Consent to Examination or Treatment Policy and Procedure

Policy Statement: Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare.

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4.1	Draft	December 2010	Governance	Review in line with NHSLA standards	Revised policy
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1 Circulation

This Policy should be read by all staff involved in the consent process and applies equally to staff in a permanent, temporary or contractor role acting for or on behalf of the Heart of England NHS Foundation Trust (HEFT).

2 Scope

This policy addresses the procedures and responsibilities for obtaining consent to examination or treatment.

This policy does not address the topic of Delegated Consent, which is the subject of a separate Trust Policy.

3 Definitions

"Consent" is a patient's agreement for a health professional to provide care or treatment. For consent to be valid, the patient must:

- Have capacity to make the particular decision;
- Have received sufficient information to make it; and
- Not be acting under duress.

The Trust recognises two mechanisms for taking valid informed consent, they are:

- Classical Consent - Consent for the procedure is taken by the healthcare professional who is competent to perform the procedure.
- Delegated Consent - Consent is taken by a healthcare professional who is not competent to perform the procedure, but has been trained to take delegated consent for this procedure. Please see the delegated consent policy for more details.

4 Reason for Development

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. This right is enshrined in the Mental Capacity Act 2005, the Human Rights Act 1998 and in common law. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery (excluding compulsory treatment for mental disorder under Part IV of the Mental Health Act 1983).

Whilst gaining valid consent protects healthcare staff from charges of assault, battery or the criminal charge of ill treatment or neglect under the Mental Capacity Act, it is also a matter of common courtesy between health professionals and patients. Staff who take consent are responsible for ensuring they are familiar with the patient's medical history.

5 Aims and Objectives

- To ensure that consent is obtained lawfully and consistently
- To ensure that patients make informed decisions when they have the capacity to do so
- To ensure that patients who do not have capacity have decisions made regarding their treatment in line with the Mental Capacity Act.

6 Standards

The giving of consent by a patient to a particular intervention does not constitute the consent process. The consent process encompasses the whole process of information provision, discussion and decision-making as part of 'seeking consent'.

The consent procedure and process is outlined in **Attachment 1.**

6.1 Documentation

For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the treatment/investigation and the discussions that 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. The Trust monitors compliance with this requirement through annual documentation audits.

6.2 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 is not *proof* of valid consent. If a patient is rushed into 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.

A Trust consent form must be completed if any of the following circumstances apply:

- 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.

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

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 the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past) it would be helpful to do so.

6.3 Assessing Capacity

There is a presumption that patients who are 16 or over have the mental capacity to make decisions for themselves unless this can be proved otherwise:

"A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself to the matter because of an impairment of or disturbance in the functioning of, the mind or brain" (section 2(1) Mental Capacity Act 2005 (MCA))

In applying the above principle and deciding whether an individual has the mental capacity to make a particular decision, a healthcare professional must follow the test for capacity as set out in the "Mental Capacity Act 2005: Code of Practice" ("the COP") (Chapter 4). A person is unable to make a decision if they cannot:

- understand the information about the decision to be made (the MCA calls this relevant information);
- retain that information in their mind;
- use or weigh that information as part of the process of the decision making process; or
- communicate their decision (whether by talking, using sign language or any other means).

6.4 Independent Mental Capacity Advocates (IMCA's)

In most situations, people who lack capacity will have a network of support from family members or friends who take an interest in their welfare (see Chapter 10 COP). However, some people who lack capacity may have no one to support them with decisions about their healthcare or where they live so the MCA creates an Independent Mental Capacity Advocate (IMCA) to represent and support them in their best interests.

Health care professionals have a statutory duty to instruct and consult with an IMCA where:

- an NHS body is proposing to provide serious medical treatment; or
- an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and
    - the person will stay in hospital longer than 28 days, or
    - they will stay in the care home for more than eight weeks.

6.5 Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS) provides a legal framework to prevent the unlawful deprivation of a person's liberty occurring. It provides protection for vulnerable people aged 18 or over who lack the capacity to consent to care or treatment in a registered hospital or care home, who may need to be deprived of their liberty to protect them from harm.

6.6 Tissue

Most of the principles of consent found in this policy equally apply to removal or use of tissue from the living or deceased. However the Human Tissue Act 2004 (HTA) governs the law relating to such practice. In particular the HTA Code of Practice on Consent[1] should be considered when making decisions related to consent for the removal or use of tissue- whether from living or deceased persons.

[1] http://www.hta.gov.uk/_db/_documents/2006-07-04_Approved_by_Parliament_Code_of_Practice_1_-_Consent.pdf

6.7 Clinical Photography and Conventional or Digital Video Recordings

Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure and for what purposes the recordings will be used. For further guidance please refer to the Photographic & Video Recording Consent and Confidentiality Policy.

6.8 Research

No patient should be subject to research treatments without their explicit consent. Section 31 of the Mental Capacity Act 2005 sets out the consent requirements in relation to 'intrusive research'. Research is intrusive if it is of a kind that would be unlawful if it was carried out on or in relation to a person who had capacity to consent to it, but without his consent.

It is unlawful to carry out intrusive research on, or in relation to a person who lacks capacity to consent unless specific conditions are satisfied (see sections 30 to 33 of the Mental Capacity Act 2005).

When obtaining consent to participation in research treatments, healthcare professionals should take particular care to ensure that the patient has the fullest possible information about the proposed research study.

7 Responsibilities

7.1 All staff

All healthcare professionals that perform a procedure that requires consent to be taken are responsible for ensuring that the consent is valid; it is they who will be held responsible in law if this is challenged later. If consent for the procedure is not valid, then the healthcare professional performing the procedure may be liable for criminal charges of assault or battery, civil charges of trespass upon a person, or negligence.

Consent will be valid when it is given voluntarily by an appropriately informed person who has the capacity to consent to the procedure in question, and when it is taken by a healthcare professional who can perform the procedure or in accordance with the delegated consent policy.

All staff must notify the relevant ward manager and consultant the names and PIDs of patients that have been assessed as not having capacity to make a decision for examination or treatment.

7.2 Specific Staff responsibilities

Specific members of staff and committees have particular functions in relation to the Consent Policy as detailed below.

7.3 Chief Executive

The Chief Executive is ultimately responsible for ensuring that whenever consent is taken this is done by an appropriately trained individual. He / she will delegate this responsibility to the Director of Safety and Governance and the Group Medical Directors.

7.4 Director for Safety & Governance

The Director for Safety & Governance is responsible for ensuring that when consent is taken it is done appropriately and in accordance with this policy. This includes ensuring that all staff who take consent have been trained on how to consent for treatment. He/she is responsible for supporting the implementation of this policy and ensuring the policy is reviewed to incorporate any new legislation. These include reviewing the policy in light of new legislation. He/she is also responsible for ensuring there are appropriate systems in place and reporting compliance with this policy to the Board.

7.5 Group Medical Directors

The Group Medical Directors will oversee the implementation and compliance with this Policy in their respective Groups. They may delegate local operational responsibility to Clinical Directors.

7.6 Group Operation Directors

The Group Operation Directors are responsible for the operational delivery of the Consent Policy. The Group Operation Directors will be responsible for any action plan resulting from an audit, complaint or incident in relation to consent, and will provide reports on areas of non compliance to the Group Quality and Safety Committee.

7.7 Clinical Director

The Clinical Director has operational responsibility for ensuring that staff within their directorate adhere to this policy.

In the event that concerns are raised via incidents, complaints, claims, audit or observation regarding the competence of a healthcare professional to take consent, the Clinical Director is responsible for ensuring that the individual receives appropriate training to improve the quality of consent taking and monitors the individual's adherence to this policy.

