Dorset County Hospital
NHS Foundation Trust

POLICY FOR CONSENT TO EXAMINATION OR TREATMENT

Policy Title	Policy for Consent to Examination or Treatment		
Policy Number	**0127**	**Policy Version Number**	**14**
Applicable to	All healthcare professionals and those working alongside health professionals.		
Aim of the Policy	To ensure that the Trust meets all its obligations under legislation and guidance.		
Next Review Due Date	**1 March 2026**		
Author/ Reviewer	Alastair Hutchison, Chief Medical Officer		
Policy Sponsor	Nick Johnson, Interim Chief Executive		
Expert Group	Clinical Practice Group		
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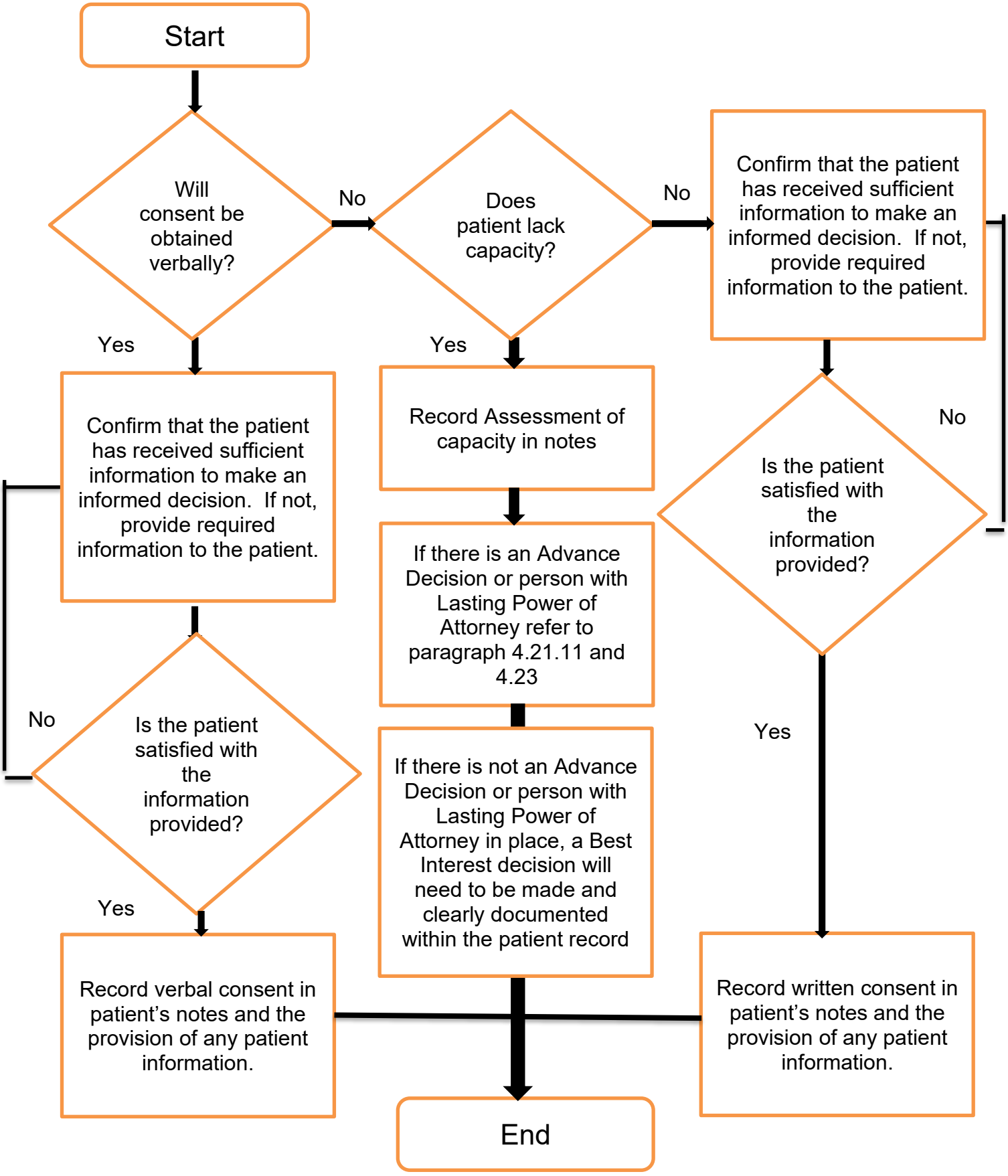
Index

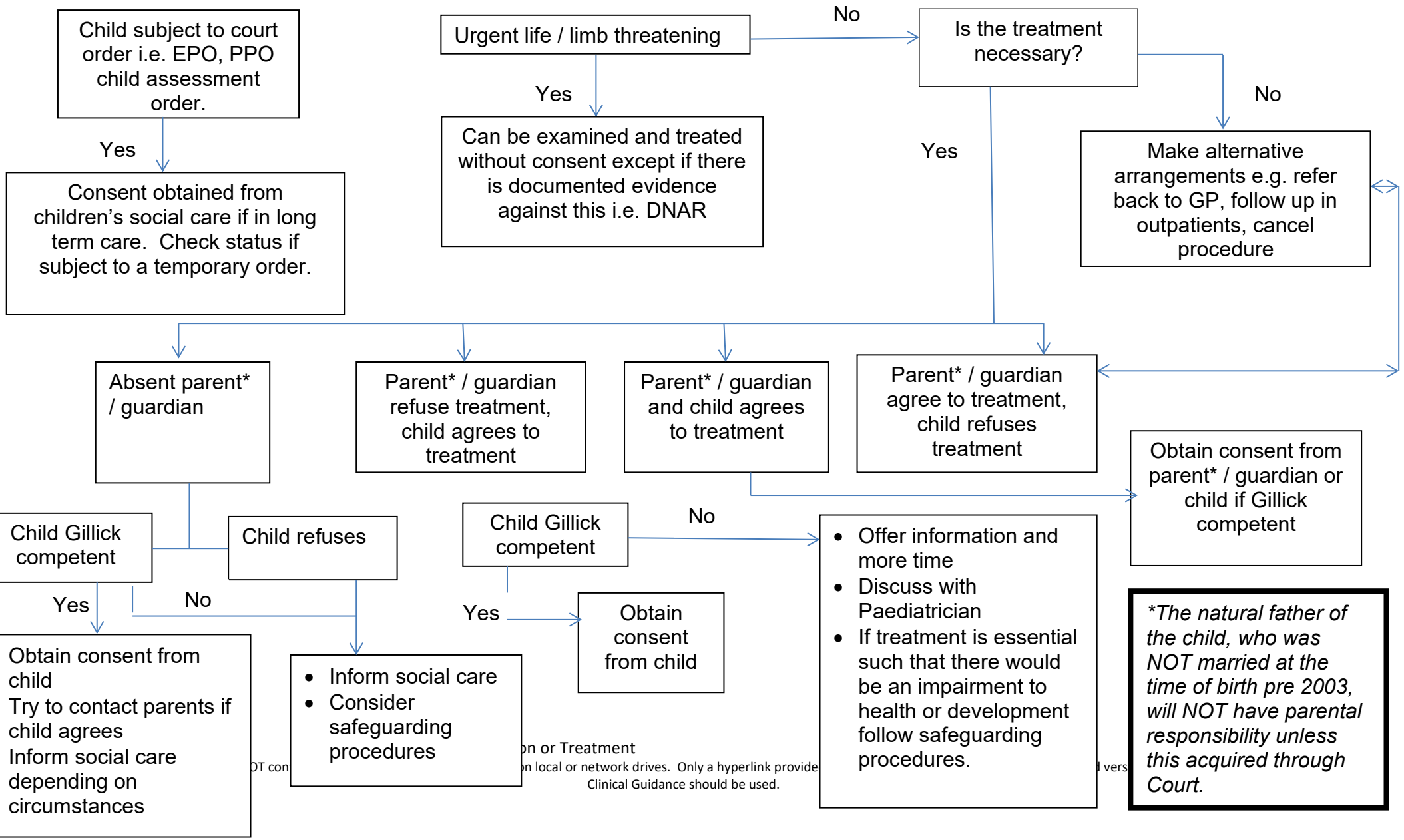
Quick Reference Guide Appendix C
Consent Flow Chart

NB: If you will not be carrying out the procedure and have not been trained to obtain consent for this procedure then you must not obtain consent.



Consent Flow Chart for Children under 16 years of age.

