Rotherham Doncaster and South Humber NHS Foundation Trust

Consent to care and treatment policy

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1. Document summary

1.1 What is this policy about?

This policy is about consent. Consent means a person agrees to care, treatment or an examination. Staff must ask for consent before care or treatment starts.

1.2 Giving consent

The person must understand what is being offered. Staff must explain the care or treatment, the benefits, the important risks and other choices. Information must be given in a way the person can understand. The person must be free to decide and must not be pressured.

1.3 Changing your mind

A person can say no to care or treatment. They can also change their mind after saying yes. Staff must explain what may happen, respect a valid decision and record it clearly.

1.4 Making a decision

Most people aged 16 or over can make their own decisions. Staff must help the person to understand and decide. If the person cannot make the decision at that time, staff must follow the Mental Capacity Act and decide what is in the person's best interests. Staff must check whether the person has already recorded their wishes or chosen someone who can decide for them.

1.5 Children and young people

Some children under 16 can make their own decision if they understand enough. This is called being Gillick competent. If they cannot make the decision, staff will usually ask someone with parental responsibility.

1.6 Special situations

The policy also explains what staff must do in an emergency, near the end of life, during resuscitation, when making photographs or recordings, and when giving medication or electro-convulsive therapy (ECT). Different rules may apply when treatment is given under the Mental Health Act.

1.7 What staff must do

- Ask for consent before care or treatment.
- Give clear information and support the person to decide.
- Use the correct consent form when written consent is needed.
- Record the discussion and decision in the person's health record.
- Ask a manager or specialist for advice if they are unsure.

2. Introduction and aim

Care or treatment may only be given when the patient has given valid consent, or when there is a clear legal authority to proceed. Relevant authority may come from the Mental Health Act 1983, the Mental Capacity Act 2005, the Children Act, a court decision or common law. Treatment for a mental disorder without consent may only be given to a patient who is detained, or liable to be detained, under the Mental

Health Act. Staff must follow Part 4 of the Mental Health Act and Chapter 23 of its Code of Practice.

The Trust must meet Regulation 11, Need for Consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission monitors how providers meet the consent requirements in Regulation 11, sections 11(1) to 11(5).
Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), referred to in this policy as the Trust, must obtain consent lawfully. The member of staff seeking consent must understand the proposed care or treatment well enough to explain it and answer the patient's questions.

This policy sets out the standards and steps that Trust staff must follow when seeking consent. It mainly covers healthcare, but social care staff must also obtain consent before interventions such as touching a patient. It also explains when consent is required for patients detained under the Mental Health Act.

3. Procedure

3.1 Who should seek consent?

Every colleague who provides care or treatment must check that the patient has given valid consent before it begins.
The colleague seeking consent must understand the proposed care or treatment, including its benefits and risks, well enough to answer the patient's questions. If consent is delegated, the person delegating must be satisfied that the colleague is competent. Poor delegation may make the consent invalid.

When an anaesthetist is involved, for example for electro-convulsive therapy (ECT), they must obtain valid consent for the anaesthetic after discussing its benefits and risks. See the electro-convulsive therapy (ECT) clinical guidelines policy.

A colleague must not seek consent if they feel pressured to do so or do not understand the process. They must speak to their manager. Advice is also available from the executive medical director by phone or email.

3.2 Duration of consent

Valid consent continues unless the patient withdraws it. Staff must review consent if treatment is delayed, new information changes the benefits or risks, there are concerns about capacity, or treatment and monitoring continue over time.

3.3 Withdrawal of consent, patients aged 16 years or older

A patient aged 16 or over who has capacity may withdraw consent at any time, unless treatment is authorised under the Mental Health Act. Staff must explain the likely outcome of not receiving treatment and respect the patient's decision.

If the patient previously signed consent form 1, they should sign and date a new consent form 1 to record their changed decision. The health professional must record the reason for withdrawal and sign and date the new form.

If there is concern that the patient may not understand the consequences of withdrawing consent, staff must assess capacity and record the assessment and conclusion in the electronic health record. See the Trust's Mental Capacity Act (MCA) (2005) policy. If the patient lacks capacity, the decision about whether to continue must be made under the Mental Health Act or through a Mental Capacity Act best-interests decision, as appropriate.

3.4 When consent is refused, patients aged 16 years or older

A patient must be free to refuse care or treatment. If a patient aged 16 or over has capacity and makes a voluntary, informed refusal, staff must respect it unless the Mental Health Act or exceptional common-law authority applies.

Staff must record the refusal clearly in the patient's record. If refusing the care, treatment or equipment could cause serious harm, staff should complete consent form 3. The form must show that the patient's condition, the proposed care or treatment, its benefits and the risks of refusal were discussed. The patient and the colleague who held the discussion must sign and date the form, which must be stored in the electronic record.

3.5 Patients aged 16 years or older who lack capacity to consent

Parents, relatives and members of the healthcare team usually cannot consent for a patient aged 16 or over. If the patient lacks capacity, care or treatment may be given in their best interests after a capacity assessment, unless it is refused by a valid and applicable advance decision, a health and welfare attorney, or a court-appointed health and welfare deputy.

For an intervention that carries a high risk or a risk of serious harm, staff must document the capacity assessment and use consent form 4. The form must record the best-interests decision, any valid advance decision, health and welfare attorney or court-appointed deputy, and any authorised person's decision. The health professional seeking consent must sign and date the form, together with anyone giving a second opinion where appropriate.