7.8 Matron

Matrons are responsible for ensuring that the consent process is followed in line with this policy by nursing staff. This includes ensuring that the assessment of capacity is carried out correctly.

7.9 Safety and Governance Team

The Safety and Governance Team will carry out an annual audit of compliance against this policy. The results of this audit will be presented at the Directorate Audit forum and to the Clinical Standards Committee. Any areas of non-compliance will be highlighted so that appropriate action can be taken to rectify this.

7.10 Investigations Team

The Investigations Team is responsible for providing consent and Mental Capacity Act training to staff as necessary and providing advice on complex legal situations in relation to consent.

8 Committee responsibilities

8.1 Trust Board

The Trust Board is responsible for ensuring appropriate consent procedures are in place. The Trust Board will receive the policy as ratified by the Governance and Risk Committee and assurance reports in relation to compliance with this policy. Operational responsibility for this Policy is delegated to the Governance and Risk Committee and Group Quality and Safety Committees.

8.2 Governance and Risk Committee

The Governance and Risk Committee will ratify the policy. The Governance and Risk Committee will oversee compliance with the Consent Policy across the Trust and receive reports outlining remedial action that has been taken in relation to areas of concern regarding consent. It will delegate operational and monitoring responsibility to Group Quality and Safety Committees.

8.3 Group Quality and Safety Committee

The Group Quality and Safety Committee is responsible for ensuring that robust consent processes are integrated into the Trust's established clinical governance systems.

When required, the Group Quality and Safety Committee will provide assurance reports to the Governance and Risk Committee regarding remedial action that has been taken in relation to areas of non-compliance with this policy.

9 Training

The Investigations Team will ensure provision of training for relevant managers, supervisors, and clinical staff, to enable them to carry out their duties and responsibilities, relating to consent. Training is provided to all clinical staff (including nursing staff and allied healthcare professionals) on corporate induction.

In addition group training can be provided by the Investigations Teams on request.

10 Monitoring and Compliance

Compliance with this Policy will be monitored through a Trust annual audit of consent, which will be reported to each directorate, and the Clinical Standards Committee. In addition, all directorates will be required to assess compliance with the policy following any related incident or complaint.

Any areas of non-compliance with the policy highlighted by the audit or the directorate review will be reported to the Group Quality and Safety Committee. It is the responsibility of the Quality and Safety Committee to ensure that an action plan is developed and implemented, where necessary.

Criteria	Monitoring mechanism	Responsible	Committee	Frequency
Process for obtaining consent is obtained in line with policy	Documentation audit	Governance Team and Senior Investigations Manager	Clinical Standards Committee	Annually
Staff understand the process for recording consent	Documentation audit	Governance Team and Senior Investigations Manager	Clinical Standards Committee	Annually

New staff are trained on the consent and the MCA process	Attendance sheets Feedback from session	Mandatory Training and Senior Investigations Manager	Mandatory Training Committee	Monthly

11 Attachment 1: Consent Procedure

The giving of consent by a patient to a particular intervention does not constitute the consent process. The consent process encompasses the whole process of information provision, discussion and decision-making as part of 'seeking consent'.

The consent process may also involve reviewing a consent decision after the initial decision to consent has been made. For example, advising the patient of new evidence of risks or new treatment options and reconfirming their consent. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient's condition.

12 Consent Process

12.1 Single Stage Process

In many cases, it is 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.

As outlined in the policy, if a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient opportunity to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed.

12.2 Two or more stage process

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. This may be on just one occasion, or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages, i.e. the information stage and the confirmation stage. In the eventuality that consent has been obtained within a primary care setting, consent still needs to be obtained within the Trust.

12.3 Information stage

This stage involves the provision of information about the treatment/investigation, discussion of options between the patient and the healthcare professional, and the patient's initial (oral) decision. Before patients can come to a decision about treatment, they need comprehensive information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). Healthcare professionals must ensure that they provide patients with sufficient information to enable them to make an informed judgment on whether to give or withhold consent. It is advisable for healthcare professionals to inform the patient of any significant, unavoidable or frequently occurring risks.

Once a decision to have a particular treatment/investigation has been made, patients should also be provided with information about the procedures for admission and their inpatient stay; where to go, how long they will be in hospital, how they will feel afterwards and so on.

Healthcare professionals should also seek patients' views on possible additional procedures which may be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue.

With patients for whom English is not their first language, healthcare professionals must ensure that all appropriate steps are taken to facilitate patients' understanding of the information provided. This may be via the use of an interpreter, or patient information leaflets printed in their language. More information about these sources of patient information can be found in Attachment 10.

The consent form should be used as a means of documenting the information provided to the patient and the signing of a consent form stands as evidence that the patient and the clinical team have discussed the patient's procedure and the associated risks. 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.

12.4 Confirmation stage

If a form is signed before a patient arrives for treatment, the member of the healthcare team responsible for the procedure **must** check with the patient at this point whether they have any further concerns, whether their condition has changed and whether they wish to continue with the procedure. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure.

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.

13 Anaesthesia

Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks with the patient. 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. Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or 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.

14 Emergencies

In emergencies, the two stages of consent (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.

In emergency situations patients may not be able to consent to treatment. At such times clinicians can act in the patient's best interests but should seek to ensure that an adult patient has not registered a Lasting Power of Attorney, appointing someone else to consent to or refuse treatment on the patient's behalf or that they have not made a valid Advance Decision refusing treatment. Details on these two points can be found in sections 17.5 and 19.

15 Documentation

For significant procedures as outlined in the consent to examination and treatment policy, it is essential for health professionals to document clearly both a patient's agreement to the treatment/investigation and the discussions that led up to that agreement. This should be done through the use of a consent form (with further detail in the patient's notes if

necessary). The Trust monitors compliance with this requirement through annual documentation audits. For minor procedures, consent can be documented in the patient's medical records.

Standard consent forms and forms for adults who are unable to consent for themselves are available through the Trust stationary ordering system. These forms can also be located electronically on the Trust's SharePoint site by using the keyword "Consent".

There are four versions of the standard consent form:

- **Form 1** for adults or competent children
- **Form 2** for parental consent for a child or young person under 18 who is not able to consent for themselves
- **Form 3** for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care
- **Form 4** for adults who lack the capacity to consent

The use of form 3 is optional but may be thought more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.

The standard consent form provides space for a health professional to record information provided 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 and are aware of their own knowledge limitations (in accordance with the Delegated Consent Policy).

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 confirm that the patient still wishes to go ahead with the procedure and answer any further questions which the patient may have. This reconfirmation should be indicated on the consent form by both the patient and a healthcare professional. 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, although the healthcare professional in question MUST have access to appropriate colleagues to respond to questions which they cannot answer.

16 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 is not *proof* of valid consent. If a patient is rushed into 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.

A consent form must be completed if any of the following circumstances apply:

- 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.

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

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 the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past) it would be helpful to do so.

17 Assessing Capacity

There is a presumption that patients who are 16 or over have the mental capacity to make decisions for themselves unless this can be proved otherwise:

"A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself to the matter because of an impairment of or disturbance in the functioning of, the mind or brain" (section 2(1) Mental Capacity Act 2005 (MCA))

In applying the above principle and deciding whether an individual has the mental capacity to make a particular decision, a healthcare professional must follow the test for capacity as set out in the "Mental Capacity Act 2005: Code of Practice" ("the COP") (Chapter 4):

17.1 What is the test for capacity?

Stage 1

Does the person have an impairment of, or disturbance in, the functioning of the person's mind or brain?

This stage requires proof that the person has an impairment of the mind or brain, or some sort of disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Mental Capacity Act (see further paragraphs 4.11-4.12 COP) (it does not matter if this is permanent or temporary).