Quick Reference Guide Appendix D



Executive Summary

Policy title	Consent to Examination or Treatment
Purpose	This policy sets out the standards and procedures in the Trust that aims to ensure that health professionals are able to comply with the guidance issued by the Department of Health. Patients have a fundamental legal and ethical right to determine what happens to them. Valid consent to treatment is absolutely central in all forms of healthcare, from providing personal care and support to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients and their families.
Applicable to	All healthcare professionals and those working alongside health professionals.
Aim of policy	To ensure that the Trust meets all its obligations under the following guidance and Legislation:- • Human Rights Act 1998 • Department of Health Reference Guide to Consent for Examination or Treatment • Human Tissue Act 2004 (and associated Code of Practice, July 2006) • Mental Health Act 1983 and 2007 (and associated Code of Practice, 2008) • Mental Capacity Act 2005 (and associated Code of Practice, 2007) • Children's Act 1989 • Chaperone Policy (Trust policy 1504) • NHSLA Standards • Care Quality Commission's Schedule of Applicable Publications
Main features	Describes circumstances in which consent to examination, treatment and care should be sought and the framework for obtaining valid consent within DCH.
Policy lead	Alastair Hutchison, Medical Director
Development group	Safeguarding adults and children Divisional Governance Patient Safety Group.

1. Introduction

1.1 It is a general legal and ethical principle that it is crucial to obtain valid, informed consent before starting treatment, undertaking a physical investigation, or providing personal care, for a person. This principle reflects the right of individuals to determine what happens to them and is a fundamental part of good practice. A health professional (or other health or social care staff) who do not respect this principle may be liable both to legal action by the patient and to action by their professional body. The Trust is also likely to be liable for the actions of its staff.

1.2 Valid consent to treatment is therefore absolutely central in all forms of health and social care, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients.

1.3 The Department of Health has issued a range of guidance documents on consent, and these should be consulted for details of the law and good practice requirements on consent. There are a range of consent forms for clinical and non-clinical procedures, including the taking photographs or filming of patients, available on the Trust Intranet site under clinical guidelines.

2. Aim and objectives of the policy

2.1 This policy sets out the standards and procedures in this Trust which aim to ensure that health professionals are able to comply with the guidance. Whilst this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

2.2 In addition this document provides guidance to ensure individuals and their human rights are respected and upheld.

3. Who the policy is for

3.1 The policy applies to all staff directly and indirectly employed staff within Trust and other persons working within the organisation.

3.2 It sets out the standards and procedures that have been put in place to ensure that health and social care professionals are aware of their obligations and are able to comply with statutory and professional guidance.

3.3 The policy does not cover the consent process for subsequent use of removed tissue, organ donation or participation in research and/or innovative treatment.

3.4 Exceptions

3.4.1 Certain statutes set out specific exceptions to the principles noted in the following Sections. These are briefly noted below. Those concerned with the operation of such statutes should consult more detailed guidance.

3.4.2 Part 4 of the Mental Health Act 1983 (‘the 1983 Act’) sets out circumstances in which persons liable to be detained under the 1983 Act may be treated without consent for their mental disorder. The Mental Health Act Code of Practice offers guidance on consent and medical treatment in this context.

3.4.3 The Public Health (Control of Disease) Act 1984 (‘the 1984 Act’) provided that, on an order made by a magistrate, persons suffering from certain notifiable infectious diseases could be medically examined, removed to and detained in a hospital without their consent. A magistrate when ordering the detention of a person in a

hospital could not order that a person undergo medical treatment. The treatment of such persons must be based on the common law principles previously described. The 1984 Act is now amended by the Health and Social Care Act 2008. Under part 2A there is express provision prohibiting regulations under new sections 45B or 45C from legislating for the administering of medical treatment by force. Nor will there be power for a magistrate to order compulsory treatment under new section 45G, which gives powers to magistrates to make orders in relation to persons who pose a threat to the health of others.

4. Definitions, Legislation and Guidelines

4.1 What is consent and what isn't consent.

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

For the consent to be valid, that patient must:

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

4.2 For consent to be valid, it must be given voluntarily by:

- an appropriately informed person who has the capacity to consent to the intervention in question. This will be the patient or someone with parental responsibility for a patient under the age of 18 (see Section 4 for guidance on assessment of capacity and for guidance in seeking consent in young people and children),
- someone authorised to do so under a Health and Welfare Lasting Power of Attorney (LPA) Appendix 1 or
- someone who has the authority to make treatment decisions as a Health and welfare court appointed deputy.

4.3 Acquiescence, where the person does not know what the intervention entails, is not 'consent'.

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

4.5 Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no-one else can give consent on their behalf, unless there is a legal document (Lasting Power of Attorney) in place giving someone authority to make decisions about the patient's healthcare. A full copy must be seen by the Practitioner/ Clinician and a full copy retained in the patients notes However, treatment may be given if it is in the patient's best interest, as long as it has not been refused in advance in a valid and applicable advance decision. Where

the person's capacity to consent is in doubt, It is important that a capacity assessment is completed and recorded in the patients notes. A best interest decision must then be made in line with the Mental Capacity Act 2005.

4.6 For further information on advance decisions see the Department of Health's '*Reference guide to consent for examination or treatment* (Chapter 1, paragraph 19), Advance Decisions To Refuse Treatment Policy and Section 4 within this document.

4.7 Legislation and Guidelines

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

- *Reference guide to consent for examination or treatment* provides a comprehensive summary of the current law on consent and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. These can be accessed on the internet at http://www.dh.gov.uk/en/index.htm
- *12 key points on consent: the law in England* has been distributed widely to health professionals working in England. This one page document summarises those aspects of the law on consent which arise on a daily basis and is attached as Appendix B. Further copies are available from http://www.dh.gov.uk/en/index.htm
- The Mental Capacity Act 2005
- Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people that have learning disabilities and with older people on the internet at http://www.dh.gov.uk/en/index.htm
- The GMC also issued guidance entitled "Decision Making and Consent" addressed to doctors in 2020, but useful for other staff to read as well.

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

4.8 Type of consent

- Verbal and non verbal/ implied
- Voluntary
- Informed
- Written

4.8.1 Verbal and non-verbal/ implied consent

Consent may be expressed verbally or non-verbally: an example of non-verbal consent would be where a person, after receiving appropriate information, holds out an arm for their blood pressure to be taken. However, the person must have understood what examination or treatment is intended and why, for such consent to be valid.

4.8.2 Voluntary consent

For consent to be voluntary it must be given freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment. Such

pressure can come from partners or family members, as well as health or social care healthcare professionals. Healthcare professionals should be alert to this possibility and where appropriate should arrange to see the person on their own in order to establish that the decision is truly their own.

4.8.3 Informed consent

To give valid consent, the person needs to understand the nature and purpose of the procedure. It is important that the Practitioner seeking consent is mindful of the person's health literacy and level of understanding. They should do all they reasonable can to support the person's understanding. Any misrepresentation of these elements will invalidate consent. The individual should be informed of any 'material' or 'significant' risks or unavoidable risks, even if small, in the proposed treatment; any alternatives to it; and the risks incurred by doing nothing. Where relevant, information about anaesthesia should be given alongside information about the procedure itself.

4.8.4 Written Consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but it is not *proof* of valid consent. If a patient is rushed in to signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent giving, not a binding contract.

4.8.4.1 It is rarely a legal requirement to seek written consent, but it is good practice to do so if any of the following circumstances apply:

- A surgical intervention is planned
- The treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side effects' or 'complications')
- The procedure involves general/ regional anaesthesia or sedation
- Providing clinical care is not the primary purpose of the procedure
- There may be significant consequences for the patient's employment, social or personal life
- The treatment is part of a project or programme of research approved by this Trust.

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

4.8.4.3 It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. Good practice would be to gain verbal consent for such interventions. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example, if they have declined, or become distressed about, similar care in the past), it would be helpful to do so.

4.8.4.4 The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances.

4.9 Legalities

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

4.9.1 Case law on consent has evolved significantly over recent years. Further legal developments may occur after this policy has been ratified, and all healthcare health care professionals must remember their duty to keep themselves informed of legal developments that may have a bearing on their practice.

4.9.2 The Human Rights Act 1998 came into force in October 2000, giving further effect in the UK to the rights enshrined in the European Convention on Human Rights. The main articles that are likely to be relevant in medical case law are Article 2 (protection of the right to life), Article 3 (prohibition of torture and inhuman or degrading treatment or punishment), Article 5 (the right to liberty and security), Article 8 (the right to respect for private and family life), Article 9 (freedom of thought, conscience and religion and Article 14 (prohibition of discrimination in the enjoyment of Convention rights).

4.9.3 Compliance with the Human Rights Act is largely reflected in existing good ethical practice, but all health healthcare professionals should be aware of the Human Rights Act and ensure that they act in compliance with it. The British Medical Association (BMA) has a handbook of ethics and law that gives advice on how the Human Rights Act relates to a range of relevant issues.

4.9.4 The Mental Capacity Act 2005, which came fully into force on 1 October 2007, sets out a statutory framework for making treatment decisions for people who lack the capacity to make such decisions themselves. The Act establishes overarching statutory principles governing these decisions, setting out who can make them and when. It sets out the legal requirements for assessing whether or not a person lacks the capacity to make a decision. This is a complex area of practice; application of the act and the standard of practice related to it with regard to consent is covered in detail in Section 3.