3.5.1 Independent mental capacity advocate (IMCA)

The Trust must instruct an independent mental capacity advocate (IMCA) when serious medical treatment is proposed, or not providing it may have serious consequences, and the patient lacks capacity with no family or friends available to consult other than paid carers. The IMCA supports the best-interests process but does not make the decision. In an emergency, the healthcare professional must act in the patient's best interests and involve an IMCA as soon as possible afterwards.

3.6 Children or young people who are not Gillick competent, parental responsibility

If a child under 16 is not Gillick competent, consent must be sought from someone with parental responsibility, provided the decision is within the scope of that

responsibility. This may include the birth mother; a father who was married to the mother at conception, birth or later; a civil partner or partner registered as a legal parent on the birth certificate; the local authority where a care order applies; or a person named in a relevant court order.

An unmarried father has parental responsibility if named on the birth certificate for a birth registered from 1 December 2003, or if parental responsibility was gained through a court order or agreement. Consent is legally required from only one person with parental responsibility, although staff should involve others close to the child where appropriate. Use consent form 2. Seek legal advice for complex or serious treatment if it is unclear whether the decision is within parental responsibility.

3.7 Refusal of treatment children and young people

A refusal by a young person aged 16 or 17 who has capacity, or by a Gillick-competent child under 16, may in some circumstances be overridden by a person with parental responsibility. If the child is not Gillick competent and the person with parental responsibility refuses treatment, staff must consider and record the risks.

If refusal may cause significant harm, staff should complete consent form 3. It must record the discussion with the child or young person and, where relevant, the person with parental responsibility, including the benefits of treatment and the risks of refusal. The relevant person and the colleague who held the discussion must sign and date the form, and it must be stored in the electronic record. Staff must fully record the decision and reasons, consider whether the Mental Health Act applies, and seek safeguarding advice about a referral to children's social care. Where disagreement remains, staff must seek legal advice and, if needed, a court decision.

3.8 End of life care

A person nearing the end of life may have reduced or changing capacity because of delirium, infection, dehydration, organ failure, dementia or another condition. Staff must use the same consent framework as for any other care or treatment and assess capacity for the decision at the time it is needed.

3.8.1 Advance consent

If loss of capacity is likely, staff should encourage the patient to discuss their wishes while they have capacity. An advance statement should clearly describe the care or treatment the patient would prefer. It is not legally binding but must be considered in a later best-interests decision. A patient who wants to refuse a particular treatment should be supported to make an advance decision to refuse treatment. If valid and applicable when the patient lacks capacity, the treatment must not be given.

3.9 When patients do not want to know

If a patient does not want detailed information, staff should respect this as far as possible. They must still explain that the patient needs basic information to give valid consent and that they can ask for more information at any time.

The health professional must record that the patient declined relevant information and decide whether treatment can proceed. If the treatment carries significant risk, they should seek advice from the relevant clinical lead or associate medical director.

3.10 Consent to visual and audio recordings

Staff must obtain consent before making any visual or audio recording, including photographs used for examination or treatment. They must explain why the recording is needed and how it may be used. Patients may refuse use for teaching, audit or research without this affecting their care. Recordings must be anonymised before use.

3.11 Emergencies

In an emergency, staff should seek consent from a conscious patient who has capacity whenever time allows. If treatment is immediately needed to save life and consent cannot be obtained, staff must record why treatment was necessary and explain this to the patient after recovery.

A valid and applicable advance decision to refuse treatment must be respected. See the Trust's advance statements and advance decisions to refuse treatment policy.

3.12 Resuscitation status

A person in cardiac arrest cannot give consent. Staff must begin cardiopulmonary resuscitation (CPR) immediately unless there is a valid and applicable advance decision or current form recording a decision not to attempt CPR, such as a DNACPR or ReSPECT form.

Staff must record the treatment in the electronic health record and complete the cardiac arrest report form.

3.13 Consent forms

Use the correct form when written consent is required: form 1 for a patient aged 16 or over with capacity, or a Gillick-competent child; form 2 for consent from a person with parental responsibility for a child under 16; form 3 for informed refusal; and form 4 for a patient aged 16 or over who lacks capacity.

Forms are available in the electronic patient record system or SystmOne. Completed forms must be uploaded or scanned into the patient's electronic record.

3.14 The Mental Health Act consent forms

Mental Health Act consent forms differ from the standard Department of Health forms and are available from local Mental Health Act offices. Send every completed form to the Mental Health Act office and keep a copy in the patient's electronic clinical record.

3.15 Consent and the Mental Health Act (1983)

The Trust must follow the Mental Health Act rules for consent to treatment. These requirements are monitored by the Care Quality Commission. Staff involved in treatment under Part 4 must understand the Mental Health Act Code of Practice and the reference guide to the Mental Health Act.

The responsible clinician must make sure that the Mental Health Act consent-to-treatment requirements are followed.

3.15.1 The Mental Health Act (1983) three, month rule

Part 4 consent-to-treatment rules apply to patients detained under the Mental Health Act, except those detained under sections 4, 5(2), 5(4), 35, 135 or 136, and section 42 conditionally discharged patients. For medication for mental disorder, section 63 authorises treatment during the first three months. Staff should still seek the patient's consent before each dose wherever possible. After three months, section 58 safeguards apply.

3.16 Mental Health Act, consent to treatment forms

A patient detained under the Mental Health Act may receive treatment for mental disorder for up to three months without consent. After that period, medication may only continue with the patient's valid consent or certification by a second opinion appointed doctor (SOAD).

