CONSENT AND THE MENTAL CAPACITY ACT
(LAWFUL AUTHORITY FOR PROVIDING EXAMINATION, CARE OR TREATMENT)

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1. Introduction

This Policy provides comprehensive advice on the process of obtaining lawful consent for all patients, including those who lack capacity to consent and those detained under the Mental Health Act (MHA) 1983 cared for by the University Hospitals of Derby and Burton NHS Foundation Trust (the Trust). It is essential that all healthcare professionals understand and practice the principles and processes for acquiring lawful authority for undertaking the examination, care and treatment they undertake each day. Health professionals must be also be aware of the relevant legislation and Codes of Practice and also any guidance on consent and mental capacity issued by their own regulatory body. This will ensure patient rights are protected, protect individual professionals from unfounded complaints or claim as well as protect the Trust, given the vicarious liability they have for the individuals they employ.

The principles of consent in general are embedded within an iterative process which includes appropriate and accurate documentation of the proposed procedure, including risks and benefits to the patient.

The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them.

Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. When a patient formally gives their consent to a particular intervention, this is only the endpoint of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking 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.

In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

All capable adults have a right to determine what happens to their own bodies. Articles 3 of the European Convention on Human Rights (ECHR) (brought into legislative force by the Human Rights Act 1998 (HRA)) provide support to this long- established common law principle. Valid lawful authority for providing or administering examination, care or treatment is therefore always required. Ensuring appropriate lawful authority is in place to undertake examination, care or treatment is absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery.

If an adult has the capacity to consent to or refuse examination, care or treatment, lawful authority can only come from their valid and informed consent or, where they lack capacity, by application of the processes of the Mental Capacity Act 2005 (See appendix 1) or where they are detained under the MHA, by following the procedures laid out in Part 4 (or Part 4A for Community Treatment Order patients) of the MHA (for treatment for mental disorder only).

The situation in relation to 16 and 17-year old patients is generally now the same as for adults. Although the common law still suggests that a competent 16 or 17-year old patients refusal of examination, care or treatment can be overridden by the consent of a person with parental responsibility (PR) for them, all

guidance and advice is that further legal authority is sought before proceeding (e.g. court order) should this situation arise. (See Appendix 2 for guidance with regard to identification of who has PR).

In relation to children of 15 and under (see Appendix 3): if they have the capacity to consent to the examination, care or treatment then their valid and informed consent provides sufficient lawful authority for proceeding with the examination, care or treatment (although ideally the parents would also be involved). As above, although the common law still suggests that a competent child's refusal can be overridden by the consent of a person with parental responsibility for them, all guidance and advice is that further legal authority is sought before proceeding (e.g. court order) should this situation arise. Where a child of 15 or under lacks the capacity to make the decision, the lawful authority to proceed can be found in the consent of an individual with parental responsibility (see Appendix 2)

In interpreting this Policy and the procedures contained within it staff are expected to consider the following overarching principles:

- For consent to be valid it must be given voluntarily (free from coercion or force) by an appropriately informed person who has the capacity to consent to the intervention in question. Acquiescence or compliance where the person does not know what the intervention entails is not consent
- All patients aged 16 or over should be assumed to have the capacity to give or with-hold their consent to all examination, care or treatment proposed or suggested unless it can be demonstrated that they lack this capacity in respect of that decision at that time
- Whether it is thought that the patient has capacity or not, all patients (and their carers) must be provided with time and easily understandable information about their care and treatment that helps them to make informed decisions and choices
- All efforts should be made to involve and communicate with the patient. Consideration should always be given to whether a translator, signer, speech and language therapist or specialist team is required as well as the use of terminology and general language
- Just because a patient refuses the examination, care or treatment proposed or chooses an option considered 'unwise' by healthcare professionals does not mean they lack capacity. Unless it can be shown that the patient lacks capacity to make the decision, evidenced by the Mental Capacity Act 2 stage test, (i.e. they cannot understand information given to them, retain or weigh it up or communicate their decision), the patient must be allowed to make 'unwise' decisions
- Where an adult patient lacks the mental capacity to give or with-hold consent for themselves in relation to examination, care or treatment at a particular time, any decision must be made following the person's "best interests" processes outlined by the MCA and Codes of Practice
- Care and treatment to achieve what is in a patient's best interests should be delivered in the least restrictive way possible, enabling patients to maintain the maximum possible level of independence, choice and control
- A patient's ability to make a decision may be different for different decisions at different times and therefore any determination that a patient lacks capacity is only in relation to the specific decision in question and at the time the determination was made.

