St Erme Medical

Consent policy and procedure

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Consent Policy & Procedure

Introduction

The purpose of this policy is to set out ST ERME MEDICAL's approach to consent and the way in which the principles of consent will be put into practise. It is not a detailed legal or procedural resource due to the nature and complexity of the issues surrounding consent.

Where possible, a doctor or other clinician must be satisfied that a patient understands and consents to a proposed treatment, immunisation or investigation, as well as the nature, purpose, benefits and risks of the procedure. Drawings, interpreters, videos or other means may be used to help ensure that the patient understands the situation, and has enough information to give 'Informed Consent'.

As a result of the Montgomery Judgement in 2015, consent must be clarified regarding not just the available options, but also the risks. The doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in proposed treatment, and of reasonable alternatives. A risk is "material" if a reasonable person in the patient's position would be likely to attach significance to it, or if the doctor is or should reasonably be aware that their patient would be likely to attach significance to it.

Types of consent

1. Implied Consent

Implied consent will be assumed for many routine physical contacts with patients. Where implied consent is to be assumed by the clinician, in all cases, the following will apply:

- An explanation will be given to the patient with regards to what the clinician is about to do, and why.
- The explanation will be sufficient for the patient to understand the procedure.
- In all cases where the patient is under 18 years of age, a verbal confirmation of consent will be obtained and entered into the medical record.
- Where there is a significant risk to the patient, "Expressed Consent" is to be obtained in all cases (see below).

Expressed Consent

Expressed consent (written or verbal) will be obtained for any procedure which carries a risk that the patient is likely to consider as being substantial. A note will be made in the medical record detailing the discussion about the consent given and the risks of the procedure. A Consent Form may be used for the patient to express consent (see below) which should then be attached to the clinical record.

Obtaining Consent

- Consent (Implied or Expressed) will be obtained prior to the procedure, and prior to any form of sedation.
- The clinician will ensure that the patient is competent to provide a consent (i.e. is 16 years old or over) or has "Gillick Competence" if under 16 years. Further information about Gillick Competence and obtaining consent for children is set out below.
- Consent will include the provision of all information relevant to the treatment.
- The clinician should explain the proposed treatment and any alternatives available to the patient, the risks and benefits of each option, and support the patient choice about which treatment best meets your needs.
- Questions posed by the patient will be answered honestly, and information necessary for the informed decision will not be withheld unless there is a specific reason to withhold. In all cases where information is withheld then the decision will be recorded in the clinical record.
- The person who obtains the consent will be the person who carries out the procedure (i.e. a nurse carrying out a procedure will not rely on a consent obtained by a doctor unless the nurse was present at the time of the consent).
- The person obtaining consent will be fully qualified and will be knowledgeable about the procedure and the associated risks.
- The scope of the authority provided by the patient's consent will not be exceeded unless in an emergency.
- St. Erme Medical acknowledges the right of the patient to refuse consent, delay the consent, seek further information, limit the consent, or ask for a chaperone.
- Clinicians will use a Consent Form where procedures carry a degree of risk or where, for other reasons, they consider it appropriate to do so (e.g. malicious patients).
- No alterations will be made to a Consent Form once it has been signed by a patient.
- Clinicians will ensure that consents are freely given and not under duress (e.g. under pressure from other present family members etc.).
- If a patient is mentally competent to give consent but is physically unable to sign the Consent Form [*], the clinician should complete the Form as usual, and ask an

independent witness to confirm that the patient has given consent orally or non-verbally.

Other aspects which may be explained by the clinician include:

- Details of the diagnosis, prognosis, and implications if the condition is left untreated
- All options for treatment, including the option not to treat
- Details of any subsidiary treatments (e.g. pain relief)
- Patient experiences during and after the treatment, including common or potential side effects and the recovery process.
- Probability of success and the possibility of the need for further treatments.
- The option of a second opinion.

Consent for children

Everyone aged 16 or over is presumed to be competent to give consent for themselves unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him/her to understand fully what is proposed" (known as Gillick Competence), then he/she will be judged competent to give consent for him/herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign a Consent Form for themselves, but they may like a parent to countersign as well.

For children under 16 (except for those who have Gillick Competence as noted above), someone with parental responsibility should give consent on the child's behalf by signing accordingly on the Consent Form [*].

Clinicians will be guided by the GMC accessed on: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years

Mental Capacity Act

The **Mental Capacity Act (MCA)** 2005 became fully effective on 1st October 2007 in England & Wales and provides a framework to empower and protect people who may lack capacity to make some decisions for themselves. 'A person who lacks capacity' is defined as a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken.
The lack of this capacity could be due to a mental health condition, a severe learning disability, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident and may be on either a temporary or a permanent basis.

The MCA makes clear who can take decisions in which situations, and how they should go about this.

Anyone who works with or cares for an adult who lacks capacity must comply with the MCA when making decisions or acting for that person. Within St. Erme Medical, the provisions will apply to doctors, nurses and those to whom a referral may be made.

The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) may apply to people who are in a care home or hospital. This includes where there are plans to move a person to a care home or hospital where they may be deprived of their liberty. The care home or hospital is called the *managing authority* in the Deprivation of Liberty Safeguards. This does not apply at St Erme Medical.