Stage 2

Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make a specific decision (see paragraph 4.13 COP). It must be remembered that an assessment of capacity is relevant only to the particular treatment planned and does not mean that the patient is then unable to make other decisions about their care or treatment.

Patients must be given all practical and appropriate support to help them make a decision for themselves (see Chapter 2 of the COP). Stage 2 can only apply if all practical and appropriate support to help the person make decision has failed (see Chapter 2 COP)

17.2 Inability to make a decision

Once the above two stage test has been satisfied, a healthcare professional must then decide whether the patient has an "inability to make a decision".

A person is unable to make a decision if they cannot

- understand the information about the decision to be made (the MCA calls this relevant information);
- retain that information in their mind;
- use or weigh that information as part of the process of the decision making process; or
- communicate their decision (whether by talking, using sign language or any other means).

The first three points should be applied together. If a person cannot do any of these three things, they will be treated as unable to make the decision. The fourth point only applies in situations where people cannot communicate their decisions in any way. For further guidance, see paragraphs 4.16 – 4.25 in the COP.

Ward Manager and/or Consultant to check documentation of the outcome capacity assessment in the medical records.

17.3 Incapacitated patients and best interests

Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, **only an attorney appointed under a Lasting Power of Attorney by the patient or a court appointed Deputy may give consent or refuse treatment on their behalf if authorised to do so.** However, treatment may be provided by clinicians in the patient's best interests provided the patient has not made a valid and applicable Advance Decision refusing the specified treatment. For further details on Advance Decisions and Lasting Powers of Attorney see sections 19 and 17.5 of this procedure.

The Mental Capacity Act gives clear guidance on the efforts that clinicians should make in involving patients who lack capacity in the decision making process and includes a Best Interests Checklist that **must be completed for every decision that is taken "in the best interests" of a mentally incapacitated patient**. The Best interest's checklist is set out in 'Assessment of Capacity' tool at **Attachment 4.** A healthcare professional has a statutory duty under the Mental Capacity Act to apply the Best Interests Checklist in accordance with the Mental Capacity Act and the Code of Practice. In arriving at that Best Interests decision, the Healthcare Professional has a duty to consult with friends, family or unpaid carers or if applicable an IMCA before arriving at a Best Interests decision.

Any decision to proceed with a treatment in the patient's best interests must be documented on consent form 4 (form for adults who lack the capacity to consent to investigation or treatment), along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and that consultation has been undertaken with the involvement of people engaged in caring for the patient or interested in their welfare. The standard consent forms should never be used for adult patients unable to consent for themselves. For more minor interventions, this information should be entered in the patient's notes.

17.4 Independent Mental Capacity Advocates (IMCA's)

In most situations, people who lack capacity will have a network of support from family members or friends who take an interest in their welfare (see Chapter 10 COP). However,

some people who lack capacity may have no one to support them with decisions about their healthcare or where they live so the MCA creates an Independent Mental Capacity Advocate (IMCA) to represent and support them in their best interests.

An IMCA is a specific type of advocate that will only have to be involved if there are no family or friends or unpaid carers who can be consulted or where it is not appropriate to consult, e.g. the person is abroad and cannot be contacted or vulnerable adult protection procedures have been instigated. An IMCA will not be the person who will make the decision as to what treatment is in the patient's best interests, but the person who will make that decision has a duty to consult with an IMCA and to take into account the views expressed by the IMCA before arriving at a best interests decision. An IMCA is not a decision maker and healthcare professionals are not bound by their views.

Health care professionals have a statutory duty to instruct and consult with an IMCA where:
an NHS body is proposing to provide serious medical treatment; or
an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and
- the person will stay in hospital longer than 28 days, or
- they will stay in the care home for more than eight weeks.

If it is identified that an IMCA is required please use one of the telephone numbers below:

For patients at Heartlands and Good Hope Hospitals call Advocacy Matters 0121 354 6136 or 07813 847 520, or you can complete an Advocacy Matters IMCA Referral Form, located on the policy sharepoint site on the Trust internet.
For patients at Solihull Hospital call POhWER 0300 456 2370, or you can complete a Pohwer IMCA referral form, located on the policy sharepoint site on the Trust intranet.

17.5 Lasting Power of Attorneys

People aged 18 and over can formally appoint someone to make decisions about their health, personal welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. The power which is given to someone else is called a Lasting Power of Attorney (LPA) and the person appointed will be known as an attorney. The person making an LPA is called the donor. The LPA will give the attorney authority to make decisions on behalf of the donor and the attorney will have a duty to act or make decisions in the best interests of the person who has made the LPA.

There are two different types of LPA:

- A personal welfare LPA is for decisions about both health and personal welfare
- A property and affairs LPA is for decision about financial matters

Please note a checklist, for staff dealing with a potential Lasting Power of Attorney, can be found at **Attachment 6**.

When faced with an LPA, healthcare professionals should read the LPA if it is available in order to understand the extent of the attorney's power. For example, a personal welfare LPA may limit the types of decisions which the attorney may make on the patient's behalf. If there is concern about the remit or validity of an LPA document or if there is dispute within an LPA as to what is in the patient's best interests please contact the Investigations Team or on call manager immediately.

18 Refusal of Treatment by Adults

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. An adult patient who has capacity is entitled to refuse any treatment (except in circumstances governed by Part IV of the Mental Health Act 1983 – see Attachment 11) and this decision must be respected, even where this may result in death.

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.

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.

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.

19 Advance Decisions

A person aged 18 or over may make an advance decision to set out what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent to this treatment for themselves in the future.

An Advance decision must be made by a person when they do have capacity to make decisions. Advance decisions do not need to be in writing, however if the decision is in relation to life-sustaining treatment, it must be in writing, witnessed and signed, and include the explicit term 'even if life is at risk'. All advance decisions must include the specific treatment the patient wants to refuse, and the circumstances in which the refusal will apply.

If a person has made an advance decision refusing a particular medical treatment, and that advance decision is valid and applicable, then the refusal has the same force as when a person with capacity refuses treatment. Failure to follow an advance decision could result in criminal or civil liability.

If a health care professional feels that an advance decision is not valid, or is not applicable to the treatment in question, health care professionals can continue to treat the patient as long as such treatment is in their best interests, and the Investigations Department should be informed of the situation as soon as possible.

Please note a checklist, for staff dealing with a potential Advance Decision statement or document, can be found at **Attachment 8**.

20 Reasons for refusal

Where a competent patient refuses treatment, their wishes must be respected, even where the reason for that decision may seem irrational.

One common treatment refusal is that of blood or blood products. Commonly such patients will be a patient who is one of Jehovah's Witnesses however other patients are often reluctant to accept blood products due to fears of, for example, HIV or CJD infection. Jehovah's Witnesses in particular will invariably not permit any of the following to be administered in their treatment:

1. Whole blood;
2. Red cells;
3. Plasma;
4. Platelets;
5. White cells.

Fractions of any of the above four primary components (2-5) may be acceptable but are a matter of individual patient choice. If certain blood products are refused by a competent patient clinicians should discuss alternative blood derivates as detailed above with the patient and consider the possibility of cell salvage. The Blood Transfusion Co-ordinator should be contacted to advise in such circumstances.

The general position of Jehovah's Witnesses on a range of clinical treatments can be found at Attachment 5.

21 Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS) provides a legal framework to prevent the unlawful deprivation of a person's liberty occurring. It provides protection for vulnerable people aged 18 or over who lack the capacity to consent to care or treatment in a registered hospital or care home, who may need to be deprived of their liberty to protect them from harm.