4.9.5 There are circumstances when an individual who is under the legal of age of consent (16, as set out in the Mental Capacity Act 2005) may be deemed competent to give consent in the absence of a parent or guardian with parental responsibility ('Gillick competence'). Again this is a complex area of practice entailing an assessment of Gillick competence in addition to other considerations all of which require specific expertise.

4.9.6 If an individual is unable to read or write, they may be able to make their mark on a form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the clinician seeking consent, and for the fact that the person has chosen to make their mark in this way to be recorded in the case notes.

4.10 Provision of information

4.10.1 The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition (In a format that the individual can understand- plain English, Easy Read, Signs and symbols, braille etc) and about possible treatments /investigations and their risks and benefits (including the risks/benefits of doing nothing). Discussion

of the risks is vital and evidence of this discussion will be requested in the defence of any Clinical Negligence claim or inquest (if relevant). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on.

4.10.2 Patients and those close to them will vary in how much information they want: from those who want as much detail as possible to those who ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

4.11 Provision for patients whose first language is not English

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

4.12 Access to more detailed or specialist information

Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflet, patients should be guided towards the following facilities to assist patients to obtain such information:

- Patient Experience and Engagement Lead on tel: 01305 254786
- NHS Choices

4.12.1 The Patient Experience and Engagement Service provide a confidential service, acting as a 'gateway' to independent expert guidance and on the spot advice. They will give advice on navigating NHS services and departments and finding the right pathway for the patient. They will help to explain what to do, who to contact and how to access a service. They are able to provide information on local NHS, social care services, voluntary sector organisations and national and local self help groups. They will provide this information or signpost the patient to it, thereby enabling a pathway between NHS care and general well-being.

4.13 Access to health professionals between formal appointments

4.13.1 After an appointment with a health professional in primary care or in out-patients, patients will often think of further questions which they would like answered before they make their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone, than to make another appointment or to wait until the date of an elective procedure (by which time it is too late for the information genuinely to affect the patient's choice). Services should ensure that, where possible, contact details are available for patients to be able to access further information about their condition or treatment.

4.13.2 In addition, a vast amount of information is now available on the Internet and the healthcare professional will guide the patient in the use of recommended patient information sites. These may include:

- www.nhs.uk
- www.dh.gov.uk/consent

4.14 When Should Consent be Sought?

4.14.1 The seeking and giving of consent is usually a process, rather than a one-off event. When a patient formally gives their consent to a particular intervention, this is only the endpoint of the consent process. Clinicians should consider the whole process of information provision, discussion, decision-making and documentation as part of 'seeking consent'. This process may take place at one time, or over a series of meetings and discussions, depending upon the seriousness of what is proposed, the urgency of the patient's condition and the cognitive capacity of the patient.

4.15 Single stage process:

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

4.16 Two or more stage process:

4.16.1 For major interventions and procedures that carry significant risks a consent form should be used to document the process. Clinicians should, whenever possible, seek the person's consent to the proposed procedure well in advance. It is essential to allow sufficient time for:

- the patient to absorb the information necessary for them to make their decision, and
- the clinician to respond to the person's questions and provide adequate information.

4.16.2 Stage 1

Stage 1 should consist of an initial (oral) decision that includes the provision of information, discussion of options, potential outcomes and complications. This discussion should be undertaken using terminology that the patient can understand.

4.16.3 Stage 2

The second stage should be undertaken closer to the start of the procedure; the patient should be given the opportunity to discuss the procedure again, to confirm that they still wish to go ahead and give their consent.

4.16.4 In no circumstances should a person be given routine pre-operative medication before being asked for their consent to proceed with the treatment.

4.17 Duration of consent

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

4.17.2 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

the patient still has capacity) still wishes the intervention to proceed, even if no new information needs to be provide or further questions answered. Any discussions that do take place should be noted within the patient record.

4.18 Restricted Consent

4.18.1 A patient has the right to give restricted consent, which in reality gives patients the ability to list any intervention which is not acceptable, without further specific consent. Restricted consent may involve patients wishing to consider further such procedures/ treatments as progressing to major surgery following preliminary biopsy, or, in the case of Jehovah's Witnesses, blood transfusion.

4.19 Refusal of Consent

4.19.1 If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment (whether contemporaneously or in advance), this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983. This is the case even where this may result in the death of the person (and/or the death of an unborn child, whatever the stage of the pregnancy). Refusal of treatment by those under the age of 18 is covered in paragraph 4.25.

4.19.2 The situation for children is more complex: see the Department of Health's Seeking consent: working with children for more detail. The following paragraphs apply primarily to adults.

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

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

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

4.20 Withdrawal of Consent

4.20.1 A person that has capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a person does object during treatment, it is good practice for the healthcare professional, if at all possible to stop the procedure, establish the person's concerns and fully explain, and ensure that the person understands, the consequences of not completing the procedure. It should be acknowledged, that at times, an apparent objection may be a cry of pain rather than withdrawal of consent, and appropriate reassurance may enable the healthcare professional to continue with the person's consent. If stopping the procedure at that point would genuinely put the life of the person at risk, the healthcare professional may be entitled to continue until that risk no longer applies.

4.20.2 Assessing capacity during a procedure may be difficult and factors such as pain, panic and shock may diminish capacity to consent. The healthcare professional should try to establish whether at that time the person has capacity to withdraw a previously given consent. If capacity is lacking, it may sometimes be justified to continue in the person's best interests, but this must not be used as an excuse to ignore distress or a valid withdrawal of consent.

4.21 Mental Health Act 1983 (amended 2007) and Consent

4.21.1 It is important to note that if an individual is detained under a section of the Mental Health Act, Part 4 or Part 4A (Consent to Treatment) will apply. However; the Mental Health Act only allows for treatment that the purpose of which is to alleviate, or prevent a worsening of, the mental disorder or one or more of its symptoms or manifestations. This policy should be followed for any treatment that falls outside of the Mental Health Act.

4.22 Mental Capacity Act 2005 and Consent

4.22.1 Under the terms of the 2005 Mental Capacity Act, those over 16 are presumed to have sufficient capacity to decide on their own medical treatment unless there is significant evidence to suggest otherwise. LPAs, Advance Decisions and DOLS are applicable to over 18yrs of age. For further guidance see the Mental Capacity Act and Deprivation of Liberty Safeguards page on the intranet.

There are five statutory principles that must be followed when making any decisions under the Mental Capacity Act.

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person should not be treated as unable to make a decision unless all practicable steps to help them do so have been taken, without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

4.22.2 In order to assess an individual's capacity, Professionals must ask themselves:

- Is the person unable to make the decision in question? If so:
- Is there an impairment or disturbance in the functioning of the person's mind or brain? If so:
- Is the person's inability to make the decision because of the identified impairment or disturbance?

4.22.3 Examples of impairments or disturbances in the mind or brain include:

- mental health conditions, such as schizophrenia or bi-polar disorder (manic depression),
- dementia,
- serious learning disabilities,
- long-term effects of brain damage,
- physical or mental conditions that cause confusion, drowsiness, or a loss of consciousness,
- delirium, and
- intoxication, caused by drug or alcohol abuse.

4.22.4 Someone is thought to be unable to make a decision if they cannot:

- understand information about the decision,
- retain that information,
- To use or weigh that information as part of the decision-making process
- communicate their decision by talking, using sign language, or by any other means.

4.22.5 If someone makes a decision about treatment that most people would consider to be irrational or unwise, it does not necessarily mean they lack capacity. It is the process they go through in reaching the decision that is important. The capacity test always needs to be applied and a person can only be said to lack capacity if they have an impairment described in 4.21.3 and are unable to do one of the four tests in 4.21.4.

4.22.6 It is possible for capacity to fluctuate. In such cases, it is good practice to establish, while the person has capacity, their views about any clinical intervention that may be necessary during a period of anticipated incapacity and to record these views. It should also be asked if a decision can be made at a time when they have capacity. The Act allows people to plan ahead for a time when they may not have the capacity to make their own decisions: it allows them to appoint a person to make health and social care decisions, including medical treatment, on their behalf or to make an advance decision to refuse medical treatment. Health and social care healthcare professionals practicing in fields where the Mental Capacity Act is likely to impact on their practice must ensure that they are fully conversant with its content and practical implications of the act for practice

4.22.7 Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for them, unless there is a valid health and welfare lasting power of attorney authorising them to or they have been appointed by the courts as a deputy authorised to make that decision; even then, they must undertake their role in line with the Mental Capacity Act Code of Practice. It is important to note that the person's capacity should be assessed by the clinician proposing the treatment, they are the decision maker.

4.22.8 However, treatment may be given if it is in their best interests, as long as it has not been refused in a valid and applicable advance decision to refuse treatment, it does not go against the decision of an attorney where a health and welfare Lasting Power of Attorney covers that decision, a decision of the Court of Protection (DH July 2009 Section 2 25-30), or a Court Appointed Deputy appointed to decide on that decision (DH July 2009, Section 2, 17-20).