This Policy applies to all employees of the Trust, including Non-Executive Directors, Governors, volunteers, individuals on secondment and trainees or those on placement. Contracted third parties and staff of partner organisations who provide services on behalf of the Trust to patients are also expected to adhere to this Policy.

2. Key Responsibilities and Duties

2.1 Safeguarding Adult Boards
Safeguarding Adult Boards are required to lead children's safeguarding arrangements across their locality, monitor and coordinate the effectiveness of the safeguarding and MCA performance of partner agencies. The Trust is required to undertake Safeguarding Adult (including MCA) assurance processes led by the CCG and Safeguarding Adult Boards on a yearly basis.

2.2 Clinical Commissioning Groups (CCG)
CCGs (NHS Derby and Derbyshire Clinical Commissioning Group and NHS South East Staffordshire and Seisdon Peninsula CCG) monitor Trust safeguarding performance in regular meetings with the Trust and the CCG Designated Nurses (safeguarding adults) attend the Trust Safeguarding Committee.

2.3 Trust Board
To ensure that the Trust has in place the necessary policies and procedures to enable staff to meet the standards aimed at by the Trust. To receive reports and approve action plans.

2.4 Chief Executive
As Accounting Officer of the Trust the Chief Executive has ultimate responsibility for staff adherence to legislation, guidance and Policy. Ensure appropriate management chains are in place to enable adherence to this Policy.

2.5 Executive Medical Director and Executive Chief Nurse
To ensure the Trust Board is fully briefed on areas of responsibility and Executive Committee decisions. To ensure implementation of this Policy is monitored and staff adhere to legislation, regulation and guidance in respect of consent and mental capacity.

2.6 Chief Operating Officer
To ensure the Trust Board is fully briefed on areas of responsibility and Executive Committee decision; supports the Executive Medical Director and the Executive Chief Nurse in ensuring implementation of this Policy is monitored and staff adheres to legislation, regulation and guidance in respect of consent and mental capacity.

2.7 Quality and Performance Committee
Sub-Committee of the Board with overall delegated responsibility for ensuring lawful authority is in place for all Examination, Care and Treatment carried out by the Trust.

2.8 Quality Improvement Group
See Section 7: Implementation, Monitoring Compliance and Effectiveness

2.9 Trust Safeguarding and Vulnerable People Committee (TS&VPC)
See Section 7: Implementation, Monitoring Compliance and Effectiveness

2.10 Trust Safeguarding and Vulnerable People Operational Reference Group(TS&VPORG) –The TS&VPORG has responsibility for identifying, assessing and communicating risks or barriers at the frontline to effective implementation of the Trusts duties and obligations, and to provide consultation feedback and perspective on Policy and practice development at the frontline.

2.10 Divisional Business Units

- To ensure all staff within their divisions are familiar with this Policy
- To ensure all staff have the tools, resources, and skills to deliver the standards detailed in this Policy and to follow the procedures
- To ensure advice and guidance, relevant legislation, Codes of Practice and guidance are available to all staff
- To provide reports to the Chief Operating Officer / Executive Medical Director / Executive Chief Nurse, when requested.

2.11 Head of Safeguarding and Vulnerable People and the Trust MCA Lead

The Head of Safeguarding and Vulnerable People is responsible for the MCA Lead who provides training for frontline staff in MCA and undertakes audit of performance and for ensuring that MCA action plans are implemented, monitored and followed up where necessary. To provide advice and guidance to General Managers / team leaders and frontline staff regarding the lawful authority for proposed examination, care or treatment and the Deprivation of Liberty Safeguards. To notify the CQC of any Deprivation of Liberty Safeguards applications

2.12 All Staff

To practice within the legislative framework and comply with professional Codes of Practice relevant to their discipline. To follow the procedures described in this Policy and aim to achieve the target standards.