The majority of people who will require the protection of the MCA DOLS are those with more severe learning disabilities, older people with a range of dementias or people with neurological conditions such as brain injuries.

A patient's Primary Care Trust is responsible for administering the MCA DOLS at a local level and are defined as a **Supervisory Bodies.**

The Heart of England is defined as the **Managing Authority.** The Ward Manager and patient's Consultant will assess the patient to identify if they need to be deprived of their liberty and complete the necessary forms. The forms will need to be sent to the Supervisory Body.

There are two types of Authorisation which can be requested from the Supervisory Body:

Standard - Standard authorisations will be the most common type, applied for in advance of a person being deprived of liberty when it is known this is likely to happen, and only after rigorous care planning methods have indicated that less restrictive measures cannot meet the person's needs. The six statutory assessment requirements (listed below) must be met. A standard authorisation should last only for as long as is necessary.

Urgent - urgent authorisation can be issued where there is a need to deprive someone of their liberty immediately in their own best interests to protect them from harm or if particular treatment is needed urgently (the managing authority **must** do this initially). In this situation, the hospital or care home can issue itself an urgent authorisation. However, a standard application to the Supervisory Body **must** be made at the same time as the urgent authorisation. The Supervisory Body must then complete the standard assessment process

within 7 days from the urgent self authorisation taking effect or, where this is not possible, the Supervisory Body can authorise a further urgent authorisation for 7 days.

The decision to authorise an urgent self authorisation is made by the Managing Authority. This decision must be recorded in writing, including details of why it decided to give an authorisation. An application seeking standard authorisation must then be completed and sent to the Supervisory Body.

The application forms can be accessed via the intranet under policies and procedures entitled Deprivation of Liberty Standards forms and record keeping.

The Assessment

Once the Supervisory Body has received and assessed the form they will then instruct a Best Interest Assessor to attend to the patient and carry out the following assessment. Assessments must be undertaken to establish whether the relevant person meets six qualifying requirements:

Type of Assessment	**Purpose of Assessment**
Age Assessment	The purpose of the assessment is simply to confirm whether the relevant person is aged 18 or over.
No Refusals Assessment	The purpose of the assessment is to establish whether an authorisation to deprive the relevant person of their liberty would conflict with another existing authority for decision-making for that person; such as a valid decision by a Court Appointed Deputy or an advance decision to refuse treatment.
Mental Health Assessment	To establish whether the patient has a mental disorder within the meaning of the Mental Health Act 1983. This is not an assessment to determine whether someone requires mental health treatment.
Mental Capacity Assessment	The purpose of the assessment is to establish whether the relevant person lacks capacity to decide whether or not they should be accommodated in the relevant care home or hospital to be given the care of treatment.
Eligibility Assessment	The purpose of the assessment is to clarify the relevant person's status or potential status under the Mental Health Act 1983. For example a person would not be eligible for a deprivation of liberty authorisation if they are detained as a hospital inpatient under the Mental Health Act 1983.
Best Interests Assessment	The purpose of the assessment is to establish if deprivation of liberty is occurring or is going to occur and if so, whether: • It is in the best interest of the relevant person to be deprived of their liberty • It is necessary for them to be deprived of liberty in

	order to prevent harm to themselves and • Deprivation of liberty is a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm.

It is necessary for a minimum of two different suitably qualified assessors, one of whom must be a section 12 approved doctor, to carry out the assessment. The DOLS Co-ordinator from the supervisory body will notify all parties of the decision and subsequent actions using the relevant standard forms.

If any of the assessments find that the relevant person does not meet the qualifying requirements, a deprivation of liberty authorisation cannot be issued.

If the requirements of all six assessments are met, then the supervisory body will grant an authorisation to deprive the relevant person of their liberty to protect them from harm, provided this is in their best interests and there is no less restrictive alternative. **The authorisation will be issued in writing by the Supervisory body to the Managing authority.**

A relevant person's representative (RPR) must then be appointed as soon as possible by the Supervisory Body. The maximum authorisation is 12 months and it is always subject to review or suspension at any time throughout the duration.

22 Treatment of Children & Young People

22.1 Children under the age of 16

The Mental Capacity Act does not apply to children under the age of 16 except in relation to the criminal offence of ill treatment or neglect which applies to children under 16 who lack capacity as no lower age limit is specified for the victim.

A child who lacks capacity

If a child is not competent to give consent to treatment, consent should be sought from a person with 'parental responsibility'. This will often be the child's parent but may include a guardian as appointed by the child's parent or the courts. Only one person with parental responsibility needs to give consent for the consent to be valid and the treatment to be lawfully given.

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. If any doubt exists about whether the person claiming parental responsibility for the child actually has that right, further advice should be sought from the Investigations Department.

In the event that a person with parental responsibility refuses to consent to treatment in the child's best interests, it may be necessary to make an application to the High Court to seek a declaration that the treatment is in the child's best interests and is lawful. In these circumstances, contact the Investigations Department who will instruct a Solicitor to act on behalf of the Trust. While decisions are being challenged, doctors must provide treatment to the patient to preserve life or prevent serious deterioration.

Gillick capacity

Children under 16 are not automatically presumed to have capacity to make decisions about their health care. However, a child under the age of 16 can be competent to consent to treatment on their own behalf if they are considered to be "Gillick" competent to make decision for themselves. A child will be considered to be Gillick competent if they have sufficient understanding and intelligence to understand fully what is involved in the proposed intervention. In these circumstances, consent is valid and it is not necessary to obtain additional consent from a person with parental responsibility.

There is no specific age when a child becomes *Gillick* competent to consent to treatment; it depends both on the child and on the seriousness and complexity of the treatment being proposed. Nevertheless in determining whether a child has capacity to make such a decision the health care professional should take into account, and document, his/her assessment of the child in relation to:

- Whether the child is able to comprehend and retain information (the nature, purpose and complications of treatment) material to the decision, especially regarding the consequences of having or not having the intervention in question, and
- Whether they can make a value judgement, balancing the risks and benefits?

A Gillick competent child's refusal to treatment can however be overridden by a person with parental responsibility or the courts (see here paragraph 9.4 below). Where the treatment is required as an emergency and necessary to preserve life, doctors may give treatment despite the child's refusal (this known as the "doctrine of necessity")

Healthcare professionals have a duty of confidentiality to patients who have *Gillick* capacity. In the majority of cases parents will accompany the child to a consultation and even where the child is Gillick competent, it is good practice to involve the child's family in the decision making process provided the *Gillick* competent child consents to their involvement. Where a child is seen alone, efforts should be made to persuade the child that his or her parents should be informed except in circumstances where it is clearly not in the child's best interest to do so. Healthcare professionals must however respect the views of the Gillick competent child in the event that they do not wish for their parents to be involved.

22.2 Treatment of young people (Children aged 16 and 17)

Competent 16 and 17 year old

A child aged 16 or 17 is presumed to be capable of consenting to medical treatment as if they were an adult by virtue of section 8 of the Family Law Reform Act 1969.

If a young person 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 young person's consent. It is however good practice to involve the young person's family in the decision making process provided the young person consents to this.

Incapacitated 16-17 year old

The MCA applies to young people aged 16-17 years who may lack capacity in accordance with the test for capacity under the MCA (see section 7 above and Chapter 12 COP). Healthcare professionals carrying out acts in connection with the care and treatment of a young person aged 16-17 who lacks capacity to consent within the MCA generally have protection from liability as long as the person who is carrying out the act:

- has taken reasonable steps to establish that the young person lacks capacity
- reasonably believes that the young person lacks capacity and that the act is in the young patient's best interests, and
- follows the MCA's principles.