The responsible clinician records valid consent on form T2 or CTO12. If the patient does not consent or lacks capacity, a SOAD certificate on form T3 or CTO11 is required.

3.17 Capacity and the Mental Health Act (1983)

Capacity must be reassessed when appropriate. Each assessment linked to a form T2 under section 58 must be clearly recorded.

3.18 Treatment and the Mental Health Act (1983)

Part 4 applies to medical treatment for mental disorder. Sections 57, 58 and 58A contain additional safeguards for particular treatments.

3.18.1 Section 57, treatment requiring consent and a second opinion

Section 57 applies to detained and informal patients. Psychosurgery and any other treatment covered by this section require the patient's express consent and an independent second opinion from a doctor appointed by the Care Quality Commission. Staff must contact the Mental Health Act office for advice before using this section.

3.18.2 Section 58, treatment requiring consent or a second opinion

Section 58 applies to patients liable to be detained, subject to the exceptions set out in the Act. It covers medication for mental disorder after three months of continuous treatment. The responsible clinician must personally seek consent, and the patient must have capacity to make the decision. If valid consent is not given, the required second-opinion process must be followed.

3.18.3 Section 58A, electro-convulsive therapy

Section 58A covers electro-convulsive therapy (ECT) and any related treatment specified in regulations. It applies to patients covered by the Act, subject to its stated exceptions and safeguards.

A detained patient aged 18 or over may receive section 58A treatment if they have capacity, an approved clinician or SOAD certifies this, and they consent; or if they lack capacity, the treatment is appropriate, no valid Mental Capacity Act refusal applies, and a SOAD certifies it. A patient under 18 needs the safeguards set out in section 58A, including SOAD certification. Staff must follow the Mental Health Act Code of Practice and the urgent-treatment provisions in sections 62 and 63 where relevant.

3.18.4 Consent form for electro-convulsive treatment (ECT)

The ECT consent form is part of the ECT care record, which contains the information needed for treatment and consent. Staff must follow the Trust's electro-convulsive therapy (ECT) clinical guidelines policy and use the care record available through that policy. The anaesthetist must separately obtain valid consent for anaesthesia after explaining its benefits and risks.

3.18.5 Part 4A, apply to community treatment order patients not recalled to hospital

Treatment for mental disorder must not be given to a community treatment order patient who has not been recalled unless Part 4A is followed. There must be legal authority, such as consent or a Mental Capacity Act provision, and a SOAD certificate where section 58 or 58A treatment is involved.

3.18.6 Section 63, treatments not requiring consent

Section 63 allows medical treatment for mental disorder that is given by, or under the direction of, the responsible clinician and is not covered by sections 57, 58 or 58A. This may include nursing, care, habilitation and rehabilitation. Staff should still seek the patient's consent wherever possible.

3.18.7 Section 62, urgent treatment

Section 62 allows urgent treatment despite the usual sections 57 and 58 safeguards when treatment is immediately necessary to save life; prevent serious deterioration where treatment is not irreversible; relieve serious suffering where treatment is not irreversible or hazardous; or provide the minimum treatment needed to prevent violence or danger to the patient or others where treatment is not irreversible or hazardous.

3.20 Mental Capacity Act, guidance assessment of capacity to consent to medication

Appendix H explains how to assess and record capacity to consent to medication under the Mental Capacity Act.

4. Responsibilities

4.1 Health and social care colleagues (support colleagues)

Health and social care colleagues must follow this policy, seek consent before providing care or treatment and tell their manager about any concerns. They must treat consent as an essential part of respectful, person-centred care.

4.2 Healthcare professionals

Healthcare professionals must seek consent before providing care or treatment. They must give the patient clear, relevant information so that the patient can make an informed decision. They must also follow any professional guidance that applies to their role.

Healthcare professionals must understand:

- when verbal or written consent is needed and how to record it in their service
- what information a patient needs to make an informed decision, including how to support people with communication or accessibility needs
- how to recognise when a patient may not be able to give valid consent
- what to do in a life-threatening emergency when consent cannot be obtained
- how to respect a patient's decision, including when they disagree with it, and how to respond when the decision creates concerns about care, welfare or safety
- how the law and Trust guidance relevant to their role apply in their service

5. Training

The Trust does not provide separate face-to-face training only on consent. Consent is covered in the following training:

- induction programme for medical colleagues
- training for section 12(2) approved medical practitioners
- Mental Capacity Act training (e-learning and face to face)
- Mental Health Act training

Care group management teams must assess the consent training needs of their staff. The training and competency requirements must reflect each person's role and responsibilities.

5.1 E-learning consent by colleagues whose mangers have identified that this is required

- Frequency: as identified by the service manager.
- Length: 60 minutes.
- Delivery method: e-learning module.
- Provided by: the Learning and Development team or through the Electronic Staff Record (ESR).
- Training record: held in ESR.

All colleagues must know the key requirements of this policy. Services may share these requirements through:

- continuous professional development sessions
- practice development days
- intranet
- team meetings
- local induction

6. Monitoring Arrangements

6.1 That for detained patients the consent to treatment requirements of the Mental Health Act 1983 is adhered to

- How and who by: audit of the T2, T3 and section 62 forms by service managers or modern matrons.
- Reported to: mental health legislation operational group
  It should first be reported to the local mental health legislation monitoring group and then fed into the MHL-OG, which then provides assurance reports into Mental Health Legislation Committee (MHLC).
- Frequency: each completed T2, T3 is audited on completion. A quarterly summary report is then submitted.