3. Definitions

Advance Decision to Refuse Treatment (ADRT)	At a time when a patient has the capacity to make the decision they may decide that if they lack capacity at some point in the future they do not want to receive certain forms or methods of treatment. Advance Decisions can only be made by people 18 or over. (See Appendix 4). If an advance decision relates to life sustaining treatment (such as resuscitation) it must be in writing and witnessed – ideally by a carer or relative or if this is not appropriate an advocate or independent third party - but not by a member of Trust staff unless there are special circumstances. Advance Decisions cannot be made to refuse 'basic care', defined by the British Medical Association (BMA) as procedures essential to keep the individual comfortable e.g. warmth, shelter, personal hygiene, pain relief and the management of distressing symptoms. If an advance decision is deemed to be 'valid and applicable' then it is legally binding on healthcare professionals once a patient has lost the mental capacity to make the decision contemporaneously.
Best Interests	This process determines the Decision Maker and the most appropriate option for the individual who lacks capacity, based on meeting their physical, psychological, emotional and psychological needs.
Carer	Spends a significant proportion of their life providing (unpaid)* support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, frail, disables or has mental health or substance misuse problems. *Carer's in receipt of Carer's Allowance are seen as unpaid carer's.

Consent	An individual's agreement for something to be done to them. Individuals may indicate consent non-verbally (for example by presenting their arm for their blood pressure to be checked), verbally or in writing. For the consent to be valid the individual must: • Have the mental capacity (or ability) to make the decision whether to consent or refuse • Have been provided with all of the relevant and sufficient information • Not be under duress or excessive pressure Acquiescence/compliance where the individual does not know what the intervention entails is not consent.
Consent Form	A standard prescribed from which records the process of providing the patient with information to inform their decision and the patient is asked to sign as evidence that they have received and understood the information and give their consent to the procedure.
Mental Capacity	A person's ability to make their own choices and decisions. Capacity is judged according to the specific decision to be made. In England the Mental Capacity Act says that a person lacks capacity to make a decision if they have an "impairment or disturbance in the function of the brain" either temporary or permanent and as a result they cannot **understand** the information relating to the decision (including its benefits and risks); **Retain** the information for long enough to make this decision; **Weigh up** the information involved in making the decision and **communicate** their decision.
Court Appointed Deputy	In certain situations where an individual does not have an LPA but a series of decisions needs to be made, the Court of Protection may appoint a deputy who then takes on the same functions as an attorney either for a specified period or indefinitely.
Court of Protection	The court with jurisdiction over cases involving patients who lack mental capacity. If a capacity or best interests decision is challenged and the matter cannot be resolved amicably an application can be made to the Court of Protection for a ruling. The Court of Protection can appoint deputies and monitor Lasting Powers of Attorney.
Decision Maker	The individual(s) who makes a decision on behalf of an individual who lacks the capacity to make the decision for themselves under sections 5 and 6 of the MCA 05. This person / professional is required to be the one responsible for carrying out the care and treatment. It is the decision maker's responsibility to undertake the Best Interest process.

Deprivation of Liberty (DoL)	There is no comprehensive definition of what constitutes a deprivation of liberty. The term is used in Article 5 of the European Convention of Human Rights. In case law regarding DoL it has been established that "the difference between restrictions on liberty and deprivation is one of degree or intensity not nature or substance". This means that a series of restrictions/restraints could cumulatively add up to a deprivation of liberty. The restrictions placed on any particular individual should be considered with regard to the duration of the restrictions, the frequency with which the restrictions are applied, the force used to implement the restrictions and the opposition to the restrictions that is encountered (from the individual or from family / friends / carers). If restrictions of a sufficient degree or intensity are placed on a patient that it amounts to a deprivation of liberty this must be in accordance with a process described in legislation. This could be the Mental Health Act 1983 or the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. Staff are advised to undertake DoLS checklist and discuss with the safeguarding team.
Independent Mental Capacity Advocate (IMCA)	A specialist advocate who can represent the patient and their best interests if they have no family/friends to speak on their behalf. The Mental Capacity Act 2005 introduced a duty on NHS bodies to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions or residence / placement decision when a person who lacks the capacity to make a decision has no-one who can speak for them other than paid staff. The IMCA makes representations about the person's wishes, feelings, beliefs and values. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary. To contact IMCA Services go to the Safeguarding and Vulnerable People team pages here
Lasting Power of Attorney (LPA)	A Lasting Power of Attorney (LPA) is a formal legal document which confers on the attorney (or donee as it is sometimes called) the authority to make decisions on the patient's behalf. There are 2 types of LPA: Personal Welfare and Property and Affairs. The decisions that can be made by the attorney will depend on the type of attorney they are and what is written in the LPA. To be valid an LPA must be formally written down, signed and registered with a body known as the Office of the Public Guardian. An LPA can also be verified through this body – and should be verified if a paper copy cannot be presented to staff. Click here for contact details
Lawful Authority	The legal basis on which the examination, care or treatment can be provided. Ensuring lawful authority is in place ensures that any accusations or complaints of assault or battery can be countered. In general the lawful authority will either be provided by obtaining the valid informed consent of a patient with capacity to make the relevant consent decision (based on well-established common-law consent principles) or by following the Mental Capacity Act. Lawful authority may also be provided by a Court Order.
Life Sustaining Treatment	Treatment that in the view of the person providing healthcare is necessary to keep a person alive.
Office of the Public Guardian	The Public Guardian and his/her staff are the registering authority for Lasting Powers of Attorney. They can be contacted directly to check that an LPA has been registered for details click here.

