**Heathgate Medical Practice**
**Policies and protocols**
**Consent to examination or treatment**

## Purpose

Patients have a fundamental, legal and ethical right to determine what happens to them and therefore consent to treatment is central to all forms of healthcare. Seeking consent is also a matter of common courtesy between the clinician and the patient.

The purpose of this policy is to set out the Practice approach to consent and the way in which the general principles of the Department of Health Guidance on the subject will be adopted here.

## Background

Consent is a patient's agreement for a healthcare professional to provide care or treatment. It can be provided verbally, non–verbally or in writing. Clinicians must be satisfied that a patient understands and consents to a proposed procedure[1], ensuring they are aware of its nature, the purpose and any associated risks, through clear two way communication, prior to its commencement.

**Implied consent**
This is consent that is not expressly grant by a person but rather inferred from a persons actions and the circumstances of a particular situation. It will be assumed for many routine physical contacts with patients.

**Expressed consent**
Expressed consent may be verbal or in written form and is clearly unmistakably stated. It may be obtained for any procedure, which carries a risk, that the patient or clinician is likely to consider as being substantial.

Whilst a signature on a consent form is evidence that a patient has given consent, it is not proof of a valid consent. It is rarely a legal requirement to seek written consent but is considered good practice, particularly where;

- The procedure is considered complex or involves significant risks.
- The procedure is considered extremely intimate.
- An anaesthesia or sedation is used.
- There may be significant consequences for the patient including their life style or employment after the procedure.

[1] This includes immunisation, surgical procedures, examination or other treatment

## Our policy

Considering the background information above, clinicians will discuss with patients the reasons, process and associated risk of any proposed procedure and in all cases, prior consent to this, should be obtained.

Any questions raised by the patient will be answered honestly and relevant information provided (written if necessary) to enable the patient to reach an informed decision about providing consent.

The clinician obtaining consent will be fully qualified and have the recognised competencies to undertake the proposed procedure.

Our clinicians will use their professional judgement as to whether implied or expressed consent is required.

Clinicians will obtain written consent where procedures carry a degree of risk or where they consider it appropriate to do so. No alteration will be made to the form after it has been signed. The Practice uses the standard NHS Consent Form 3 (CSP 07/03), copies of which are held in our reception areas.

Clinicians will ensure that consent is given freely and not under duress.

The scope of the consent provided will not be exceeded unless it is an emergency.

## Capacity to provide consent

Clinicians must in all cases ensure the patient is competent and has the capacity (including the mental capacity) to provide consent.

The test of capacity in patients under the age of 16 is whether they are 'Gillick competent'. If they are able to understand information about their condition and the implications of either proceeding with the proposed investigations, or doing nothing, they should be considered competent to provide consent.

There are clinical codes in SystmOne to record Gillick Competency.

The Practice has a separate Practice guide to Gillick and Fraser Competency guidance.

If a patient has the capacity to give consent but is physically unable to provide a written consent that is sought, the clinician should ask an independent witness to confirm the patient has given consent verbally. All aspects of this approval (both from the patient and the witness) must be documented.

Where consent is sought from a patient who does not have the mental capacity to provide such, the consent of the main carer (or some who holds the appropriate form of Power of Attorney) should be obtained and recorded.

Clinicians seeking consent from patients who are unable to communicate verbally because of language barriers, should seek other means of communicating, considering the use of NHS translation services where appropriate.

Only people with 'parental responsibility or guardianship' are entitled to give consent on behalf of children, (except those who are considered Gillick competent).

Clinicians should check first with the person accompanying the child whether they have such responsibility – see below.

For child immunisations, the expressed consent of one parent is sufficient for an immunisation to be given.

**Parental responsibility**

Someone with parental responsibility may consent to treatment on behalf of a non-competent child up to the age of 18 in England.

Unless she lacks capacity herself, a child's mother automatically has parental responsibility. A father will have parental responsibility if any of the following conditions apply:

1. He is married to the mother of his child (or was married to her at the time of the child's birth).
2. He has made a parental responsibility agreement.
3. He has obtained a court order granting him parental responsibility.
4. The child was born after 15th April 2002 in NI, 1st December 2003 in England or Wales or 4th May 2006 in Scotland and the father is named on the child's birth certificate.

**Withdrawal**

There may be occasions where consent has been obtained but during the procedure or investigation, a patient withdraws. If so, the procedure must be stopped and a further discussion and new consent to continue obtained. This subsequent consent must not be forced. For example with a blood test;

| |
|---|
| A patient may have agreed to have the sample taken and an arm offered but when the clinician attempts to insert the needle into the arm, it is withdrawn. In this case, despite the verbal consent, no attempt should be made to force the patient to have the sample taken. Further consent should be discussed and obtained before continuing. |

All withdrawals should be recorded in the patient record.

**Recording consent**

Consent (using Systm1 functionality where available, such as child immunisations) should be recorded in the patient record where the clinician deems it appropriate – i.e. for immunisations, minor surgery and intimate examinations. It will not be necessary to record for example when a patient provides their arm (implied consent for a blood test) or agrees for a clinician to listen to their chest as part of a consultation about a chest infection.

If written consent is taken, this should be recorded and the consent form scanned to the patient record.

The clinician should also consider recording the basis and background to the discussions, which led to the consent being agreed such as 'written information on the procedure given'.

**Associated policies and protocols**

Our chaperone policy should be considered when certain procedures are discussed, considered and undertaken.

| | |
|---|---|
| New policy created | 13th September 2012 |
| Reviewed | 12th May 2018 |
| Next review due | 12th May 2020 |