpaid carer an Independent Mental Capacity Advocate may be required.**

13. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and those circumstances arise, you must abide by that refusal.

This summary cannot cover all situations. For more detail, consult the Reference guide to consent for examination or treatment, and The Mental Capacity Act Code of Practice available from the NHS Response Line 08701 555 455 and at www.doh.gov.uk/consent and www.dca.gov.uk

Appendix B

Mental Health Act 1983

Patients detained under the Mental Health Act 1983 are subject to special provisions which govern the treatment for their mental disorder. Treatment for any disorder not associated with their mental disorder is not regulated by the MHA.

Medical Treatment for mental disorder is defined in the MHA also includes nursing care, psychological intervention, specialist mental health rehabilitation and care.

First three-month rule

Medical treatment for mental disorder can be administered to a detained patient in the first three months of their detention (starting on the first day medication was administered to the patient during the current detention) without the need to obtain the patients consent. However, the patients consent should still be sought before treatment is given, wherever practicable. Their consent or refusal would be recorded in their notes, as should the treating clinicians' assessment of the patient's capacity. (taken form MHA Code of Practice 23.37)

The administration of medication after the three-month period, and Electro-convulsive therapy (ECT) at any time, is governed by Sections 58 and 58A of the MHA respectively.

Medication (Section 58)

The administration of mediation for mental disorder after the three-moth period must be given either with the patient's valid consent, or if they are refusing, or incapable of giving consent, the treatment plan must be authorised by a Second Opinion Appointed Doctor (SOAD).

All medication for mental disorder must be documented on the appropriate statutory treatment form and a copy of which must be attached to the patients' medication chart.

If there is a change in medication prescribed, to that written on the form, or the patient's consent status changes, new statutory certification to continue the treatment is required.

ECT (Section 58A)

The consent process for the administration of ECT (including medication administered as part of the treatment) to patients detained under the MHA (and all those under the age of 18) differs from that governing the administration of medication. **The three-month rule does not apply to ECT**. Valid consent or authorisation from a SOAD must be obtained for all planned treatments irrespective of the length of time on section.

A detained patient who has the capacity to consent to ECT can only be given the treatment if they consent to it. A competent patient **refusing** ECT **cannot** be given the treatment. This includes any refusal documented on a valid Advance Decision.

If ECT is to be administered to a patient who lacks the capacity to give consent, the treatment can only be administered if a SOAD agrees that the treatment is appropriate, there is no valid advance decision refusing the treatment, no suitably authorised attorney or deputy (under the MCA) objects to the treatment on the patients behalf, or

MHA Treatment Forms

Form No	Medication / ECT	Title of Form
T1	Section 57 Treatment	Certificate of consent to treatment and second opinion
T2	Medication	Certificate of consent to treatment
T3	Medication	Certificate of second opinion
T4	ECT	Certificate of consent to treatment (patients at least 18 years old)
T5	ECT	Certificate of consent to treatment and second opinion (patients under 18) - **Required for ECT given to all under 18's detained and informal**
T6	ECT	Certificate of second opinion (patients who are not capable of understanding the nature, purpose and likely effects of the treatment)
Forms for SCT		
CTO11	Treatment in Community	Certificate of appropriateness of treatment to be given to community patient (Part 4A certificate) **Only medication stated on this form can be given is patient is recalled to hospital**