Parental Responsibility (PR)	Those individuals with the legal rights and responsibilities of parents. All biological mothers have parental responsibility automatically. Having parental responsibility gives the parent (or other individual) rights in terms of consent for examination, care or treatment where the child is unable to consent for themselves due to their age. For details of who else in the family circumstances may have PR see Appendix 2.
Power of Attorney (POA)	The authority to act for another person in specified or all legal or financial matters.
Serious Medical Treatment	Treatment which involves providing, withdrawing or with-holding treatment in circumstances where: • There is a fine balance between the benefits of a single proposed treatment and the burdens and risks it is likely to entail for the patient; • There is a choice of treatments and the decision as to which one to use is finely balanced; or • What is proposed would be likely to have serious consequences for the patient.

4. Purpose and Outcomes

The purpose of this Policy is to outline the principles and procedures regarding obtaining consent from patients who have, or do not have, capacity to consent.

The expected outcomes of compliance with this Policy are;

- Compliance with the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (CQC Essential Standards, Outcome 2: Consent to care and treatment)
- Compliance with The Human Tissue Act 2004.

5. Consent Processes

The provision of information is central to the consent process. Before patients can come to a decision about examination, care or treatment, they need comprehensible, comprehensive and in some cases very specific information of rare risks and risks pertinent to their individual health / circumstances (Montgomery) about their condition. This will also include information about possible care, treatments and investigations and their risks and benefits (including the risks / benefits of doing nothing) (See Briefing Note at Appendix 4). They also need to know whether additional care, treatment or procedures are likely to be necessary as part of the original proposal, for example a blood transfusion, or the removal of particular tissue. As part of making a decision about examination, care or treatment patients will need information about what will happen: where they will go, how long they will be in hospital, how they will feel afterwards and so on.

There will always be an element of clinical judgement in determining what information should be given. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

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

telephone and face to face interpreters are available. See Appendix 8 for full details of:

- **Sign Language Interpreters Telephone**
- **Interpreting Face To Face**
- **Interpreter Service Urgent Pager**

There may be other considerations around the provision and communication of information:

- Communicating in an appropriate way. For example, could the information be explained or presented in a way that is easier for the person to understand?
- Simple language should be used, avoiding jargon. Use of pictures or objects could be helpful.
- Making the person feel at ease. For example, are there particular times of the day when a person's understanding is better or will a particular environment make them feel more at ease?
- Supporting the person. For example, can anyone else help or support the person to understand information and to make a choice?
- Family, carers and others who know the person well can advise on the most effective methods of communication.

Information will normally be provided verbally through discussion, but a patient (and carers) may also be offered written information in the form of information leaflets or printed sheets to aid in the decision-making process. It may also be appropriate to direct patients/ carers to particular websites/ external organisations where further information is available.

Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. The Patient Advice and Liaison Service (PALS) can help to access information about the Trust, outside organisations and any health related issues. (PALS Officers can be contacted on 01283 593 110 (QHB) or 01283 593 182 (RDH).

