Consent for Examination or Treatment Policy

<table>
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<tr>
<th>CATEGORY:</th>
<th>Policy</th>
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<td>CLASSIFICATION:</td>
<td>Clinical Governance</td>
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<tr>
<td>PURPOSE</td>
<td>To set out the agreed policy for obtaining consent from patients prior to examination or treatment</td>
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Controlled Document Sponsor: Dr David Rosser Deputy CEO

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Controlled Document Lead: Richard Steyn

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Distribution

- Essential Reading for:
  - All those who carry out examinations or treatment on patients. All those with delegated responsibility to take consent

- Information for:
Consent for Examination or Treatment Policy

1 Policy Statement
1.1 The purpose of this policy is to detail clearly the structures and procedures, both Trust-wide and at specialty level, that apply to consent for Examination or Treatment.

1.2 The Department of Health has issued a range of guidance documents on consent (see references section), and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards for staff at the Trust taking consent to ensure they comply with the guidance, common law, Human Tissue Act 2004 and the Mental Capacity Act 2005. While 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 Scope
2.1 This Policy applies to all clinical services of the Trust and all clinical staff employed by the Trust including contractors, volunteers, students, locum and agency staff and staff employed on honorary contracts.

2.2 The policy does not cover taking consent for the following:
   2.2.1 consent for photographic images; this is detailed in the Trust Photographic, Video and Mobile Device Consent and Confidentiality Policy;
   2.2.3 data protection or use of patient records; and
   2.2.4 clinical trials

3 Framework
3.1 This section describes the broad framework for obtaining of consent for examination or treatment. Detailed operational instructions for the implementation of this policy are contained in the associated Consent for Examination or Treatment Procedure. The procedure may be amended by authority of the Medical Director, provided that such amendments are compliant with this policy.

3.2 The Trust's framework for ensuring full participation in consent encompasses the following:
   3.2.1 All staff providing care or treatment to a patient will first ensure that the patient has consented to receive treatment.
   3.2.2 All staff who obtain consent to treatment will either:
         a) be able to carry out the procedure; or
         b) be deemed competent to take consent for the procedure and have delegated authority to do so in accordance with the Consent for Examination or Treatment Procedure.

3.3 FY1 Doctors should not obtain consent for the performance of a procedure or examination by another practitioner.
If an FY1 Doctor is being supervised whilst performing a procedure the supervising practitioner should obtain consent. If FY1 Doctors are competent to perform a procedure unsupervised then the FY1 Doctor should obtain consent from the patient and where appropriate this should be evidenced by written consent.

3.4 If there is any suggestion that a patient lacks the capacity to consent then the practitioner will undertake an assessment of the patient's capacity, in line with the Mental Capacity Act 2005.

3.5 All staff making decisions on behalf of a patient who lacks capacity will, wherever possible, consult with the patient's representative and or carers as appropriate and will ensure, based on all evidence available, that the care provided is in the patient's best interest and take account of any preferences previously expressed by the patient.

3.6 All staff will respect patient's refusal of treatment when the patient is considered to have capacity to consent subject to 3.5.

3.7 When obtaining consent from a patient, information about what the examination or procedure entails and the risks, benefits and alternatives must be communicated in a way that the patient can understand. Whenever possible this information should be supported with patient information leaflets.

3.8 Where tissue is to be taken during a procedure for storage or use, specific consent must be taken and this must be recorded on the appropriate section of the consent form.

3.9 Training will be available to relevant staff

Delegated Consent
3.10 Clinical Directors in each specialty must ensure that the protocol for obtaining consent is followed and delegated consent competency is completed for each delegate. This will act as a guide to Junior Doctors and the Safety and Governance Department when undertaking any audit of consent.

4 Duties
4.1 Medical Director is responsible for ensuring there is a framework for reviewing compliance with the Trust policy and procedure, ensuring that the policy remains fit for purpose and is reviewed as required and at least every three years. This may be delegated to the Safety and Governance Department.

4.2 The Deputy Director for Governance
4.2.1 is responsible for monitoring adherence to this Policy as set out in the monitoring matrix in Appendix A.

4.3 Clinical Director/Senior Nurse
Senior Nurse refers to Matron or Sister/Charge Nurse
Clinical Director or Senior Nurse are responsible for ensuring that:
4.3.1 staff who will be given responsibility for taking delegated consent are identified and registered within their specialty;
4.3.2 a local procedure specific training programme is in place for staff to whom the consent process is delegated, and who are not capable of performing the procedure;
4.3.3 the Consent Competency Protocol, or a local equivalent, agreed with the Safety and Governance Department, is completed for each individual, and will provide confirmation that staff taking delegated consent have been given appropriate training to take consent for specific procedures;
4.3.4 a list of all individuals identified as taking delegated consent, and all completed competency statements are sent to the Faculty of Education.
4.3.5 where the annual consent audit identifies staff who have obtained consent for a procedure without being authorised to do so according to the Competency Statement records held, the staff member is immediately informed that they must not undertake such consent until they have been assessed as competent to do so;
   a) the staff member is given the appropriate training and has an assessment of competency undertaken within 28 days;
   b) the competency assessment document is sent to Safety And Governance Department.
4.3.6 If the annual consent audit identifies consent being obtained by FY1 level doctors inappropriately (see paragraph 3.3) then they will immediately inform that Doctor to stop taking inappropriate consent and advise their Clinical Director and their Educational Supervisor.
4.3.7 Ensuring that action plans are produced within their specialty, when necessary, as a result of the annual consent audit.