4.22.9 In a situation where a patient lacks capacity certain treatments should automatically be referred to The Court of Protection. These are:

- disagreements on decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- 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 person 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 person's best interests, or a significant interference with a person's rights

4.22.10 Under the Mental Capacity Act 2005, a person may wish to make an Advance Decision to Refuse Treatment or a statement of their preferences and wishes. Patients are able to give a Lasting Power of Attorney (LPA) to individuals. Under this

legislation, an LPA in relation to the patient's personal welfare can extend to giving or refusing consent to the carrying out or continuation of treatment, but will only extend to life-sustaining treatment if that is expressly contained in the LPA. The views of a person appointed under a Lasting Power of Attorney with regard to healthcare decisions will have legal effect. An Advance Directive/Decision is not valid if the Lasting Power of Attorney was created after the Advance Decision. Guidance on medical disclosure to attorneys and deputies

4.22.11 If the person has not made a valid and applicable advance decision; decisions about that person's treatment if they lack capacity must be made in accordance with the Mental Capacity Act. This would include considering whether the person is likely to regain capacity and, if so, whether the decision can wait, as well as the statutory principle that all practical steps must be taken to enable the person to make their own decision.

4.22.12 Where a patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented, along with the assessment of the patient's capacity. The Best Interests process MUST be followed and the best interest decision must be recorded in the patients notes. Templates for recording the assessment of capacity and best interest decision can be found on the intranet pages.

4.22.13 An apparent lack of capacity to give or withhold consent may be the result of communication difficulties rather than genuine incapacity. Healthcare professionals should involve those who know the person well and are able to support the communication process; appropriate colleagues in making such assessments of capacity, such as specialist learning disability teams; speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate. Some communication aids can be found here

4.22.14 Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. In this instance a best interests meeting (if time allows) with relevant professionals, carers, family, IMCA will be held to consider best interests – in particular in more complex cases or where there is dispute

4.22.15 Where the consequences of having, or not having, the treatment is potentially serious, a court declaration may need to be sought via the Court of Protection. To access legal advice Practitioners/ Clinicians will need to liaise with the risk department legal team in hours or clinical site managers out of hours

4.23 Independent Mental Capacity Advocates (IMCA)

4.23.1 The Mental Capacity Act has introduced a duty on NHS bodies to instruct an IMCA in serious medical treatment decisions when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. In matters that meet the definition of serious medical treatment, IMCAs are only able to represent and support people whose treatment is arranged by the NHS. They have the right to information about an individual and can see relevant healthcare records.

4.23.2 IMCAs are not decision-makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision-making for people who lack capacity is done appropriately and in accordance with the Mental Capacity Act. It is important that a referral to an IMCA is made as soon as the need is identified to give them opportunity to meet the person, try and establish views and

wishes of the person and report to the clinical decision maker. The process for making a referral for an IMCA can be found **here**

4.24 Advance Decisions to refuse Treatment

4.24.1 An advance decision gives patients the legal right to give or withhold consent to specific medical treatments prospectively. Some people with certain health conditions may have periods when they have capacity, and periods when they do not, or can reasonably anticipate that at some point in the future they will lose capacity. In such circumstances, a person can make an advance decision, stating how they would like to be treated, or not treated, in case of future incapacity.

4.24.2 Where this involves the refusal of treatment it has a specific authority under The Mental Capacity Act and is defined as an advance decision to refuse treatment. A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment.

4.24.3 If a person specifically states in their advance decision that they do not want to undergo a particular treatment, this is legally binding unless they are detained under the Mental Health Act at the time of making the decision or at the time of potential treatment. Advance decisions, interpretation and implications for clinical practice are covered in the Trust's briefing note 'Advanced Decisions: living wills' available on the Intranet and 'Resuscitation – policy and procedure including resuscitation status policy and guidelines (http://sharepointapps/clinguide/CG_docs1/0195-Resuscitation-Policy.pdf)

4.25 Treatment of children and young people

4.25.1 For the purposes of this guidance 'children' refers to people aged below 16 and 'young people' refers to people aged 16–17.

4.25.2 When children are being cared for in hospital, it will not usually seem practicable to seek their parents' consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you should remember that, in law, such consent is required.

4.25.3 Where a child is admitted, you should therefore discuss with their parent(s) what routine procedures will be necessary and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

4.25.4 Only people with 'parental responsibility' are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children. If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check. Information is provided on the intranet under clinical guidelines, 'Consent for procedures in children' (http://sharepointapps/clinguide/CG_docs1/0857-explicit-consent.pdf). The Department of Health have also issued guidance for parents, which can be used as a reference or information for the parents. This is available at: http://www.nhs.uk/NHSEngland/AboutNHSservices/Documents/Consent_%20aguideforparentsDH_4117353.pdf Please note: some parental responsibility and Court Orders specify that both parents need to be in agreement for treatment to take place. In the case of where one parent may wish treatment and the second refuses, legal advice should be sought.

4.25.5 Under the Mental Capacity Act 2005, young people aged 16 or 17 are presumed to be capable of consenting to their own medical treatment and any ancillary procedures involved in that treatment such as an anaesthetic. As for adults, consent

will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16–17 may in certain circumstances be overridden by either a person with parental responsibility or a court.

4.25.6 Section 8 of the Family Law Reform Act 1969 (revised 1987) applies only to the young person's own treatment. It does not apply to an intervention that is not potentially of direct health benefit to the young person, such as blood donation or non-therapeutic research on the causes of a disorder. However, a young person may be able to consent to such an intervention under the standard of Gillick competence.

4.25.7 In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults should be used (see the DH 'Reference Guide to Consent for Examination or Treatment 2nd Edition', Sections 1 and 2). If a young person lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, the mind or brain then the Mental Capacity Act 2005 will apply in the same way as it does to those who are 18 and over.

4.25.8 If, however, they are unable to make the decision for some other reason, for example because they are overwhelmed by the implications of the decision, then the Act will not apply, and the legality of any treatment should be assessed under common law principles. It may be unclear whether a young person lacks capacity within the meaning of the Act. In those circumstances, it would be prudent to seek a declaration from the court. More information on how the Act applies to young people is given in Section 12 of the Mental Capacity Act (2005) Code of Practice. Insert hyperlink to intranet

4.25.9 If the 16/17-year-old is capable of giving valid consent, then it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to the consent of the young person. It is, however, good practice to involve the young person's family in the decision-making process, unless the young person specifically wishes to exclude them, if the young person consents to their information being shared.

4.25.10 A child of under 16 may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent. In the case of Gillick, the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the competency to consent to that intervention. This is sometimes described as being 'Gillick competent'.

4.25.11 If the child is deemed to be Gillick competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. 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.

4.25.12 Where advice or treatment relates to contraception, or the child's sexual or reproductive health, 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 very likely to begin or continue to have sexual intercourse with or without advice or treatment, and that unless they receive the advice or treatment then the child's physical or mental health is likely to suffer.

4.25.13 If the child seeks advice or treatment in relation to abortion and cannot be persuaded to inform her parent(s), every effort should be made to help the child find another adult (such as another family member or a specialist youth worker) to provide support to the child. Healthcare professionals should also refer to the statutory guidance on underage sexual activity and the risk of harm including considering if the child is at risk of sexual exploitation (CSE). Further information is available from the General Medical Council.
(http://www.gmc-uk.org/static/documents/content/0_18_years.pdf)

4.25.14 It would be seen as good practice to involve parents along with young people when decisions are being made, however this needs to be weighed against the young persons' right to confidential treatment. Where the child under 16 lacks the capacity to consent to treatment consent should be sought by someone with parental responsibility or by the court. Clear documentation is imperative, including the rationale, and how a decision was reached regarding whether a young person is Gillick Competent or not and whether the person with parental responsibility has been involved in the consent process.

4.26 Refusal of treatment by those under the age of 18

4.26.1 If faced with a situation where a young person is refusing treatment, parents (those with parental responsibility) may still decide what is in their child's best interest and consent on their behalf until they are 18 years old. Attempts should be made to resolve this situation involving both the parents and young person, with consideration for the least restrictive methods available.

4.26.2 Where a young person of 16 or 17 who could consent to treatment, or a child under 16 but Gillick competent, refuses treatment, it is possible that such a refusal could be overruled if it would in all probability lead to the death of the child/young person or to severe permanent injury. This could be by a court, an adult with parental responsibility or under the Mental Health Act 1983 noting compulsory treatment under the MHA can only relate to treatment of the mental disorder. In serious or complex situations, a court may be asked to make a decision.

4.27 Child Lacking Capacity

4.27.1 Where a child under the age of 16 lacks competency to consent (i.e is not Gillick competent), consent can be given on their behalf by any one person with parental responsibility (if the matter is within the 'zone of parental control') or by the court. As is the case where patients are giving consent for themselves, those giving consent on behalf of child patients must have the competency 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 competency consent on their own behalf, it is good practice to involve the child as much as possible in the decision-making process.