After an appointment with a health professional in primary care or in out-patients, patients will often think of further questions which they would like answered before they 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). All Trust patient information literature therefore includes information about how to contact the Trust to ascertain further information / advice when 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.

5.1 Responsibility for ensuring lawful authority for examination, care or treatment is in place

The health professional carrying out the examination, care or treatment is ultimately responsible for ensuring that there is adequate lawful authority in place (i.e. that the patient is genuinely consenting to what is being done or the patient lacks capacity to give consent and the best interests of the patient have been determined according to the processes described in the Mental Capacity Act 2005: This is a legal requirement as well as a condition of registration with their professional body.

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

In addition, where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

- **Delegating responsibility for seeking consent/assessing ability to consent**

There are situations in which it may be appropriate for an individual other than the one who will be undertaking the examination, care or treatment to seek to obtain the consent of the patient. The development of more specialised roles within nursing, midwifery and therapies has resulted in patients receiving much of the information about complex surgical or medical procedures from non-medical staff.

Where the responsibility for seeking and documenting consent is delegated, the responsibility is also delegated for assessing, where necessary and appropriate, whether the patient lacks the capacity to give or withhold consent.

Responsibility for seeking and documenting consent should only be delegated to staff who are competent. In respect of procedures which require completion of a consent form staff will only be deemed to be competent if they have completed the process outlined at Appendices 7, 8 and 9

However, it is the healthcare professional undertaking the examination, care or treatment who remains ultimately responsible for ensuring appropriate lawful authority is in place. They must therefore ensure that when they ask colleagues to seek and document consent on their behalf they are confident that the colleague is competent to do so.

All healthcare professionals must work within their own competence and not agree to perform tasks which exceed that competence. If you feel that you are being pressurised to seek consent when you do not feel competent to do so please contact Divisional team for support and advice. (See also para 6 below for details of training requirements)

Any anomalies or discrepancies should be reported to the healthcare professional's line manager. If staff believe that a member of staff has signed a consent form but are not authorised to do so, they should raise this in the first instance with the healthcare professional's line manager Divisional team.

5.2 Assessing ability to give valid informed consent: Assessing capacity

Any healthcare professional should be able to obtain consent in respect of the examination, care or treatment they themselves undertake on a patient. For example, a healthcare assistant should be

able to obtain consent from a patient to assist them with washing and dressing and a cardiovascular surgeon should be able to obtain consent from a patient to undertake heart surgery.

5.3 With regard to the patient who may lack capacity;

The first principle of the Mental Capacity Act is that all individuals aged 16 or over should be presumed, in the first instance, to have the ability (mental capacity) to make any decision asked of them. However, to ensure that any consent obtained is always valid, healthcare professionals should also be able to detect when it is possible that the patient does not have capacity to consent and ensure that they then follow the Mental Capacity processes to ensure lawful consent is evidenced. Doubts about a patient's ability (mental capacity) to make a specific decision at a particular time may arise for a number of reasons, including:

- Patient making decisions in a manner out of keeping with their normal methods of reasoning
- Assessments have shown that the patient lacks capacity for other decisions
- The patient is behaving, or has a history of behaving, in such a way as to suggest they lack capacity
- Someone who knows the patient suggests that they may lack capacity or "aren't themselves".

If, during discussions with the patient about the examination, care or treatment or the risks or benefits of different options available, there is reason to doubt the patient's capacity the 2 stage test as required in the MCA 2005 should be adopted. The professional should use the Trust template to record the assessment. Click here

5.4 Stage 1 - is whether there is a known or suspected disease of the mind or brain. If the answer to this is no then the practitioner cannot proceed to section 2 of the test under the MCA.

5.5 Stage 2 - However if the answer is yes at stage 2, the second stage of the test should be evidenced;

- Can the patient understand the decision they need to make, why they need to make it and the information about the different options available?
- Can the patient retain the information long enough to make a decision or choice?
- Can the patient weigh up the consequences, benefits, risks and impact of choosing different options (or of not making a decision at all)?
- Can the patient communicate the outcome of their decision by any means (i.e. speech, sign language)?

If the answer to any one of these 4 questions is 'no,' the patient is determined as lacking capacity and the Best Interest process should be undertaken.