4.4 Divisional Directors/Associate Medical Directors
The Divisional Directors/Associate Medical Directors will
4.4.1 ensure Clinical Directors or Governance Leads identify where delegated consent is taken by staff not capable of performing the procedure, and maintain a register of those staff approved to obtain delegated consent and copies of their competency assessments.
4.4.3 maintain a record of which specialties undertake delegated consent, and contact Clinical Directors or Clinical Governance Leads and the Faculty of Education annually to ensure that this record is updated where required;
4.4.4 holding records of the individuals taking delegated consent, as identified by specialties;
4.4.5 holding records of all competency statements supplied by specialties.
4.4.6 monitoring compliance by conducting an annual consent audit, which will include checking that consent is being taken only by the appropriate staff in accordance with records of competency statements.
4.4.7 contacting the Clinical Service Lead where annual consent audit identifies staff who have obtained consent for a procedure without being authorised to do so according to the competency statement records held.

4.5 Medical recruitment
Will send Divisional Directors/Associate Medical Directors and the Faculty of Education a list of all medical training grade new starters and start dates on a monthly basis.
4.6 Faculty of Education

4.6.1 The Faculty of Education will be responsible for ensuring that any delegated consent protocol or local guideline includes details of how nursing and other staff are identified for taking delegated consent in the specialty, the arrangements for training and competency assessment, and the monitoring and auditing arrangements to ensure that all staff who obtain consent are authorised to do so.

4.6.2 Ensure the protocol or local guideline is on the Intranet.

4.7 All Staff

All staff providing treatment are responsible for ensuring:

4.7.1 that valid and effective consent has been provided by the patient and where written consent is required all Trust documentation has been completed as appropriate;

4.7.2 that where they are making decisions on behalf of a patient who lacks capacity they will, wherever possible, consult with the patient's representative and or carers and will ensure, based on all evidence available, that the care provided is in the patient's best interest and take account of any preferences previously expressed by the patient.

4.7.3 Will respect patient's refusal of treatment when the patient is considered to have capacity to consent subject to section 3.5 of the Procedure.

4.7.4 that they complete an incident form in line with the Incident Reporting and Management Policy and Procedure if there is any breach of this policy.

4.8 Consultant Staff

4.8.1 have an overall responsibility for the care of the patient and this will also extend to ensuring consent is appropriately obtained.

4.8.2 are to ensure that when delegating consent, delegates are fully trained and competent to obtain consent for the procedure in accordance with the Consent for Examination or Treatment Policy.

5 Implementation and Monitoring

5.1 Implementation

5.1.1 This policy will be communicated to all relevant staff via email.

5.1.2 The policy itself will be made available on the Trust intranet site.

5.2 Monitoring Appendix A provides full details on how the policy will be monitored by the Trust.

6 References

Department of Health (2009) Reference guide to consent for examination or treatment, 2nd Ed. (online) available at www.dh.gov.uk


UK Parliament (2005) Mental Capacity Act


General Medical Council (2008) Consent: patients and doctors making decisions together, (online) available at www.gmc-uk.org


NHSLA (2012/13) NHSLA Risk Management Standards

7 Associated Policy and Procedural Documentation
  7.1 Consent for Examination or Treatment Procedure
  7.2 Delegated Consent Policy
  7.3 Photographic, Video and Mobile Device Consent and Confidentiality Policy
  7.4 Incident Reporting and Management Policy and Procedure
### APPENDIX A: Monitoring

<table>
<thead>
<tr>
<th>Monitoring Of Compliance</th>
<th>Monitoring Lead</th>
<th>Reported To Person/Group</th>
<th>Monitoring Process</th>
<th>Monitoring Frequency</th>
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<tr>
<td>Adherence to this policy will be monitored by the Safety and Governance Department via an annual Trust wide audit of consent.</td>
<td>Deputy Director of Governance</td>
<td>Medical Director, Deputy Medical Directors, Divisional Directors/Associate Medical Directors</td>
<td>This will involve auditing a random sample of consent forms from those taking written consent in the Trust to ensure that documentation is being completed and that consent is being taken only by the appropriate staff.</td>
<td>Annually</td>
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<td>The results of the audit will be disseminated to specialty level where an action plan to improve the completion of the consent forms will be generated,</td>
<td>Deputy Director of Governance</td>
<td>Clinical Directors, exceptions will be reported to the Divisional Directors/Associate Medical Directors.</td>
<td>The responsibility for producing and implementing this action plan will be that of the Clinical Directors or Senior Nurses depending on the group of staff involved. The implementation of these action plans will be monitored by the Safety and Governance Department and exceptions reported to Medical Director, Divisional Directors/Associate Medical Directors.</td>
<td>Annually</td>
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