When assessing the young person's best interests (see Chapter 5 of the COP), the person providing care or treatment must consult those involved in the young person's care and anyone interested in their welfare, providing it is practical and appropriate to do so. This may include the young person's parents.

Voluntariness

Although a child or young person may have the capacity to give consent, healthcare professionals must remember that this is only valid if it is given voluntarily. This is something which should be carefully considered as children and young people may be subject to undue influence by their parent(s), other carers or a sexual partner. Healthcare professionals must establish that the decision is that of the child or young person him or herself.

Refusal of treatment by children or young people

Where a competent child or young person refuses medical treatment which is in their best interests, it is possible that such a refusal could be overruled if the refusal would in all probability lead to death or severe permanent injury for the child or young person. In these circumstances, individuals with parent responsibility can consent to the treatment on the child's or young person's behalf. It may also be necessary to make an application to the court for an Order which declares the proposed treatment lawful despite the child's refusal. Healthcare professionals should refer to the Department of Health's *Seeking consent: working with children* for more information and chapter 12 of the Mental Capacity Act Code of Practice.

23 Tissue

Most of the principles of consent found in this policy equally apply to removal or use of tissue from the living or deceased. However the Human Tissue Act 2004 (HTA) governs the law relating to such practice. In particular the HTA Code of Practice on Consent[2] should be considered when making decisions related to consent for the removal or use of tissue- whether from living or deceased persons.

24 Clinical Photography and Conventional or Digital Video Recordings

Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure and for what purposes the recordings will be used. For further guidance please refer to the Photographic & Video Recording Consent and Confidentiality Policy.

[2] http://www.hta.gov.uk/_db/_documents/2006-07-04_Approved_by_Parliament_Code_of_Practice_1_-_Consent.pdf

25 Research

No patient should be subject to research treatments without their explicit consent.

Section 31 of the Mental Capacity Act 2005 sets out the consent requirements in relation to 'intrusive research'. Research is intrusive if it is of a kind that would be unlawful if it was carried out on or in relation to a person who had capacity to consent to it, but without his consent.

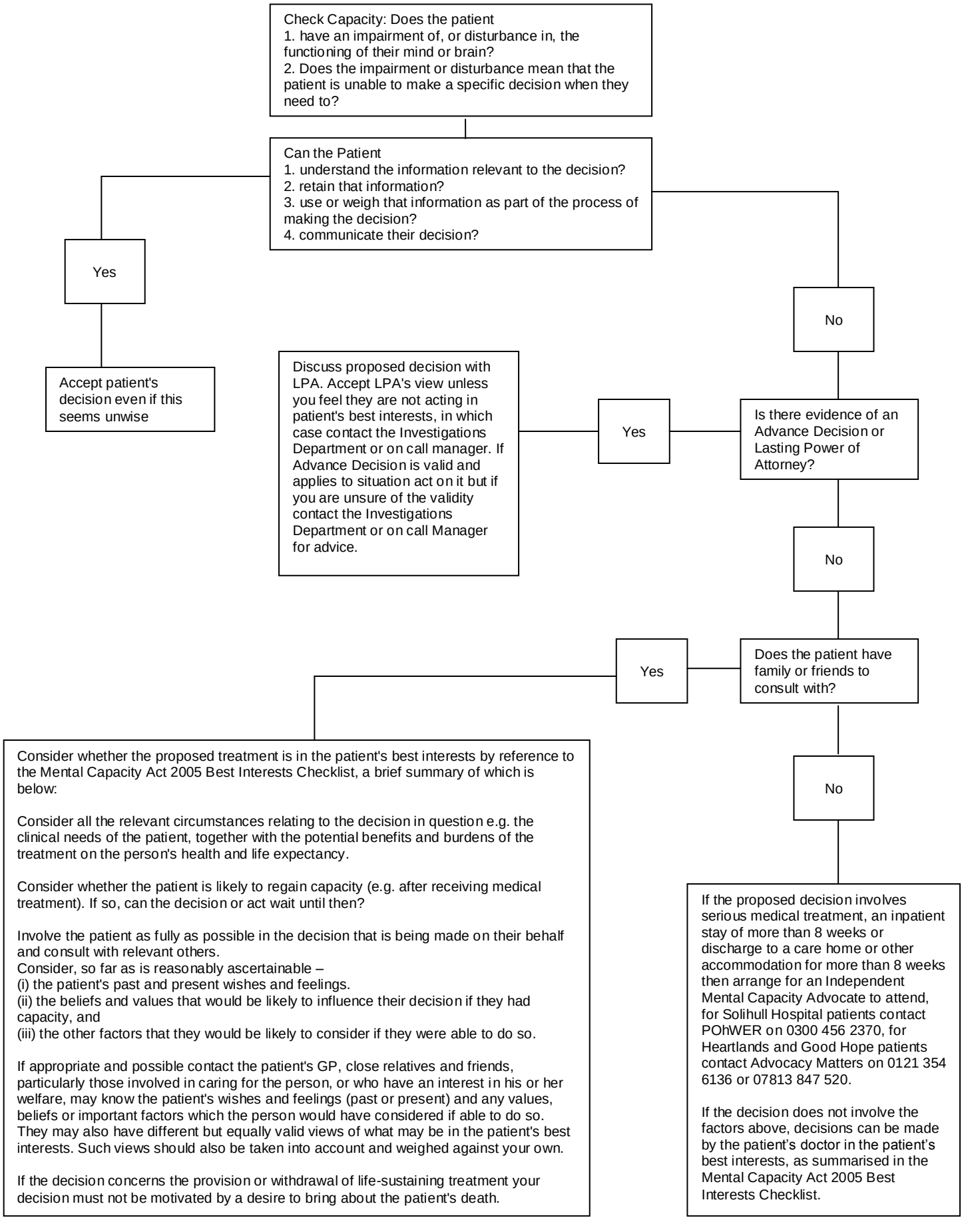
It is unlawful to carry out intrusive research on, or in relation to a person who lacks capacity to consent unless specific conditions are satisfied (see sections 30 to 33 of the Mental Capacity Act 2005).

When obtaining consent to participation in research treatments, healthcare professionals should take particular care to ensure that the patient has the fullest possible information about the proposed research study.

Section 31 of the Mental Capacity Act and its guidance does not however apply to clinical trials of medication. These trials are subject to the Medicines for Human Use (Clinical Trials) Regulations 2004 (“Clinical Trials Regulations”). Full details on the requirements for research on subjects who do not have capacity can be found in chapter 1 of the Mental Capacity Act’s Code of Practice.

This flowchart is a summary of the decisions and actions to be taken when considering capacity related treatment or decision making. It should only be used in conjunction with the detail contained within the Consent Policy and not as a standalone guide.

26 Attachment 2: MCA FLOWCHART



27 Attachment 3: Consent - A quick guide

Treatment must only be carried out if you have the patient's consent. Treatment without valid consent may result in criminal prosecution for assault/battery, a civil claim or breach of the Human Rights Act 1998. The provision of appropriate information to allow the patient to reach a decision is crucial in that process.

Certain patients may be unable to consent because they lack the mental capacity to do so. In making decisions regarding a patient's capacity and treatment therein, healthcare professionals have a statutory duty to follow and implement the principles and procedures under the Mental Capacity Act 2005 (MCA) and the Code of Practice.

If a patient has the mental capacity to consent to the treatment you may proceed. If a patient has capacity, and has been given comprehensive information to make an informed decision, and they refuse the treatment you must accept their decision, even if it seems unwise.