4.27.2 If there are child protection and safeguarding concerns then the Trust's safeguarding children policy should be consulted. If there are disputes between professionals and parents over what is in a child's best interest, then in some instances the courts will need to be involved. In some cases the significance and consequences of the decision itself will mean that the court should be involved. Other safeguarding concerns may be raised within local Raised through local Safeguarding procedures:
https://pdscp.co.uk/
https://staffnet.dchft.nhs.uk/clinicaldepartments/SafeguardingChildren/Pages/SafeguardingChildren.aspx
Advice can be sought from named and designated professionals.

4.28 Child Emergencies

4.28.1 In an emergency, it is justifiable to treat a child who lacks capacity without the consent of a person with parental responsibility, if it is impossible to obtain consent in time and if the treatment is vital to the survival or health of the child.

4.29 Treatment of children and young people who are "looked after" in local authority care

4.29.1 Section 3(5) of the Children Act 1989 (http://www.legislation.gov.uk/ukpga/1989/41/part/III), (revised Children's and Families Act 2014) states that a person who does not have parental responsibility for a child, but has de facto care if the child, may do what is reasonable in all circumstances for the purpose of safeguarding or promoting the child's welfare. It can rarely be reasonable for a temporary carer to give consent without consulting the parents.

4.29.2 When children are accommodated (section 20) by the local authority it is the local authorities responsibility to obtain parental consent to medical treatment, since parents retain full responsibility. Children who are subject to a care order (section 31); parents share parental responsibility with the local authority. It is a matter of negotiation between them who should give consent. The local authority should make attempts to consult with the parents and their consent sought.

4.29.3 In an emergency when the doctor or health care provider is not able to obtain valid consent, they may provide the treatment if they believe it is in the best interest of the child. Comprehensive documentation is advised.

4.30 Documenting Consent

4.30.1 It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient it may be advisable to document patients consent. Consent to treatment should be documented for more invasive treatments/investigations. It should be documented in the patient record that the intervention/treatment or investigation was discussed and included the probable outcomes, possible complications or side effects (if relevant) and that the patient gave consent. Whenever possible this should be completed contemporaneously.

4.30.2 For patients whose first language is not English, it is recommended to record the language in which the interpretation was undertaken in order to avoid the person later stating that the wrong language was used. Details of the interpreting service used should also be documented. All clinicians should be made aware of the documentation processes in respect of all type of consent.

4.31 Consent Forms

4.31.1 The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit. This training must be given by the person competent to undertake the procedure themselves and as such is service-specific and is organised at service level when required.

4.31.2 Local standard operating procedures should be developed for health professionals who obtain consent but do not carry out the procedure. Details should include:

- The process for identifying staff who are not capable of performing a procedure but are authorised to obtain consent for that procedure
- The process for the delivery of procedure specific training on consent, for staff to whom the consent process is delegated and who are not capable of performing the procedure needs to be included e.g. TOP.
- Specific training they have received to ensure they are able to give the correct information to the patient.

4.31.3 Standard consent forms and forms for adults who are unable to consent for themselves are available on the Trust intranet, insert hyperlink to form 4 from MCA pages under clinical guidelines. Please refer to section 4.33 for consent to Audio Visual recording.

4.31.4 In most cases where written consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out.

4.31.5 Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process.

4.31.6 Patients may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure. If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves. If this access to advice is not available the procedure should not go ahead until someone with appropriate expertise can answer the questions posed by the patient.

4.31.7 This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, a form of words should be used which requires more than a yes/no answer from the patient: for example "tell me what you're expecting to happen", rather than "is everything all right?"

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

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

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

4.32 Seeking consent for anaesthesia

4.32.1 Where an anaesthetist is involved in a patient's care, it is their responsibility to seek consent for anaesthesia, having discussed the benefits and risks. However, in elective treatment it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient will not be in a position genuinely make a decision about whether or not to undergo anaesthesia. Patients should either receive a general leaflet about anaesthesia in outpatients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient's notes or on the consent form.

4.32.2 Where the clinician undertaking the procedure is personally responsible for anaesthesia (e.g. where local anaesthesia or conscious sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

4.33 Dental Care

4.33.1 Patients complete FP17/PR to consent to examination and treatment for dental care found at http://www.nhsbsa.nhs.uk/1145.aspx Where routine dental care is being provided with adjunctive local anaesthesia, the Department of Health form FP17DC is additionally used for other than Band 1 therapies (i.e. diagnosis and maintenance) to record the procedures agreed by the patient and use of local infiltration or routine regional block anaesthesia is implied. The agent used, route and dose is always recorded in the clinical records. Additional written consent is used for conscious Sedation using appropriate Department of Health model consent forms 1-4. Guidance on completion of these forms is available on the NHS Business Services Authority website. In addition, where general anaesthesia or conscious sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.
(http://www.nhsbsa.nhs.uk/Documents/DentalServices/Completion_of_form_guidance_-_FP17_-_England_(V8)_-_04.2016.pdf)

4.34 Consent to visual and audio recordings

4.34.1 Consent should be obtained for any visual or audio recording, including photographs or other visual images. The purpose and possible future use of the recording must be clearly explained to the person or parental guardian before their consent is sought for the recording to be made.

4.34.2 If it is to be used for teaching, peer review, audit or research, people must be aware that they can refuse without their care being compromised and that when required or appropriate it can be anonymised. The General Medical Council (GMC) should be referred to, by medical and non-medical healthcare professionals, for 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.
(http://www.gmck.org/static/documents/content/Making_and_using_visual_and_audio_recordings_of_patients.pdf). Recordings and consent forms need to be retained in line with the health records Standards Policy and Retention Schedules (http://sharepointapps/corppol/CG%20docs1/Health%20Record%20Standards%20Policy%20and%20Retention%20Schedules.pdf).

4.35 Termination of Pregnancy

4.35.1 The written consent of a patient whose pregnancy is to be terminated should always be obtained. The consent of the partner or putative father is not a legal requirement. Patients who are 16 years of age may consent to treatment. The Medical Defence Union has been advised that when a patient is under 16 years her parents should be consulted, unless the patient forbids the healthcare professional to do so. The parents' refusal should not, however, prevent a termination to which the patient herself consents and which is considered to be clinically necessary. Conversely, a termination should never be carried out in opposition to the patient's wishes, even if the parents demand it. If the patient cannot consent to a termination of pregnancy because of mental incapacity, the terms of the Abortion Act 1967 (as amended) should be complied with; otherwise a declaration from the court authorising the termination will be required.

4.36 Sterilisation

4.36.1 The advantages and disadvantages of this form of contraception should always be explained to the patient, who should, in particular, be advised that it may not be possible to reverse the operation and also that no guarantee can be given that the operation will be totally effective in preventing conception. Written consent of the patient must always be obtained but the consent of the spouse is not a legal requirement. If the patient is mentally incapable of giving consent to sterilisation the court's approval should always be obtained before operating.

4.37 Clinical Research

4.37.1 Special problems arise with consent for clinical research (which includes consent for research associated with treatment and consent for research on healthy volunteers). Researchers are referred to Research Involving Patients (Royal College of Physicians). Advice is available from the Medical Protection Society and the Medical Defence Union. Expert advice on the wording of an appropriate consent form and the information to be given to the patient prior to arranging clinical research should always be sought. In any event, it should always be made clear to the patient that refusal to participate in clinical research will not adversely affect his or her care.

4.38 Tissue

4.38.1 The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing) raises some difficult issues and is currently under review. Such tissue can be very valuable in education and research, and its use may lead to developments in medical knowledge and improvements in health care for everyone. Patients should be given the opportunity to refuse permission for tissue taken from them during surgery or other procedure to be used for education or research purposes. Individual departments must ensure that they have a system in place that makes provision for the patient to record their consent or objection to the use of such tissue and for this to be notified to the laboratory. The system must be well publicised and transparent. The patient must also be able to record any objections to particular uses or use of particular tissues.

4.38.2 Explicit consent is not necessary for public health surveillance using the unlinked anonymous method, but a well-publicised opt-out policy must apply.

4.38.3 Please refer to the Human Tissue Bill (House of Commons 2003, amended 2004): Part 1, Removal storage and use of human organs and other tissue for scheduled purposes, and Part 2, Regulation of activity regarding human tissue. (http://www.publications.parliament.uk/pa/ld200304/ldbills/094/2004094.pdf)

4.39 Emergencies

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

4.40 Restrictive Practices/ Restraint/ Clinical Holding

4.40.1 Restraint should only be used as a last resort and should be the minimum response necessary for the shortest possible time, to make the patient and others as safe as possible. Mental Capacity Act Sections 5 and 6 allow restraint but where there is reasonable belief that the patient lacks capacity and the restraint is necessary and proportionate to the risk of harm and the seriousness of that harm.