6.2 The number of reported incidents on the electronic incident report system (IR1) where any issues around consent have been identified

- How and who by: on a case-by-case basis as the report is submitted by service managers or modern matrons also be identified within the trust annual summary report.
- Reported to: Quality Assurance Group.
- Frequency: annually.

6.3 The number of formal complaints received in which any issues relating to consent have been raised

- How and who by: report by complaints manager.
- Reported to: Quality Assurance group.
- Frequency: annually.

6.4 The number of serious incidents (Sis) in which any issues in relation to consent have been identified

- How and who by: review of the resulting SI action plan by the relevant care group director.
- Reported to: Quality Assurance Group.
- Frequency: at the times as identified within the action plan.

16.5 That there is a record of each patient's consent status within their clinical record (within specific audits where consent is specific to the area being audited)

- How and who by: Support care groups with their identified audits by Clinical audit department.
- Reported to: Quality assurance group.
- Frequency: Variable.

7. Related documents and associated references

- Mental Capacity Act (MCA) 2005 policy
- Advance statements and advance decisions to refuse treatment policy
- Resuscitation manual, do not attempt cardiopulmonary resuscitation (DNACPR) policy (adults)
- Resuscitation manual
- Research governance policy
- Electro-convulsive therapy (ECT) clinical guidelines policy
- When a second opinion appointed doctor attends policy
- Community treatment order policy
- Accessible Information Standards 2015.
- Care Quality Commission (CQC) Regulation 11 (2016).
- Department for Constitutional Affairs (2006) A Guide to the Human Rights Act 1998.
- Department of Health Guidance: Seeking Consent Working with Children.
- Department of Health Reference Guide to Consent for Examination or Treatment second addition (2009).
- Department of Health Good Practice in consent implementation guide (2009).
- Equality Act 2010.
- Family Law Reform Act 1969.
- General Medical Council Good Medical Practice (2013).
- General Medical Council 0-18 Guidance for all doctors (2007).
- Human Rights Act 1998, as amended 2005.
- Mental Health Act 1983.
- Mental Health Act Code of Practice.
- Mental Capacity Act 2005.
- Royal College of Surgeons Consent: Supported Decision, Making a Guide to Good Practice (2016).
- The Children Acts 1989 (6) and 2004.
- The Care Act 2014.
- The Health and Social Care Act 2008 (Regulated Activities) (amended) Regulations 2015.

8. Appendices

8.1 Appendix A guidance, obtaining valid consent patients aged 16 years and over

8.1.1 Valid consent

For consent to be valid it must be voluntary and informed, and the patient consenting must have the capacity to make the decision.

If a patient has the capacity to make a voluntary and informed decision to consent to or refuses a particular treatment, their decision must be respected.

The validity of consent does not depend on 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.

8.1.2 Provision of information

8.1.2.1 Has the patient been sufficiently informed?

To give valid consent, the patient needs to understand the nature and purpose of the intervention or treatment, the seriousness of their condition and the anticipated benefits and risks of the proposed intervention or treatment and any reasonable alternatives, including the option to have no treatment so they are in a position to make an informed decision. The provision of relevant information is therefore central to the process. Colleagues should ensure that discussions about consent are in a way that meets the patient's communication needs. The information must be comprehensible but must be given in a format that will help them understand the specific decision to be made in line with Mental Capacity Act principle 2 and accessible information standards.

When seeking consent, the health professional should check whether the patient has understood the information they have been given, and whether they would like more information and be given sufficient time to use and weigh up the information before making a decision.

Details of any supplementary information provided to the patient such as information leaflets must also be documented on the consent form. Where information leaflets are used from external sources the practitioner must ensure that the leaflets reflect best practice, and the information leaflet version is clearly documented.

8.1.2.2 Duty to inform

Patients will vary in how much information they want; some will want as much detail as possible; others may not ask for any information. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options as clarified in the decision of the Supreme Court on 11 March 2015 in the case of Montgomery versus Lanarkshire Health Board.

8.1.2.3 Material risk

The Montgomery ruling means that

- the doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risk involved in any recommended treatment and of any reasonable alternative or variant treatment, even if the risk is rare
- the test of materiality is whether, in the circumstances a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it
- the assessment of whether a risk is material cannot be reduced to percentages. Factors include the nature of the risk, the effect its occurrence would have on the life of the patient, the importance to the patient of the benefits from the treatment, the alternatives available and their risks. The assessment is fact-sensitive and specific to the characteristics of the patient

The general medical council (GMC) guidance "Consent: patients and doctors making decisions together" provides more guidance about the risks (including risk of mortality), benefits and alternatives of any proposed investigation or treatment, presented in a balanced way the patient can understand to help them make informed decisions.

8.1.2.4 The therapeutic exception

The traditional concept of the therapeutic exception (sometimes referred to as therapeutic privilege) describes the situation in which a doctor may claim exemption from the duty to provide certain information to a patient if the doctor deems that this might cause the patient psychological harm to a degree which outweighs the benefits of informing them.

The Montgomery ruling made clear that the therapeutic exception should only be used in rare cases. If it is used the reasons should be documented in the persons' case notes.

Although the ruling refers to consent obtained by doctors, the same ruling applies to all health professionals when seeking consent.

8.1.3 Capacity to consent, patients aged 16 years and over

When undertaking a discussion about providing care and, or treatment with a patient aged 16 years and over, colleagues must work on the presumption that they have the capacity to decide what, if any, care and treatment they want to receive (Mental Capacity Act principle 1).

If a patient is struggling with being able to understand the information, the patient should be given appropriate help and support to maximise their ability to enable them to make the decision themselves (Mental Capacity Act principle 2).