If the patient does not have the capacity to consent to the treatment you must check for any Advance Decision that may have been made in advance of the patients incapacity or check for the existence of a valid Lasting Power of Attorney document that might mean that someone else, appointed by the patient, can make the decision on their behalf. If there is no Lasting Power of Attorney or Advance Decision you can act in the best interests of the patient. You must consult with friends, family and unpaid carers in making a decision in a patient's best interests. If the treatment proposed is serious medical treatment or the patient is likely to be in hospital for a period greater than 28 days, you have a duty to consult with an Independent Mental Capacity Advocate (IMCA) prior to making a decision in the patient's best interests.

If treatment is required urgently, particularly to save life or maintain health, and there is no time to check for a Lasting Power of Attorney or Advance Decision (or the validity of one), or to involve an IMCA, you can proceed with treatment as long as that treatment can be said to be in the patient's best interests.

Not all treatments require a patient to sign a consent form. More minor procedures or treatments can be documented within the patient's medical records, noting that the patient has consented verbally to the treatment having been given the appropriate information. Procedures that have a greater level of risk require the signing of a consent form. There are 4 different consent forms, which can be ordered via the Trust stationary order system or downloaded from the policies website on the intranet.

Consent must be gained for the removal of any tissue taken during surgery or of tissue or organs taken post mortem.

Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure and for what purpose. They should then gain consent for the recording to be made and used for those purposes.

28 Attachment 4: Mental Capacity – Assessment of Capacity

Patient Name & PID (Insert Banda label)

Date:_____

Patients must have Mental Capacity when making decisions about their care. You should assume a person has capacity unless proved otherwise. If there is **any doubt** in the patient's capacity to make a decision relating to their care and/or treatment then the following questions should be asked:

1. What is the specific decision/action needed to be taken, for which the patient requires capacity?

2. Have you made every effort to assist the patient to make this decision themselves? Yes/ No

The Test – please circle 'yes' or 'no':

- Can the patient understand the information necessary to make this decision at this time? Yes/No
- Can the patient retain the information for long enough to make this decision? Yes/No
- Can the patient weigh up the information in order to make this decision? Yes/No
- Can the patient communicate their decision? Yes/No

Comments:

If the answer to any question in the test is "No", the patient does not have capacity to make this decision at this time and you must complete the remainder of this form.

If all four answers are "yes", the patient should make the decision. You must respect the decision, even if it seems unwise.

Result: Does the patient have capacity to make this specific Decision? Yes/No
(Document the rationale for this in medical notes)

Signed:	Name:	Date:

Remember: patients may have capacity to make some decisions but not others – this assessment needs to be carried out per decision

Lack of Capacity Established for Specific Decision above

1. Is there any prospect of the patient regaining capacity before the decision must be made? Yes/No
   (***If yes, defer decision and reassess later, if no, continue***)

2. Who within the Trust is responsible for ensuring this decision is made?

3. Does the patient have a valid Advance Decision to Refuse Medical Treatment which is relevant to this situation? Yes/No
   (If "Yes, this decision is binding unless overridden by Mental Health Act)

4. Is there a Lasting Power of Attorney appointed to make healthcare decisions on behalf of the patient? Yes/No
   (If "Yes", they should be contacted and asked to make the decision)

If you have any queries regarding an Advanced Decision or Lasting Power of Attorney, please contact the Investigations Team.

5. Does the decision require the engagement of an Independent Mental Capacity Advocate (IMCA)? Yes/No
IMCA must be engaged if patient is unbefriended and needs Serious Medical Treatment
IMCA must be engaged if patient is unbefriended and needs a Change in Accommodation
IMCA can be engaged if differences of opinion amongst family members
Contact IMCA if patient stay is more than 28 days in NHS or 8 weeks in registered care
If Adult Protection Issues must consider IMCA
Has an IMCA been contacted? Yes/No
For patients at Heartlands and Good Hope Hospitals: **Advocacy Matters – 0121 3546136**
For patients at Solihull Hospital: **POhWER 0845 223 0440** or IMCA@pohwer.net referral forms are available on http://www.pohwer.net/

Signed Name Date

Mental Capacity: Best Interest Decision Record for specific decision above

Best Interests Checklist – to be used if patients have not made an advanced decision or arranged a person to have Lasting Power of Attorney

Activity Undertaken	Yes	No	NA
Has the patient been involved in the Decision as far as possible?			
Have appropriate records been consulted?			
Have Family & Carers been consulted as appropriate?			
Has an advocate been accessed?			
Have other staff been consulted?			
Has the patient's wishes, feelings, beliefs and values been considered?			
Have less restrictive options been considered?			
Have all relevant circumstances been considered?			

Note 1: If the decision concerns life-sustaining treatment, the decision maker must not be motivated by a sole desire to bring about death

Note 2: Best interests decisions must be non - discriminatory

Details (Enter any details in this box, e.g. names of people consulted, wishes considered but not followed, other options rejected. The level of detail should reflect the seriousness of the decision)

Record the Decision in Patients Medical Notes (Detail to be proportionate to seriousness of decision)

Signed Name Date

29 Attachment 5: Jehovah's Witnesses' Position on Medical Treatment

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.

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.

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.

AUTO TRANSFUSION
Immediate intra-operative autotransfusion 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.

BLOOD TESTS
No objections

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.

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

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

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.

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

SERUMS
Not forbidden, although some Witnesses conscientiously refuse them.

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

30 Attachment 6: 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 at the Court of Protection?**

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 donee does not have power to make decisions about the patient's healthcare. The donee needs to apply for an LPA for the patient's healthcare before they can make decisions about the patient's healthcare.
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 donee 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 donee 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 donee to make decisions and, if so, have they been consulted?

YES/NO

If “yes” and the document states that the donees have “joint and several” responsibility then any one donee may give the necessary consent or refusal of treatment in the patients best interests. Proceed to Question 9. If it is only “joint” then *all* must agree to the proposed management. If the donees do agree, proceed to Question 9, otherwise follow the best interests checklist.

If “no” then proceed with the relevant authority from the single donee and proceed to Question 9.

9. Has the donee 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 donee(s) make any decision.

10. Are the the donee(s) acting in the best interests of the patient?

YES/NO

If “yes” then proceed in accordance with the wishes of the “donee”
If “no” consideration should be given to referring the matter to the Court of Protection and the case should be reported to the Investigations Team in order to obtain legal advice.

31 Attachment 7: Important Facts about Lasting Power of Attorney's (LPA's)

- 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.
- 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.
- 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.
- 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 donor'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.
- 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.
- 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.

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 Investigations Team or on call manager.

32 Attachment 8: 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;

- 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 person (donee) with a Lasting Power of Attorney, created after the AD was made, giving the donee 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 Decision 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**