Where the intervention goes beyond restraint – whether due to nature, duration, frequency and /or intensity of interventions, would need to consider use of DOLS or MHA or court – sensible to seek advice/ guidance. Where someone has capacity restraint can only be used in limited circumstances under the common law principle of necessity lacks capacity and the restraint is necessary and proportionate to the risk of harm and the seriousness of that harm

Where goes beyond restraint – whether due to nature, duration, frequency and/or intensity of interventions, would need to consider use of DOLS or MHA or court – sensible to seek advice/ guidance

Where someone has capacity restraint can only be used in limited circumstances under the common law principle of necessity

4.40.2 The Care Quality Commission (CQC) has produced a brief guide on restraint

5 Roles and Responsibilities

5.1 The Trust has a responsibility to:

- Ensure care is delivered in a context of continuous quality improvement, where implementation of the guideline is subject to regular feedback and audit.
- Providing all staff involved in the implementation of the guideline and the care of patients, with competency-based education and training in order to update their knowledge in relation to the appropriate use of consent in patient care.
- Ensure staffing levels and skill mix should reflect the needs of patients and priority should be given to the provision and allocation of resources in the management of patients.

5.2 Service Managers have a responsibility to:

- Ensure all healthcare staff including, allied health and social care professionals within the service are aware of this policy and that they have been offered training in the use of the policy.
- Ensure staff within the service are aware of the record keeping required.
- Comply with the Trust's monitoring of this Policy.

5.3 Employees have a responsibility to:

- Be accountable for all aspects of their practice. All Registered Healthcare Professionals have a professional responsibility to maintain up to date evidence based care; this includes maintaining a working knowledge of their responsibilities in relation to the consent process.
- Ensure staff are committed to maximising choice, control and inclusion for their patients.
- Recognise their personal responsibility in safeguarding people who use the services.
- Know how to identify report and respond appropriately to suspected or actual abuse because there are clear procedures that are followed in practice, monitored and reviewed.
- Ensure the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.
- Discharge their duties in accordance with their role, level of expertise and the requirements of their professional body where applicable.
- Have evidence of regular updating. This must be demonstrated through informed evidence-based practice and documentation of attendance at relevant training.
- Ensure their approach to care is interdisciplinary, involving all those needed in the management of the patient.

5.4 Students and trainees

- 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, assuming the student/trainee is appropriately trained in the procedure, the fact that it is carried out by a student/trainee does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the person that the clinician is a student, although it would always be good practice to do so. In contrast, where a student/trainee proposes to conduct a physical examination that is not part of the person's care 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.

5.5 Responsibilities

5.5.1 The health professional undertaking the care, procedure, treatment or investigation is ultimately accountable for ensuring that the person has given valid consent before the intervention begins. It is they who will be held responsible in law if this is challenged later.

5.5.2 The task of seeking consent may be delegated to another person, as long as they are suitably trained and/or qualified. In particular, they must have sufficient knowledge of the proposed intervention and understand the risks involved, in order to be able to provide any information the patient may require. They must also be able to determine whether the person has the capacity to make the decision in question and what steps need to be taken if the person lacks capacity. Health professionals are responsible for knowing the limits of their own competence, and should seek the advice of appropriate colleagues when necessary. Some services may have staff who obtain consent but who may not necessarily perform the procedure. In these instances a register of staff names should be kept.

5.5.3 Each service manager should, in conjunction with lead clinicians, clearly identify those procedures where written consent is required, or verbal consent is obtained and explicitly documented in the clinical records. They should ensure that clinicians

performing procedures are aware of these requirements and where written consent is indicated, the forms that should be used. Forms must comply with recommended best practice.

6. Equality Impact Assessment

The policy applies to all employees and patients regardless of race, including nationality and ethnic origin; sex; sexual orientation, gender re-assignment, age, religion or belief; disability; marriage and civil partnership; and pregnancy and maternity. The completed assessment for the policy is attached as Appendix A.

7. Privacy Impact Assessment

The PIA is attached as Appendix B.

8. Stakeholders and consultation

List of those groups or individuals consulted during the policy's development.

9. Dissemination

This will be disseminated via Trust communications and Divisional and Corporate governance processes.

10. Training and implementation

Training will be provided as required, competency toolkit and record is at Appendix J.

11. Monitoring and reviewing arrangements

The policy will be reviewed three yearly unless there is a change in relevant Legislation, in which case the policy will be reviewed immediately.

12. Policy Content

The policy should be referred to as necessary when seeking consent for interventions.

13. Approval and ratification

Policy will be ratified via the Patient Safety Group.

Appendix A

EQUALITY IMPACT AND COMPLIANCE ASSESSMENT

1. General

Title of document	Consent to Examination or Treatment
Purpose of document	To provide staff with a framework to support obtaining consent, and understanding why consent is important.
Intended scope	All employees of Dorset County Hospital NHS Foundation Trust. The Trust also expects volunteers, contractors and any other workers working on the Trust's premises or on its behalf to comply with this policy.

2. Consultation

Which groups/associations/bodies or individuals were consulted in the formulation of this document?	Safeguarding Adults and Children Divisional Governance meetings Patient Safety Group
What was the impact of any feedback on the document?	Feedback was incorporated where possible
Who was involved in the approval of the final document?	Safeguarding Adults and Children Divisional Governance meetings Patient Safety Group
Any other comments to record?	None

3. Equality Impact Assessment

Does the document unfairly affect certain staff or groups of staff? If so, please state how this is justified.	The policy applies to all employees regardless of race, including nationality and ethnic origin; sex; sexual orientation, gender re-assignment, age, religion or belief; disability; marriage and civil partnership; and pregnancy and maternity.
What measures are proposed to address any inequity?	None
Can the document be made available in alternative format or in translation?	Yes, on request.

4. Compliance Assessment

Does the document comply with relevant employment legislation? **Please specify.**	Human Rights Act 1998 Department of Health Reference Guide to Consent for Examination or Treatment Human Tissue Act 2004 (and associated Code of Practice, July 2006) Mental Health Act 1983 and 2007 (and associated Code of Practice, 2008) Mental Capacity Act 2005 (and associated Code of Practice, 2007) Children's Act 1989 NHSLA Standards Care Quality Commission's Schedule of Applicable Publications

5. Document assessed by:

Name	Mandy Ford
Post Title/Position	Head of Risk Management and Quality Assurance
Date	30.05.2017

Appendix B

Privacy Impact Assessment Screening Questionnaire

Project/Policy/Procedure Title: Policy to Consent to Examination or Treatment

Project Lead: Date:

	Assessment Question	Yes	No
1	Does the project/policy/procedure use or suggest new or extra technologies that will have a greater impact on privacy?		NO
Comments:			
2	Is the justification for the new data-handling unclear or unpublished?		NO
Comments:			
3	Does the project/policy/procedure involve an additional use of existing identifier?		NO
Comments:			
4	Does the project/policy/procedure involve use of a new identifier for multiple purposes?		NO
Comments:			
5	Does the project/policy/procedure involve new or substantially changed identity authentication requirements?		NO
Comments:			
6	Will the project/policy/procedure result in handling of significant amount of new data about each person, or significant change in existing data-holdings?		NO
Comments:			
7	Will the project/policy/procedure result in the handling of new data about a significant number of people or a significant change in the population coverage?		NO
Comments:			
8	Does the project/policy/procedure involve new linkage of personal data with data in other collections, or significant changes in data linkage?		NO
Comments:			
9	Does the project/policy/procedure involve new or changed data collection policies or practices that may be unclear or intrusive?		NO
Comments:			

10	Does the project/policy/procedure involve new or changed data quality assurance processes and standards?		NO
Comments:			
11	Does the project/policy/procedure involve new or changed data security arrangements?		NO
Comments:			
12	Does the project/policy/procedure involve new or changed data access or disclosure arrangements?		NO
Comments:			
13	Does the project/policy/procedure involve new or changed data retention arrangements?		NO
Comments:			
14	Does the project/policy/procedure involve changing the medium of disclosure for publicly available information in such a way that data becomes more readily available than it was before?		NO
Comments:			
15	Will the project give rise to new or changed data-handling that is in any way exempt from legislative privacy protections?		NO
Comments:			
Does the project/policy/procedure require further privacy impact assessment?			NO

If the project/policy/procedure does not require any further Privacy Impact Assessment, this document should be signed by the Project Lead/Policy Author and relevant Information Asset Owner.

The project/policy/procedure should state that it is exempt from a Privacy Impact Assessment, and this questionnaire should be kept with project/policy/procedure documentation.

No further Privacy Impact Assessment need.

Signed _____ Date _____
Project Lead/Policy Author

Signed _____ Date _____
Information Asset Owner

Appendix E

Jehovah's Witnesses' Position on Medical Treatment

1. This details the general beliefs of Jehovah's Witnesses with regards to the treatments listed below. However this list is not exhaustive and a health care worker should not assume that this is the patient's view unless the patient expresses it explicitly.