8.1.4 Capacity to consent, young people aged 16 to 17 years

Young persons aged 16 or 17 are presumed to have capacity to consent to or refuse care and, or treatment in their own right. Consent will be valid only if it is given voluntarily by an appropriately informed young person with capacity to consent to the particular intervention.

If the 16-to-17-year-old has capacity to give valid consent, it is not legally necessary to obtain consent from a person with parental responsibility. However, it is good practice to involve the young persons' family in the decision-making if the young person agrees.

Parents cannot override consent or refusal from a competent 16- or 17-year-old.

8.1.4.1 Lack of capacity, patients aged 16 years and over

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

Patients may be able to consent to some interventions but not others or may have capacity at some times but not others.

A person'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 person does not have the capacity to consent.

Capacity should not be confused with a healthcare professional's assessment of the reasonableness of the person's decision. A patient should not be treated as unable to make a decision merely because they make an unwise decision (Mental Capacity Act principle 3).

A person lacks capacity if both:

- they have 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
- that impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made

An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. A person is unable to make a specific decision if they cannot do one or more of the following things:

- understand the information given to them that is relevant to the decision
- retain that information long enough to be able to make the decision
- use or weigh up the information as part of the decision-making process
- communicate their decision, this could be by talking or using sign language or other methods of communication

8.1.4.2 Establishing capacity

Where there is no doubt about the patient's ability to give informed consent there is no requirement to carry out an assessment of capacity.

If there is doubt about the patient's ability to give valid consent, the health professional must assess the capacity of the patient to take the decision in question. The evidence of the assessment and the conclusions drawn from it should be recorded on the trust MCA1 form and in the patient's notes. This should include reference to the information given to the patient which is relevant to the decision.

8.1.5 Is the consent given voluntary?

Once it has been determined that a patient has the capacity to make a particular decision at a particular time, a further requirement for consent to be valid is that it must be given voluntary and freely, without pressure or undue influence being exerted on the patient to either accept or refuse treatment. Such pressure can come from partners or family members, as well as health or care practitioners. Patients must not be coerced into consenting, as this would invalidate consent.

Although patients will value in many cases the support of a friend or family member for comfort and help through their decision-making process, it is important to ensure

that any decisions represent the patient's own views and is not unduly influenced by the wishes of another person.

8.2 Appendix B guidance, obtaining valid consent to patients under 16 years

8.2.1 The concept of Gillick competence

Children under the age of 16 years are not automatically presumed to be legally capable of making their own decisions about their healthcare as the Mental Capacity Act does not apply. However, under 16's may be capable of giving valid consent to a particular treatment or intervention if they have sufficient understanding and intelligence to enable him or her to understand fully what is proposed. This is sometimes known as being Gillick competent. There is no specific age at which a child under 16 becomes capable of consenting to a particular treatment. It depends on the child and the seriousness and complexity of the treatment proposed. The routine assessment of competence in under 16's should be appropriate to the child's age.

8.2.2 Gillick competence

Victoria Gillick challenged the Department of Health guidance which enabled doctors to provide contraceptive advice and treatment to girls under 16 without their parents knowing. In 1983 the judgement from this case laid out criteria for establishing whether a child under 16 has the capacity to provide consent to treatment; the so-called Gillick test. It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options.

Healthcare professional should not judge the ability of a particular child or young person solely on the basis of his or her age. For a young person under the age of 16 to be Gillick competent, she or he should have:

- the ability to understand that there is a choice and that choices have consequences
- the ability to weigh the information and arrive at a decision
- a willingness to make a choice (including the choice that someone else should make the decision)
- an understanding of the nature and purpose of the proposed intervention
- an understanding of the proposed intervention's risks and side effects
- an understanding of the alternatives to the proposed intervention, and the risks attached to them
- freedom from undue pressure

It is important to give children under 16 appropriate information depending on their age and communication skills. This could include easy read or child friendly leaflets.