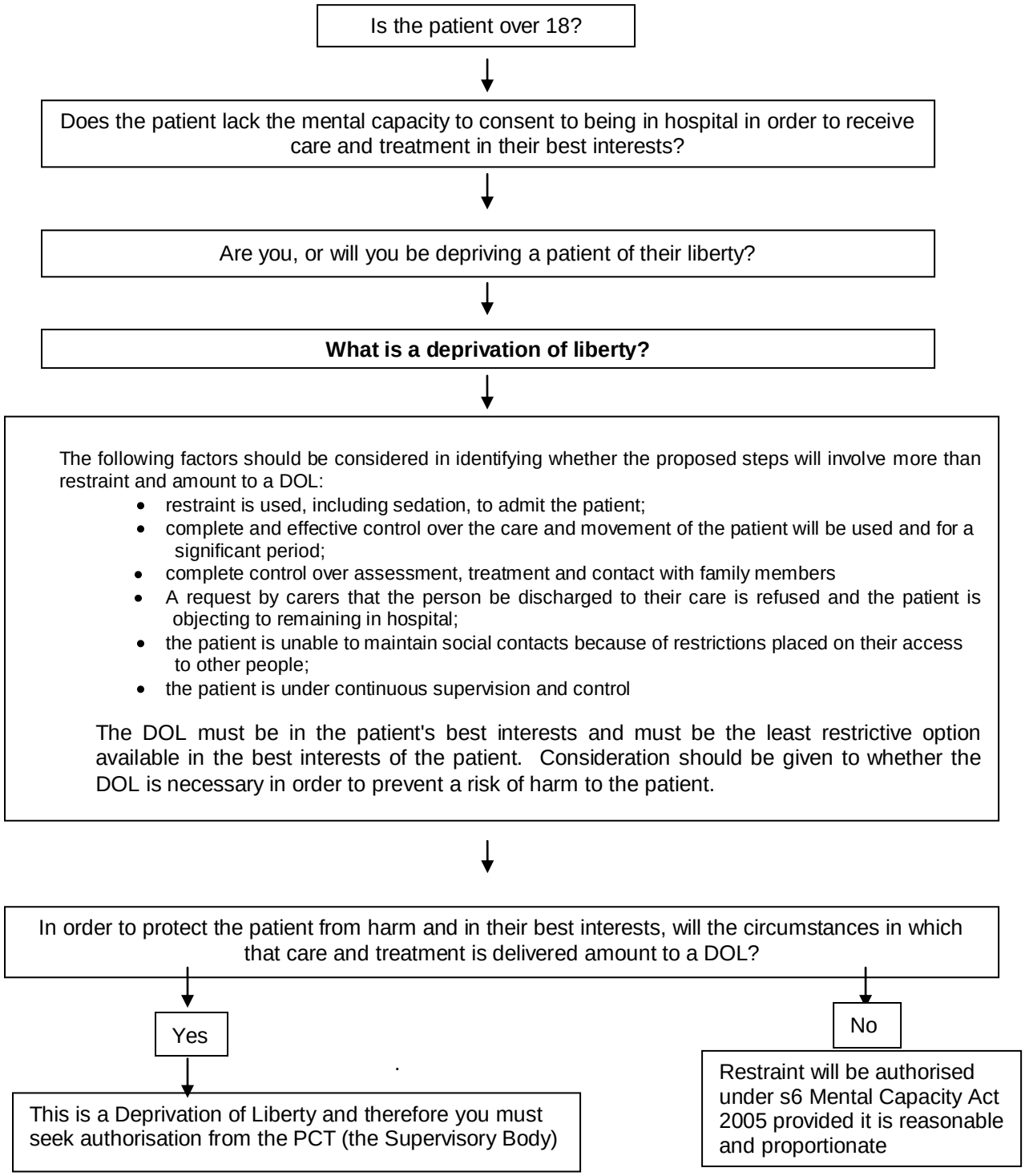
- It must be in writing, which includes being written on the person's behalf or recorded in their medical notes.
- It must be signed by the maker in the presence of a witness who must also sign the document. It can also be signed on the maker's behalf at their direction if they are unable to sign it 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.

33 Attachment 9: Making Decisions Regarding Deprivation of Liberty and the Application Process

The following flow chart should be followed prior to a planned admission where possible and reviewed or considered during inpatient stay



Authorisation procedure

1. Inform the Matron of the clinical area and the patient's Consultant of the circumstances;
2. Review the decision with the member of the team applying for the DOLS;
3. Application for the DOLS will be made in writing by the Senior Sister, deputy or Senior Nurse on duty;
4. It is best practice to pre-empt the need to deprive a patient of their liberty and for a DOLS application to be made in advance using the standard authorisation process which must be completed within 21 days. A standard authorisation form must be completed by using the Department of Health forms (http://sharepoint/safeguardingadults/default.aspx
5. If the patient is already being deprived of their liberty (for example, in an emergency), urgent self authorisation must be arranged which lasts for 7 days whilst the standard authorisation process is underway. In such circumstances, an urgent self authorisation should be made and a standard authorisation form must be completed at the same time by using Department of Health (DH) forms http://sharepoint/safeguardingadults/default.aspx
6. It will be the responsibility of the Senior Sister, deputy or Senior Nurse to oversee the application and to feed back to the MDT & the Matron for Safeguarding Adults of the outcome of the application
7. Complete an IR1

Procedure for completing the application for authorisation

1. The completed DOLS application forms together with relevant assessments and care plans should be faxed securely to the Birmingham PCT on 0121 380 9232. Or for Solihull patients to 0121 711 6224.
2. A Best Interest Assessors and Section 12 Doctor (appointed by the PCT) will review the application, visit the patient on the ward and make a series of assessments
3. If all assessments concur, the DOL will be authorised for a stipulated time period. An Independent Mental Capacity Advocate (IMCA) may be appointed.
4. You will be given copies of the authorisation, assessments and subsequent actions as soon as practicable. A Relevant Person's Representative will be appointed and it is important that the ward staff know who this person is and their role.
5. In the event that authorisation is given, it will be the responsibility of the Senior Sister or deputy to monitor any conditions attached to the authorisation. The outcome of the application and the actions/conditions attached to the authorisation must be communicated to the team responsible for the patient's care via the MDT meetings and form part of the patients care plan.
6. If authorisation is denied, it will be unlawful to deprive the patient of their liberty and the relevant controls/restrictions must be ceased and/or not carried out

34 Attachment 10: Sources of Patient information

1. Patient Advice and Information Database (PAID)

The Trust has a Patient Advice and Information Database (PAID) which provides a library of Patient Information Leaflets written by professional staff within the Trust, which are written to contain information about risks, benefits and alternatives to treatment. Information has also been reproduced (with permission) from legitimate sources e.g. Royal College of Surgeons. All Information is audit checked and signed off by the Clinical Director responsible for each speciality.

PAID is designed to be used by any member of staff (with the correct authorisation) the database is an online system accessible via the Trust's Intranet.

The system produces the first sheet of each leaflet personalised to the patient, printing the patient's name, hospital Number, Sex, Date of Birth and NHS Number at the top of the leaflet. All documents are currently produced in "standard" print size, but leaflets will become available in large print formats**.**

The system records against the electronic patient record when the leaflet was printed, who requested the information and what version of the information was printed. This links into and forms part of the electronic audit trail for each patient.

Version control is operated through the system manager and all documents have a review date, and are archived and updated by the system manager.

Approximately 10% of all leaflets produced are checked by a separate, group, including patients and carers for readability and plain English.

2. **Inpatient Bedside Folder**

The Trust has an Inpatient Bedside Folder available by each bedside, which gives information useful to patients, their relatives and carers. As well as covering general information about the hospital, the folder also has sections on:

- Teaching and Training of medical students
- Consent to Treatment
- Laboratory Medicine (Pathology)
- Keeping your medical records safe (Confidentiality in the NHS)

3. **Provision for patients whose first language is not English**

This 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.

The Trust has an Equal Access Co-ordinator who is part of the Quality Management Department.

Information about access to the Interpreting Services is available on the Quality Management Department website on the Trust Intranet, as is the Operational Policy for the use of the interpretation service. The interpretation service provides:

- Access to verbal interpreters for 5 South Asian languages;
- In-house software to translate patient information from English into any relevant written language, which is available to all departments;
- Access to an external verbal translation service as part of the Birmingham Integrated Language and Communication Strategy (BILCS) which is hosted by Heart of Birmingham PCT;
- Telephone access to a verbal interpreting service for emergency and out of hours requirements in the Accident and Emergency Departments.
- The Trust is also committed to offering equity of access to its services for all patients placing a high value on the respect and dignity of the individual, recognising social and cultural diversity. Equal access means that everyone, irrespective of their ethnic origin, race, colour, age, gender or disability, are able to gain entry, understand and utilise appropriate information and fully participate in care decisions.
- If a patient does not understand English and if the circumstances permit it is appropriate to enlist the aid of an interpreter. It is not appropriate to use children to interpret for family members who do not speak English.