2. The decision of individual Adult Jehovah's Witnesses to refuse blood and blood components is a matter of personal choice. Healthcare professionals should explain the risks in not accepting blood and blood components and ensure that these risks are fully understood by the patient. This should be documented, along with the reasons for the patient's refusal. In these circumstances, healthcare professionals should not be liable for any adverse consequences directly arising from the curtailment of management options by the exclusion of blood products.

3. **ABORTION**

Deliberately induced abortion is unacceptable. If, at the time of childbirth, a choice must be made between the life of the mother and the child, it is up to the individuals concerned to make that decision.

4. AUTO TRANSFUSION

Immediate intra-operative auto-transfusion is permitted by many Witnesses provided the circuit is linked in the patients‟ circulatory system and there is no storage. However, preoperative collection and subsequent reinfusion is not permitted.

5. BLOOD TESTS

No objections.

6. BLOOD TRANSFUSIONS

Transfusions of whole blood, packed RBC‟s and plasma i.e. the fluid part of blood – for blood proteins, (see below) as well as WBC and platelet administration are rejected.

7. FRACTIONS

Each Witness will decide individually whether to accept such fractions as albumin, immunoglobulins and haemophiliac preparations.

8. HAEMODIALYSIS

Permitted by many Witnesses provided non-blood prime is used.

9. HAEMODILUTION

Intraoperative haemodilution is permitted by many Witnesses when the equipment is arranged so as to keep the blood in a constant link to the patients‟ circulatory system.

10. HEART BYPASS

Permitted by many Witnesses provided non-blood prime is used.

11. SERUMS

Not forbidden, although some Witnesses conscientiously refuse them.

12. EXPANDERS

Non-blood volume expanders are acceptable. Examples are: Saline, Dextran, Gelatin, Ringer‟s Solution, Haemaccel and Hetastarch

Appendix F

Checklist guidance for considering the legality of a potential lasting power of attorney (LPA)

Please document clearly in the patient's records or on this form your reasons for answering "yes" or "no" for any of the questions below. This form must be placed in the patient's records.

1. Does the donor/ patient have capacity? YES / NO
If "yes" the patient should make the decision.
If "no" proceed to question 2

2. Has the patient made any subsequent Advance Decision that is valid and applicable to this decision? YES/NO
If "yes" follow the Advance Decision.
If "no" proceed to question 3

3. Have you seen the LPA? YES/NO
If "yes" proceed to question 4
If "no", if the patient's condition allows ask to see the LPA. In the interim you can treat the patient in their best interests.

4. Is the LPA registered with the Office of the Public Guardian? YES/NO
If "yes" proceed to question 5
If "no" the LPA is not valid and the attorney is not able to consent or refuse treatment on behalf of the patient. (However they should be consulted under the Best Interests checklist).

5. Does the LPA cover the patient's property and affairs only? YES/NO
If "yes" the named person does not have power to make decisions about the patient's healthcare. The named person needs to apply for an LPA for the patient's healthcare before they can make decisions about the patient's healthcare. They are still likely to be someone you should consult in making a best interests decision
If "no" and it clearly also covers healthcare issues proceed to question 6.

6. Does the LPA limit the healthcare decisions which can be made? YES/NO
If "yes" then check the treatment decision is covered by the LPA and if it is, then proceed with treatment, unless it is in relation to life sustaining treatment, in which case go to question 7. If not, follow the best interests' checklist.
If "no" then the named person can consent and refuse treatment on the person's behalf. Go to Question 7.

7. If the treatment involves life sustaining treatment, has the patient expressly given authority in the LPA for the named person to make the decision? YES/NO
If "yes", then proceed to Question 8.
If "no", then give life sustaining treatment if in the patient's best interests

8. Does the Lasting Power of Attorney allow for more than one named person to make decisions and, if so, have they been consulted? YES/NO
If "yes" and the document states that the named person have "joint and several" responsibility then any one named person may give the necessary consent or refusal of treatment in the patient's best interest. Proceed to Question 9. If it is only "joint" then *all* must agree to the

proposed management plan. If the named persons do agree, proceed to Question 9, otherwise follow the best interest checklist.
If "no", then proceed with the relevant authority form the single named person and proceed to Question 9.

9. Has the named person(s) been fully informed of the nature, risks and consequences of the treatment being proposed as well as the consequences of accepting or refusing the treatment on behalf of the patient? YES/NO
If "yes" proceed to question 10.
If "no" you must do so before the named person(s) make any decision.

10. Are the named person(s) acting in the best interests of the patient? YES/NO
If "yes" then proceed in accordance with the wishes of the named person(s)
If "no" consideration should be given to referring the matter to the Court of Protection and the case should be reported to the Risk Team in order to obtain legal advice.

Appendix G

Important Facts about Lasting Power of Attorney's (LPA's)

1. The introduction of the LPA for property and affairs means that no more Enduring Powers of Attorney (EPA) can be made from April 2007, but the Mental Capacity Act makes transitional provisions for existing EPAs to continue whether they are registered or not. This means that pre-existing EPAs can continue to be used post April 2007 (whether registered or not) and can continue to be registered after April 2007. These only relate to financial decisions.

2. There are two types of LPA – health and welfare and property and affairs. There are specific forms which should be used.

3. Before an LPA can be used it must be registered with the Office of the Public Guardian. This is vital, without registration an LPA is not valid. Check that the document contains the appropriate stamp.

4. When the person has the capacity to make the decision for himself or herself a personal welfare attorney will have no power to consent to, or refuse treatment, at any time or about any matter.

5. If the person in your care lacks capacity and has created a personal welfare LPA, the attorney will be the decision-maker on all matters relating to the person's care and treatment, providing the authority in the LPA is not limited. Unless the LPA specifies limits to the attorney's authority, the attorney will have the authority to make personal welfare decisions and consent to or refuse treatment (except life-sustaining treatment) on the person's behalf. The attorney must make these decisions in the best interests of the person lacking capacity and if there is a dispute that cannot be resolved, e.g. between the attorney and a doctor, it may have to be referred to the Court of Protection if it cannot be resolved informally.

6. If the decision is about life-sustaining treatment, the attorney will only have the authority to make the decision if the LPA gives them that express authority in writing and it is signed and witnessed.

7. It is important to read the LPA if it is available to understand the extent of the attorney's power and any limits on decision-making.

8. If there is concern about the validity of a LPA document or there is dispute within an LPA as to what is in the patient's best interests please contact the Risk Team or on call manager.

Appendix H

Checklist Guidance for Considering a Potential Advance Decision Statement or Document

Please document clearly in the patient's records or overleaf your reason for answering "yes" or "no" for any of the questions below. This form must be placed in the patient's records.

1. Does the patient have capacity or may he/she have it at some time in the future when he/she could take the decision to consent to or refuse treatment for him/herself?

YES/NO

If "yes" then the Advance decision (AD) is not applicable and the patient's views should be obtained or the healthcare professional should wait until the patient regains capacity to seek his/her views
If "no" proceed to question 2.

2. Is there evidence that the AD has been revoked or altered? This need not be in writing and may be a verbal revocation or alteration. (NB – a previous AD refusing life-sustaining treatment may be revoked orally but any alteration to an AD to include refusal of life sustaining treatment must be in writing). **YES/NO**

If "yes" the revocation or alteration should be followed.
If "no" proceed to question 3.

3. **Is the AD valid?** **YES/NO**

In answering this question please consider each of the following;
Is the patient 18+? If not the patient's wishes may still be considered but are not legally valid.
Has the patient withdrawn the AD when he/she had capacity to do so?
Has the patient done anything subsequently which is clearly inconsistent with the AD?
Is there a named person with a Lasting Power of Attorney, created after the AD was made, giving the named person authority to give or refuse consent to the treatment to which the AD relates?

If the answer to 1 or more of the above questions is "yes" then the AD is not valid and is not binding, otherwise continue to question 4

4. **Is the AD applicable to the treatment in question?** **YES/NO**

Does the treatment in question fall outside of what is specified in the AD?
Are any particular circumstances specified in the AD now absent?
Are there reasonable grounds for believing that circumstances now exist which the patient did not anticipate at the time of making the AD and which would have altered their decision had they anticipated them?

If any answer to the above is "yes" then the AD is not applicable and is not binding.

Additional checks where the Advance Directive indicates a refusal of life-sustaining treatment.
1. **Have the following relevant conditions been satisfied for any AD which relates to life-sustaining treatment?** **YES/NO**

It must be in writing, which includes being written on the person's behalf or recorded in their medical notes.

It must be signed by the person in the presence of a witness who must also sign the document. It can also be signed on the person's behalf at their direction if they are unable to sign it for themselves.

It must be verified by a specific statement made by the maker that says that the advance decision is to apply to the specified treatment even if life is at risk. If there is a separate statement this must also be signed and witnessed.

If "no" then the AD is not valid. If "yes" treat the patient in line with the contents of the AD.