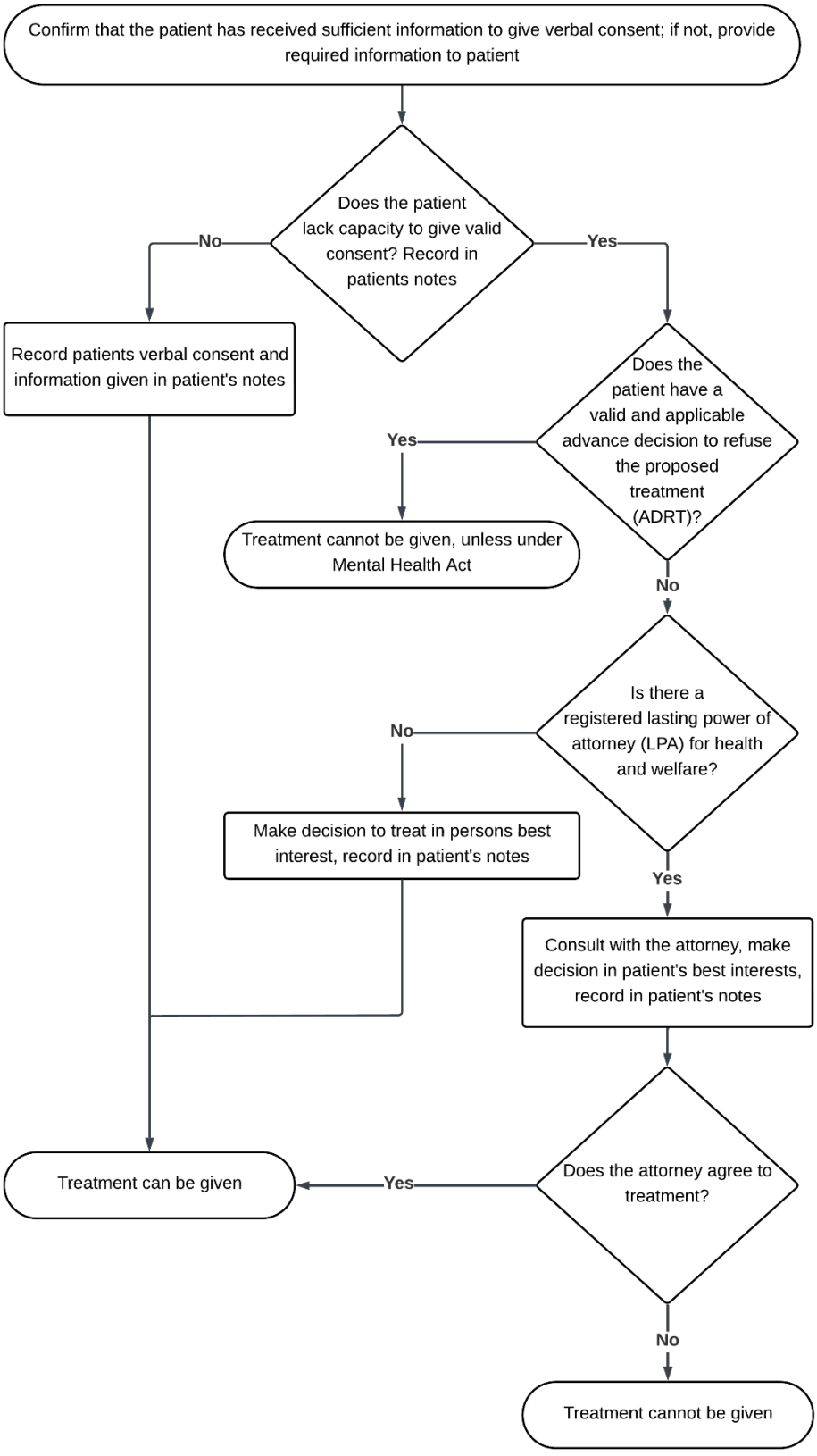
8.2.3 Information sharing

Parents generally need to be provided with information about their child's problems and treatment in order to adequately support and care for them. Check the clinical records to see whether there is evidence of a discussion with the child, and where

appropriate their parent(s), about information sharing and confidentiality and the limits of confidentiality. The extent and nature of the discussion will vary according to the age of the child and the nature of treatment as some treatments, for example family therapy, directly involve the parents, whereas others such as medication or individual counselling involve the child. Where information is shared with parents about the problems or treatment of a competent child, the child's consent to share the information should be obtained and evidence recorded in the notes. The consent should be absolutely clear and should cover the specific detail of what will be shared, the reason the information is being shared, as well as any special aspects of the processing that may affect the individual. It should also be freely given, for example without undue influence from the parents.

Where a competent child refuses to allow information to be shared with their parents, there should be evidence that the risks of not sharing the information have been considered. Where it is thought to be in the child's best interests to share information, there should be evidence of attempts to seek a compromise. It is sometimes possible to provide parents with general information about the treatment or condition as a compromise, rather than the specific details of the child's case. Where it is the clinician's opinion that it is necessary to share information in the best interests of the competent child, against their wishes, the Caldicott guardian should be consulted.

8.3 Appendix C consent flow chart 1, routine care and treatment



1. Confirm that the patient has received sufficient information to give verbal consent. If not, provide required information to patient.
2. Does the patient lack capacity to give valid consent? Record in patients notes.

- No, record patients verbal consent and information given in patient's notes, **treatment can be given**.

3. Does the patient have a valid and applicable advance decision to refuse the proposed treatment (ADRT)?

- Yes, **treatment cannot be given, unless under Mental Health Act**.

