C4: Consent to Care and Treatment Policy

Document Summary Table	
Person Responsible for Policy:	Clinical Services Manager
Date of Approval:	15/03/2023
Next Review Date:	31/03/2025
Ratified by:	Hospice Governance Group

AIMS OF THE POLICY

To ensure that suitable procedures are in place for obtaining, and acting in accordance with, the consent of patients in relation to the care and treatment provided to them.

SCOPE

This policy applies to all employees (including sessional and bank staff), volunteers, visitors and contractors.

This policy relates to all patients (adults, children and young people) accessing all services provided by Blythe House Hospicecare and Helen's Trust

THE POLICY

In [Montgomery v Lanarkshire Health Board, 11 March 2015], the Supreme Court firmly stated that informed consent is now part of English law.

In recognition of the significance of consent to care and treatment, the Care Quality Commission (CQC) includes 'need for consent' as one of its fundamental standards which came into force on 1 April 2015. Breaches of 'need for consent' or its components will constitute a prosecutable offence. This means that where care and treatment is given without valid consent, and/or against the specific wishes of the patient or without lawful authority, the CQC can move directly to prosecution without first serving a warning notice.

The Clinical Services Manager will:

- Ensure that the requirements of this policy are included in local induction and training;

- Ensure that all healthcare professionals understand the principles of consent outlined in this policy;
- Ensure that health care professionals involved in taking consent for examination or treatment undertake role-related mandatory training.

Healthcare professionals must obtain valid consent before examination or treatment. Valid consent means obtaining consent from:

- a properly informed person;
- who has the capacity to consent;
- free from undue influence i.e. voluntarily

Assessment of capacity to consent identifies the patient's ability to make a particular decision at a particular time. For adults who lack capacity to consent, staff should consult the Hospice's Mental Capacity Act Policy (C6), and have regard to the Mental Capacity Act Code of Practice. Staff should also be aware that the patient may have an attorney (person with a lasting power of attorney for health and welfare decisions – LPA), an independent mental capacity advocate (IMCA) or a court appointed deputy acting on their behalf.

Young people aged 16-17 are presumed to be able to consent for themselves subject to their having capacity to make the decision in question [Family Law Reform Act 1969 and Mental Capacity Act 2005]. Children below 16 may be competent to give consent depending on their maturity and the nature of the decision. Appendix 1 provides a further guide to application of law to consent.

Any conversations with children must be pitched at an appropriate level for their level of understanding.

Where a child is not competent to give consent, only a person (or body) with parental or guardian responsibility may consent on the child's behalf.

Consent may be oral or written. Not all consent needs to be written, but written consent can provide evidence that consent has been discussed with the patient.

Consent forms need to be signed AND dated by the person giving consent.

For photographs and video recordings, written patient consent must be obtained using the Hospice's Consent to Photography or Video recording form.

Duration of consent

Consent is a continuous process rather than a one-off decision. It is important that patients are given continuing opportunities to ask further questions, to review decisions about their health care and to change or withdraw their consent if they choose to do so.

When a patient gives valid consent to an intervention, that consent remains valid for an indefinite duration unless the patient withdraws it. However, if new information becomes available regarding the proposed intervention/procedure (for example new evidence of risks or new treatment options) between the time when consent was sought and when the intervention/procedure is undertaken, the health care team should inform the patient and reconfirm their consent. Similarly, if the patient's condition has changed significantly in the intervening time, it may be necessary to seek consent again, on the basis that the likely benefits and/or risks of the intervention/procedure may also have changed

PROCEDURE

It is expected that referrals received into the Hospice will include information that confirms consent to refer to Hospice services has been provided by the patient or their representative. Where consent has not been included, the referrer will be asked to obtain consent in order for the Hospice to action the referral.

Following their initial triage and/or assessment, patients are asked to give their consent to the implementation of their agreed personal support plan and any care, treatment and support they receive, and to the request to their GP for the provision of appropriate medical information.

Written patient consent is specifically required before a complementary therapy or treatment is given.

Patients are provided with information about how to change any aspect of their support plan including how to withdraw or change their consent at any time.

Where appropriate, key workers will discuss advance care planning with individual patients and complete the necessary documentation to ensure that their wishes for future care are recorded should their condition deteriorate and they are unable to communicate their wishes.

Key workers will be sensitive in their discussions with patients regarding their wishes about resuscitation in the event of cardiac or pulmonary arrest. They will document that information to ensure that members of the multi-disciplinary team are aware of any mandates not to resuscitate.

RELEVANT LEGISLATION, GUIDANCE AND REFERENCES

Children's Act 1989
Gillick Competence 1996
Family Law Reform Act 1969
Mental Capacity Act (MCA) 2005
Mental Health Act 1983

This policy should be read in conjunction with the following Blythe House Hospicecare and Helen's Trust policies:

- C6 Mental Capacity Act Policy

MAPPING TO RELEVANT REGULATORY BODY

NMC
CQC
BACP
Complementary Therapy Professional Bodies

VERSION HISTORY

Version	Approved by	Revision date	Description of change	Author
1	Hospice Governance Group	02/2021		SL
2	Hospice Governance Group	03/2023	Update	Clare Walker

APPENDICES

Appendix 1: Diagram to guide application of law to consent

<table>
<tr><th>Age in Years</th><th>Children's Act 1989</th><th>Gillick Competence 1996</th><th>Family Law Reform Act 1969</th><th>Mental Capacity Act (MCA) 2005</th><th>Mental Capacity Act and Safeguarding</th><th>Mental Health Act 1983</th><th>Family Courts or Family Division of High Court</th><th>Court of Protection</th></tr>
<tr><td>0

11</td><td rowspan="3">Someone with 'Parental Responsibility' required to consent.

In emergency situations the consultant may consent in the child or young person's best interests.</td><td>Approx age….</td><td></td><td>Only applies to decisions about property and financial affairs (from the Court of Protection)</td><td rowspan="3">MCA can apply if someone mistreats or neglects a child who lacks capacity</td><td rowspan="4">Mental Health Act may apply if neither Children's Act or MCA appropriate</td><td rowspan="3">Generally hear cases involving CYP where there are disagreements between parties (YP, person with PR and/or care providers). Decisions only apply until YP 18 years old.</td><td rowspan="4">Hear cases where decisions would apply beyond 18 years old e.g. where a 17 year old is to live who will not regain capacity.</td></tr>
<tr><td>12

15</td><td>Young people can consent if 'Gillick Competent' This is generally in addition to consent from PR but may be instead of.</td><td></td></tr>
<tr><td>16

17</td><td>Presumes that YP have capacity to consent except for
• Organ Donation
• Non therapeutic procedures
• Research</td><td>Applies if someone lacks capacity to make a decision. Note exceptions cannot:
• make Lasting Powers of Attorney
• make advanced decisions to refuse treatment
• make a will</td></tr>
<tr><td colspan="6">There are currently no specific rules for deciding when to use either the Children Act 1989 or the Mental Capacity Act 2005 or when to apply to the High Court. Seek advice if unsure.</td></tr>
<tr><td>18+</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Evidence required</td><td>Consent</td><td>Consent</td><td>Consent</td><td>MCA two stage test of capacity</td><td>MCA two stage test of capacity</td><td>MHA documentation</td><td>Court order</td><td>Court order</td></tr>
<tr><td>Confidentiality</td><td colspan="7">Care should be taken not to unlawfully breach a YP right to confidentiality</td><td></td></tr>
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