Appendix I

Exceptions to the Principles of Consent

1. Part IV of the Mental Health Act 1983 ("the 1983 Act") sets out circumstances in which persons liable to be detained under the Act may be treated without consent for their mental disorder. The 1983 Act has no application for treatment to physical disorders unrelated to the mental disorder, which remains subject to the common law principles of consent described in the main body of this policy. The Mental Health Act Code of Practice offers guidance on consent and medical treatment in this context.

2. Healthcare professionals must never assume that a patient lacks capacity simply because they are suffering from a mental disorder and/or they are detained under the 1983 Act. The patient's capacity must be assessed in every case in relation to the particular decision being made.

3. The Mental Health Act 2007 has made significant amendments to the 1983 Act but while the 1983 Act will continue to provide legal authority, within certain limits and subject to certain safeguards, to treat detained patients for mental disorder without consent, the following should be noted:-

   - It is not permissible to administer electro-convulsive therapy (ECT) to a patient who has capacity to consent to it, but who does not (including via an Advance Decision). The only exception to this would be in an emergency if it was immediately necessary to save a patient's life or to prevent a serious deterioration of the patient's condition.
   - It is not permissible to administer ECT as treatment for a mental disorder in any circumstances to any child or young person unless it has been independently approved in accordance with the 1983 Act.
   - Patients subject to a Community Treatment Order (CTO) may only be treated for mental disorder in accordance with the 1983 Act. Unless they have been recalled to hospital, it will not be permissible to treat such patients without their consent if they have the capacity to consent to the treatment in question but do not do so. Treatment for mental disorder of patients subject to CTOs who lack capacity to consent will be permitted subject to the rules set out in the new Part 4A of the 1983 Act.

4. However, none of these changes affect the principle that treatment for physical disorders unrelated to the mental disorder for which the patient is receiving compulsory treatment, does not come within the scope of mental health legislation.

Appendix J

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

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Outstanding care for our patients in ways which matter to them

Standard of Proficiency/ Competency Assessment in Gaining Consent to Treatment/ Investigation in Adults

(18+ years. Excluding that for Sedation or General Anaesthetic, Screening, Organ Donation, Post Mortem, Research or Practitioner's own Learning)

This Competency Tool is applicable to all Health Professionals new to the written consent process or wishing to update their knowledge and practice when:

- Seeking written consent for a treatment to be performed by another
- Seeking written consent for a treatment to be performed by themselves

This competence does not cover any initial decision to offer treatment but should include checking that the patient is aware of all options available to them where more than one option could be available

Until the competence is signed off and completed all episodes of consent should be undertaken with direct supervision from an accountable-practitioner who is already competent in the procedure or treatment being offered.

The trainee practitioner agreeing to undertake consent should ensure they comply with both their regulatory requirements and the policy of the organisation

Statement:

The Health Professional providing information for consent must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about the procedure.

The Healthcare Professional must receive Generic Principles of Consent Training. This training, if not already undertaken is available via their ESR eLearning account, eLearning module 000 Patient Consent – this should be successfully completed prior to commencing this competency tool.

Procedure Specific Training must be provided by a Healthcare Professional who is competent to undertake the procedure themselves and as such is service-specific (DCHFT Policy to Examination or Treatment Version 12 http://sharepointapps/clinguide/CG%20docs1/0127-consent.pdf)

Issue and implementation of this competence must be made in agreement with the Healthcare Professional's Line Manager and agreement of who will be able to undertake supervision and procedure specific training must be agreed.

Supervision in undertaking consent should be direct until the competence is signed off completed by the trainee, their supervisor and manager. A copy should held in the employees personnel file by the manager

The Practitioner undertaking to supervise and assess the trainee must check the person seeking consent is:

- conversant with the specific procedure
- understands risks and benefits
- understands alternatives and consequences of not accepting proposed treatment

It is essential that the Practitioner undertaking to complete this competence is fully up to date with their Core Mandatory Training and has accessed the most resent version of any Policies / Guidelines relevant to their practice in particular:

• Safeguarding Adults	• Safeguarding Children	• Mental Capacity Act
• Deprivation of Liberty Safeguards	• Dementia Awareness	• Equality & Diversity
• Information Governance	• completed 000 Patient Consent	• Fully conversant with the Trust Consent to Examination and Treatment Policy and how it may be applied to their practice
• Any local and national Policies and Guidelines Specific the their Area of Practice and the specific Treatment being assessed against		

This competence is issued to:

Name of Trainee…… Signature……Position……..

Authorised by …… Signature……Position……..

Supervisor/Assessor…… Signature……Position……..
The identified supervisor must be made in agreement with their manager

Date Issued……

This competence assessment has been issued for the assessment of gaining consent for:

1.	
2.	
3.	
4.	

Standard **The trainee is able to:**	**Evidence – Trainee to document for the specific procedure / treatment**	**Practitioner Self Declares** **Sign and Date**	**Assessor Agrees** **Sign and Date**
Underpinning Knowledge - Before Seeking Consent the trainee is able to:			
Identify why a written consent is required. e.g. • *Invasive* *High risk/side effects* • *Prolonged duration* • *Complexity of information* • Consequences to life style • *Expert Advisory Body recommendation*			
Explain the rationale for when and where consent is sought *(e.g. During consultation, not immediately prior to treatment where there are complex decisions to be made and it is a non-urgent procedure)*			

Demonstrate clearly that they can identify patients who are • *competent to consent* • *incompetent to consent* and actions/escalation to be taken when consent cannot be gained from the patient			
Standard **The trainee is able to:**	**Evidence – Trainee to document for the specific procedure / treatment**	**Practitioner Self Declares** **Sign and Date**	**Assessor Agrees** **Sign and Date**
Understand who is legally permitted to provide consent when consent is not possible by the patient for non-urgent care *This may include how and when the following apply:* • *Best Interest Decision* • *IMCA* • *Advanced Decisions/Living Wills* • *Lasting Power of Attorney for Health & Wellbeing*			
Understand the purpose of written consent and how this differs from valid consent and confirmation of consent			

Written consent is a means of recording decisions and information it does not prove validity of consent *Patients are still able to change their mind Having signed a consent form does not imply they have to continue with the plan – the right to withdraw consent*			
Select appropriate documentation • Type of Consent Form Needed • Leaflets and other Aids used to support information *Any Leaflets used should not be done so in isolation but as a supplement that the patient may refer back to to recall the information provided during the consent process*			
Standard **The trainee is able to:**	**Evidence – Trainee to document for the specific procedure / treatment**	**Practitioner Self Declares** **Sign and Date**	**Assessor Agrees** **Sign and Date**
When seeking consent for treatment to be undertaken by another the trainee practitioner is able to explain their own accountability in confirming that consent is Valid			
Before Seeking Consent but as part of the patient consultation the trainee is able to demonstrate that they can:			
Identify and discuss all the options for treatment/investigation including potential outcomes and risks/benefits with the patient	List Options		

All options must be identified where applicable *Specific Risks need to be discussed and where mitigation is possible must be offered as part of consent* *This could be as simple as pain relief or the need to wear personal protective equipment such as sunglasses, to as complex as sperm donation prior to administering certain medications* Demonstrate when joint agreement of option is confirmed	List Outcomes & Risks and any Mitigations Benefits		
Standard **The trainee is able to:**	**Evidence – Trainee to document for the specific procedure / treatment**	**Practitioner Self Declares** **Sign and Date**	**Assessor Agrees** **Sign and Date**
Gaining Consent the trainee is able to:			
Explain to the Patient fully what is involved and who will be delivering the treatment			
Demonstrate that they understand the steps needed to ensure consent is Valid and Confirmed • *All relevant information*			

Patient Consent Competency Assessment Framework, Practice Educator Dorset County Hospital

• *Understood* • *Retained* • *Communicate Decision*			
Accurately complete the required documentation for a Written Consent Able to demonstrate sufficient documentation on correct forms with further annotation in patient notes if required. *Either:* *Consent Form 3* *Or* *Consent Form 4 & Best interest decision form*			
Include how the patient will be able to Withdraw their Consent at any stage and their right to do so			
Standard **The trainee is able to:**	**Evidence – Trainee to document for the specific procedure / treatment**	**Practitioner Self Declares** **Sign and Date**	**Assessor Agrees** **Sign and Date**
This should be supervised and demonstrated at minimum of 10 times	Date	Trainee Signature	Supervisor Signature
	1		
	2		
	3		
	4		
	5		
	6		
	7		
	8		

	9		
	10		
Supervisor & Manager – your signatures signify your agreement that following a period of supervised practice and assessment, the trainee has now demonstrated an acceptable standard to continue unsupervised. **Trainee -** Here after it is understood that it is the your professional responsibility to maintain competence and currency in practice	**Person in Training** I now feel competent and capable to gain consent for the procedure identified in this document Name…….. Signature…….. Position…….. Date……..	**Supervisor** I confirm that this competence has successfully been achieved and adequate knowledge and capability has been demonstrated to proceed unsupervised Name…… Signature…….. Position…….. Date……..	**Manager** Please do not sign until all aspects of the competence are signed and completed Name…… Signature…….. Position…….. Date……

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