4. Is there a registered lasting power of attorney (LPA) for health and welfare?

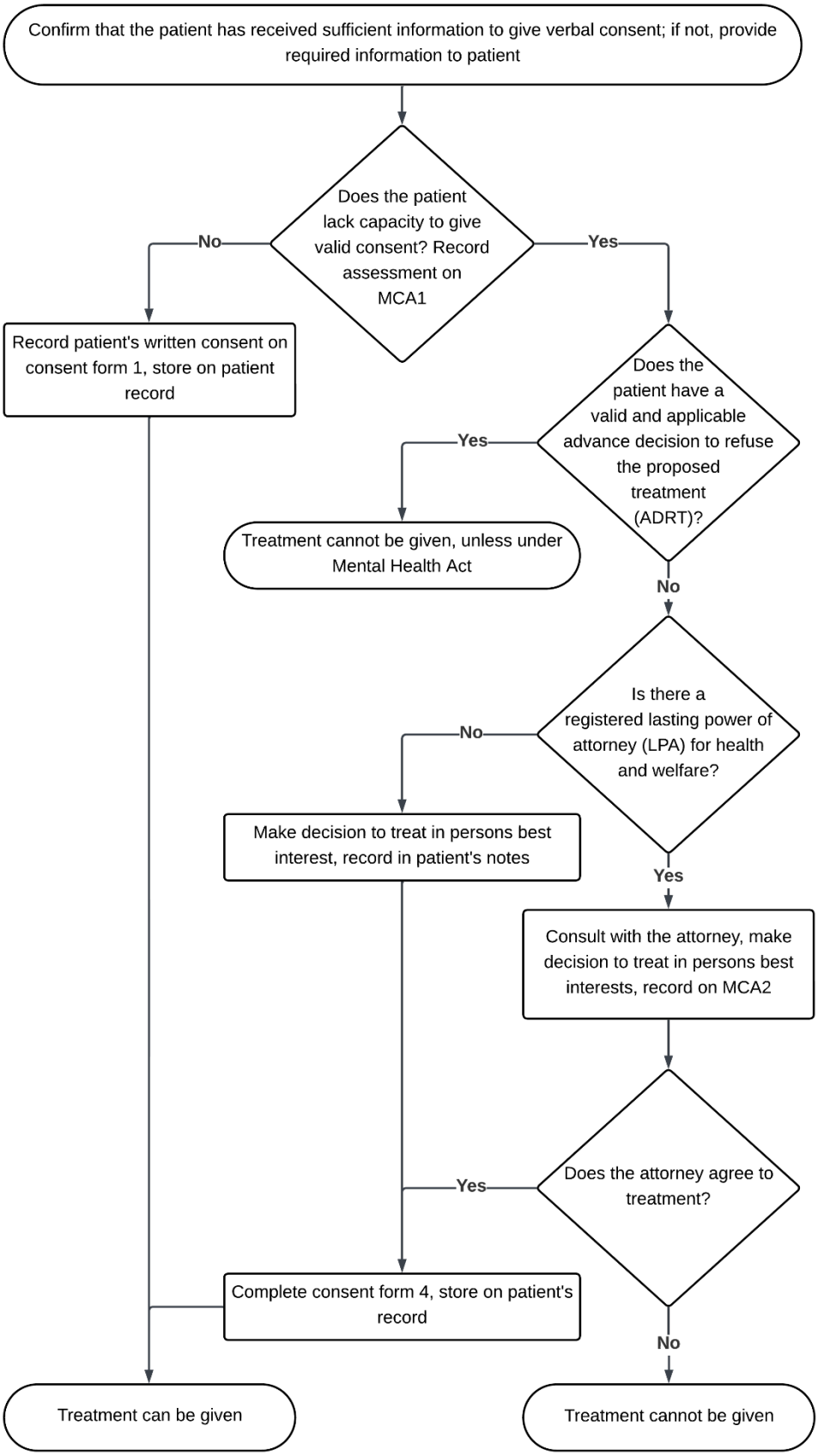
- No, make decision to treat in persons best interest. Record in patient's notes, **treatment can be given**.

5. Consult with the attorney, make decision in patient's best interests. Record in patient's notes.

- Attorney agrees to treatment, **treatment can be given**.

6. Attorney does not agree to treatment, **treatment cannot be given**.

8.4 Appendix D consent flow chart 2, treatment that presents high risk or significant harm



1. Start, confirm that the patient has received sufficient information to make an informed decision. If not, provide required information to patient.
2. Does the patient lack capacity to give valid consent? Record assessment on MCA1.
    - No, Record patient's written consent on consent form 1. Store on patient record, **treatment can be given**.
3. Does the patient have a valid and applicable advance decision to refuse the proposed treatment (ADRT)?
    - Yes, **treatment cannot be given, unless under Mental Health Act**.
4. Is there a registered lasting power of attorney (LPA) for health and welfare?
    - No, make decision to treat in persons best interests. Record on MCA2. Complete consent form 4, store on patient's record. **Treatment can be given**.
5. Consult with the attorney, make decision in patient's best interests. Record on MCA2.
6. Attorney does not agree. **Treatment cannot be given**.

8.5 Appendix E consent forms

To download the trust consent forms click on the relevant link for the form you require:

- Refer to appendix G1: consent form 1 patients aged 16 and over with capacity to consent to care and or treatment or children under 16 with Gillick competence to consent (staff access only).
- Refer to appendix G2: consent form 2 parent (or person who has parental responsibility) agreement to care and or treatment for a child or young person (under 16 years of age) (staff access only).
- Refer to appendix G3: consent form 3 informed refusal (staff access only).
- Refer to appendix G4: consent form 4 patients aged over 16 who lack the capacity to consent to care and or treatment (staff access only).

8.6 Appendix F Guidance, assessment of capacity to consent to medication (approved by Dr G. Tosh. Medical Director 15 June 2023)

8.6.1 Introduction

It is a general, legal and ethical principle that valid consent must be obtained before providing care and, or treatment (including examination) to a patient. This principle reflects the right of patients to determine what happens to their own bodies and is a fundamental part of good practice.

Care and, or treatment can only be provided to someone with their informed valid consent or with specific legal authority (which may be provided through the Mental Health Act (MHA) 1983, Mental Capacity Act (MCA) 2005, Children Act, Common Law etc.).

The Care Quality Commission (CQC) include consent as part of their ongoing monitoring process as part of the "fundamental standards". Regulation 11 sections 11(1) to 11(5).

As a provider the trust must make sure that consent is obtained lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and, or treatment that they are asking consent for.

Consultation with colleagues indicates that there is a lack of understanding of how an assessment of capacity should be approached in relation to consent to medication given that a patient could be on several medications for both their mental health and physical health conditions. Also, because a person’s capacity can fluctuate, and their medication regime can change this makes it difficult for staff to understand when to reassess capacity to consent.

The trust consent to care and treatment policy gives guidance for colleagues around consent to specific treatments which should be referred to, but it was felt that more guidance was needed around recording assessment of capacity to consent to the person’s medication regime.