4. **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 leaflets. This Trust has made the following arrangements to assist patients to obtain such information:

- Patients who require further information can contact their clinician or may seek assistance from the Patient Advisory Liaison Service. Details of how the patient can contact PALS are contained within the leaflet 'Patient rights and responsibilities' held in each department throughout the Trust.
- PAID also provides Trust contact telephone numbers and links to information from other sources i.e. NHS Direct, Cancer, BACUP.

5. **Access to health professionals between formal appointments**

After an appointment with a health professional in primary care or out-patients, patients will often think of further questions which they would like answered before they take 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. Health professionals should therefore ensure that the patient is given an appropriate telephone number of the clinic, specialist department or pre-op assessment should they require further advice in relation to any concerns.

6. **Open access Clinics**

Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need before proceeding with an investigation or treatment.

A significant number of patients will have their assessments performed at outpatient clinics, and information regarding their intended treatment and consent can be provided at this point.

7. **Healthcare Information Centre**

The Healthcare Information Centre is a resource for patients, visitors and staff within Heartlands and Good Hope hospitals. It provides a wide range of material in a variety of formats including booklets, leaflets, video, audiotape, CDROM and the Internet. Wherever possible material will be made available in the language and format of choice expressed by the service user. A television and video is available to enable people to access information provided in this media. An audio tape player will also be provided.

Access to the Internet will be made available to users in two ways. They can choose to use the facilities without direct support, or they can ask a member of staff to assist them in their information search. The homepage users will be directed to is the EQUIP database, written and regularly update by the NHS. Information requests are welcomed by telephone or email.

There will be a selection of nationally recognised and readily available leaflets for public use i.e. British Heart Foundation and Diabetes UK. Validated materials that have been written locally relating to specific services within the Trust and local community will also be available. Guidance will regularly be sought from clinicians as to the suitability of the material on offer.

8. **Independent Mental Capacity Advocates (IMCA's)**

When an IMCA is required for patients at Heartlands and Good Hope Hospitals, contact Rethink on 0121 326 7022. For patients at Solihull hospital contact POhWER on 0845 223 0440. These services are available 9am – 5pm on Mondays to Fridays. If a decision cannot wait until the services are available, treatment must be provided by a doctor in the patient's best interests.

35 Attachment 11 Exceptions to the Principles of Consent

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.

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.

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.

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.

36 Attachment 12 Equality Impact Assessment

Policy/Service Title: Consent to Examination or Treatment	**Directorate: Healthcare Governance**
Name of person/s auditing/developing/authoring a policy/service: Clara Cooper	
Aims/Objectives of policy/service: to define a systematic approach and required standards for the development, ratification, implementation, monitoring, review and retirement of Policies and associated Procedures.	

Policy Content:

- For each of the following check the policy/service is sensitive to people of different age, ethnicity, gender, disability, religion or belief, and sexual orientation?
- The checklists below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant with equality legislation.

1. Check for DIRECT discrimination against any group of SERVICE USERS:

Question: Does your policy/service contain any statements/functions which may exclude people from using the services who otherwise meet the criteria under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
1.1	Age?		x				
1.2	Gender (Male, Female and Transsexual)?		x				
1.3	Disability?		x				
1.4	Race or Ethnicity?		x				
1.5	Religious, Spiritual belief (including other belief)?		x				
1.6	Sexual Orientation?		x				
1.7	Human Rights: Freedom of Information/Data Protection		x				

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

2. Check for INDIRECT discrimination against any group of SERVICE USERS:

Question: Does your policy/service contain any statements/functions which may exclude employees from operating the under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
2.1	Age?		x				
2.2	Gender (Male, Female and Transsexual)?		x				
2.3	Disability?		x				
2.4	Race or Ethnicity?		x				
2.5	Religious, Spiritual belief (including other belief)?		x				
2.6	Sexual Orientation?		x				
2.7	Human Rights: Freedom of Information/Data Protection		x				

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING DIRECT DISCRIMINATION = 0

3. Check for DIRECT discrimination against any group relating to EMPLOYEES:

Question: Does your policy/service contain any conditions or requirements which are applied equally to everyone, but disadvantage particular persons' because they cannot comply due to:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
3.1	Age?		x				
3.2	Gender (Male, Female and Transsexual)?		x				
3.3	Disability?		x				
3.4	Race or Ethnicity?		x				
3.5	Religious, Spiritual belief (including other belief)?		x				
3.6	Sexual Orientation?		x				
3.7	Human Rights: Freedom of Information/Data Protection		x				

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

4. Check for INDIRECT discrimination against any group relating to EMPLOYEES:

Question: Does your policy/service contain any statements which may exclude employees from operating the under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
4.1	Age?		x				
4.2	Gender (Male, Female and Transsexual)?		x				
4.3	Disability?		x				
4.4	Race or Ethnicity?		x				
4.5	Religious, Spiritual belief (including other belief)?		x				
4.6	Sexual Orientation?		x				
4.7	Human Rights: Freedom of Information/Data Protection		x				

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING INDIRECT DISCRIMINATION = 0

Signatures of authors / auditors: **Clara Cooper** **Date of signing: 21/01/2010**

37 Attachment 12: Consultation and Ratification Checklist

Title	Consent to Treatment and Examination Policy

	Ratification checklist	Details
1	Is this a: Policy	
2	Is this: Revised	
3*	Format matches Policies and Procedures Template (Organisation-wide)	**Yes**
4*	Consultation with range of internal /external groups/ individuals	**Yes**
5*	Equality Impact Assessment completed	**Yes**
6	Are there any governance or risk implications? (e.g. patient safety, clinical effectiveness, compliance with or deviation from National guidance or legislation etc)	**Yes. Compliance with policy is mandatory for patient safety**
7	Are there any operational implications?	**No**
8	Are there any educational or training implications?	**Yes, provided via corporate induction and mandatory training**
9	Are there any clinical implications?	**Yes - clinical staff should comply with policy**
10	Are there any nursing implications?	**Yes - nursing staff should comply with policy**
11	Does the document have financial implications?	**No**
12	Does the document have HR implications?	**No**
13*	Is there a launch/communication/implementation plan within the document?	**Yes**
14*	Is there a monitoring plan within the document?	**Yes**
15*	Does the document have a review date in line with the Policies and Procedures Framework?	**Yes**
16*	Is there a named Director responsible for review of the document?	**Yes**
17*	Is there a named committee with clearly stated responsibility for approval monitoring and review of the document?	**Governance and Risk Committee**

Document Author / Sponsor

Signed …… ……

Title……

Date……

Ratified by (Chair of Trust Committee or Executive Lead)

Signed …….…… ….……..……

Title…….……..……

Date……..……..……..……

38 Attachment 13: Launch and Implementation Plan

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Action	***Who***	***When***	***How***
Identify key users / policy writers	Senior Investigations Manager	January 2011	Full communications launch Walkarounds on each site re checklists
Present Policy to key user groups	Senior Investigations Manager	January 2011	Walkaround on each site
Add to Policies and Procedures intranet page / document management system.	Governance Gatekeeper	January 2011	Trust Intranet
Offer awareness training / incorporate within existing training programmes	Senior Investigations Manager	Ongoing	Corporate Induction and mandatory training programme
Circulation of document(electronic)	Governance Gatekeeper	January 2011	Trust Intranet