8.6.2 Guidance for inpatient colleagues

Medication prescribed prior to inpatient admission. For those patients who are not detained under the Mental Health Act 1983 and who are admitted onto a ward with a number of medications prescribed prior to admission either for physical conditions, or for treatment of their mental health, the prescribing clinician (in the community) should have obtained the patient's consent at the time when the medication was initially prescribed.

Where the patient has capacity and is consenting to take the medications it would be sufficient to record the details of the medications previously prescribed on the and make a general statement in the patient's electronic patient record to confirm that the patient is able to give consent to continue taking the medication. Where the patient is unable to consent, consideration should be given whether the medication will continue to be given in their best interest and a general statement in the patient's electronic patient record to indicate this should be made. For example, existing medication might not be in their best interests to continue if there is a contra-indication with new medication being considered as part of their treatment whilst on the ward.

Where the patient is refusing to take the medication and there are doubts about the patient's capacity to make decisions about their medication, then consideration of an assessment of capacity would be needed, and the outcome recorded on MCA1. The assessment of capacity would need to ensure that information relevant to the type of medications is given to the patient and they are able to understand and retain the information to be able to use and weigh up and communicate their decision. They must also understand the consequences of refusal.

If the person lacks capacity to consent to the medication and is refusing, then a best interest's decision would need to be made, taking into account any advanced statements and advanced decisions to refuse treatment, the views of the person and the views of any interested parties whether the patient should continue to be given the medication. This should be recorded on MCA2. If the person has a valid lasting power of attorney for health and welfare, then consent should be sort from the persons with the necessary power to make the decision on the person behalf.

8.6.3 Medication prescribed during Inpatient admission, low risk

For any new medication being prescribed by health professionals for minor ailments, such as constipation, coughs and colds, influenza, dyspepsia, gastroesophageal reflux, irritations to the skin, allergic reactions or mild to moderate pain relief etc, it will not usually be necessary to gain separate formal consent to each medication which is considered low risk to the patient. Such as:

- Aspirin
- Paracetamol or Ibuprofen or Codeine
- antibiotics
- Cetirizine
- Senna
- Drapolene
- Laxatives
- simple linctus
- Peptac or Maalox Suspension

- Bonjela

In many cases, it will be appropriate for a health professional to provide the medication immediately after discussing it with the patient. If the patient is willing for the medication to be given, they will give their consent and medication can be given immediately. It should be noted in the patient's electronic patient record that the patient is able to give consent as part of their care plan.

Where there is any doubt about a patient's capacity to give valid consent, to a range of low risk medications for physical conditions they can be grouped together and recorded as one assessment of capacity if they are being prescribed at the same time, providing there is evidence that attempts have been made to make the patient aware of why they are needed and the type and range of dosage likely to be used is recorded on the MCA1.

8.6.4 Medication prescribed during Inpatient admission, high risk

For those medications that present a high risk to the patient colleagues should seek separate assessment of capacity to consent. This includes medication which needs close monitoring or has significant side effects such as:

- antidepressants
- antipsychotics (oral and any intramuscular (IM)) such Olanzapine or as Clozapine which has a strict monitoring regime involving the requirement for regular blood tests to be taken
- Lithium which requires monitoring on blood levels, checks for thyroid and renal functioning, Serum calcium levels and blood pressure
- Morphine
- Warfarin
- Thyroxine
- Methadone
- controlled drugs, such as Temazepam, Tramadol, Midazolam, Strong Potassium Chloride Solution BP 15% and Barbiturates
- intra-muscular vitamin supplements

Where there is any doubt about a patient's capacity to give consent, capacity must be established before the patient is asked to give consent. Details of the assessment of capacity and conclusions reached must be recorded on MCA1. There is no requirement to record multiple MCA1's to cover, for example, clozapine, lithium, valproate etc, one MCA1 could capture the specific decisions being assessed (consent to mental health drugs clozapine, lithium, valproate etc), but should provide details of the medications being offered.

The assessment of capacity should provide evidence whether the patient is able to understand the nature and purpose of the medication; the seriousness of their condition; the anticipated benefits and risks of the medication or consequences of refusal; and be able to retain, use and weigh up the information and communicate their decision.

If the person lacks capacity to consent to the medication and the medication cannot be provided under the provisions of the Mental Health Act, a best interest's decision

would need to be made, taking into account any advanced statements and advanced decisions to refuse treatment, the views of the person and the views of any interested parties whether the patient should continue to be given the medication. This should be recorded on MCA2. If the person has a valid lasting power of attorney for health and welfare, then consent should be sort from the persons with the necessary power to make the decision on the person behalf.

8.6.5 Hospice, hospice at home

If a patient has a condition that will impair their capacity as it progresses or is otherwise facing a situation in which loss or impairment of capacity is a foreseeable possibility, the healthcare professionals responsible for their care and treatment should encourage them to think about and to discuss their wishes and concerns with the healthcare team as soon as possible whilst they have the capacity to do so. Where possible colleagues should seek to develop an advance statement with the patient concerning their medication and treatment pathway that they are likely to receive whilst in the Hospice or receiving Hospice at home services. The patient must clearly articulate the particular care and, or treatments to which they are consenting to.

If the patient does not want to receive a particular treatment, they should be encouraged to write an advanced decision to refuse treatment (ADRT) which can be used at the time should they lack capacity.

If no advance statement or advanced decision to refuse treatment has been obtained, then colleagues should follow the principles of the Mental Capacity Act (2005) as above.