5.6 The Best Interest Process

The Trust template should be used to evidence compliance with the law- Click here

In relation to particular examination, care or treatment the first steps would be to try and find out if any of the following exist:

- **Advance Decision to Refuse Treatment**

  Where a valid and applicable Advance Decision to Refuse Treatment exists this may limit the options available when considering which option is in the patient's best interests. (See Appendix 1).

- **Lasting Power of Attorney for Health and Welfare**

  Under English law, no-one is able to give consent to the examination, care or treatment of an adult who lacks the capacity to give consent for themselves unless they have been authorised to do so under a Lasting Power of Attorney or they have the authority to make treatment decisions as a Court Appointed Deputy. Therefore without this being in place parents, relatives or members of the healthcare team cannot obtain or give consent on behalf of such an adult. In order to determine if the decision falls within the scope of authority of a Lasting Power of Attorney or a Court Appointed Deputy the full court approved document will need to be seen and checked to ensure it has been registered; please click here for details of how to contact the Court of Protection. Where a Lasting Power of Attorney exists with the particular decision falling within their scope of authority, they will be the decision maker unless they appear to be acting maliciously or wilfully against the interests of the patient in which case the safeguarding team must be contacted and possible approach made to the court of protection.

- **Court Appointed Deputy or court order**

  Where a Court Appointed Deputy exists with the particular decision falling within their scope of authority, they will be the decision maker.

- **The Decision Maker Section 5 and 6 MCA**

  In the circumstances where there is no Power of Attorney (POA) / court appointed deputy or valid ADRT, Section 5 of the Mental Capacity Act states that the person responsible for carrying out the care and treatment becomes the Decision Maker and can take action in connection with the care or treatment of a patient (without valid informed consent), as long as:

    - Reasonable steps have been taken to establish that the patient lacks capacity
    - The person taking the action believes that the patient lacks capacity
    - The person taking the action believes that the action is in the patient's best interests and it is the least restrictive option.

  The Mental Capacity Act therefore provides healthcare professionals with protection from criminal and civil legal liability for acts or decisions made as long as the requirements of the Act are followed.

  This process should consider the effects of different options on the patient's overall medical, psychological, emotional and social well- being. Steps that need to be followed in determining what is in a patient's best interests are as follows:

    - When determining what is in a person's best interests, hard assumptions must not be made about what is in someone's best interests on the basis of the person's age, appearance, condition or any aspect of their behavior.
    - All of the relevant circumstances should be considered and all of the different ways

the possible examination, care or treatment options may affect the patient.

- Consider how urgently the decision needs to be made and whether the patient may regain the capacity to make the decision for them if the decision can be delayed safely and without lasting detriment to the patient.
- Even though the patient has been assessed as lacking the capacity to make the decision about the examination, care or treatment, encourage their participation in the decision-making process as this will help in determining any wishes, feelings or beliefs they may have
- The decision-maker must not be motivated by a desire to bring about death. This still allows for decisions not to provide life-saving treatment e.g. CPR as these are motivated by a desire not to prolong suffering
- The past and present wishes, beliefs and values of the patient and any factors they would be likely to consider should be ascertained and considered
- Any relevant individuals e.g. carers, family and people named by the patient should be consulted about their understanding of what the patient would want and what they believe would be in the patient's best interests and why.

Whilst a valid and applicable Advance Decision to Refuse Treatment will be legally binding on the healthcare professional, other advance statements of wishes or preferences are not legally binding. However these statements should be taken into consideration by the healthcare professional as an expression of the wishes and feelings of the patient.

On the basis of all the information gathered the decision maker will need to decide what they believe to be in the patient's best interests. Once the Best Interests of the patient have been determined, this provides sufficient lawful authority to undertake the examination, care or treatment deemed to be in their best interests in the least restrictive way possible.

5.7 Care in an emergency

Clearly in emergency situations, the extent to which other individuals can be consulted with and the past wishes, feelings and beliefs of the patients ascertained will be limited and the best interests will primarily be focused around what is in the medical best interests of the individual in order to save life or prevent serious deterioration at that time. The more time available to make a Best Interests decision the greater the expectation will be that thorough consultation and engagement occurs and all options and consequences are considered and discussed with relevant individuals. Nevertheless the record of decision making should reflect the MCA principles.

5.8 Independent Mental Capacity Professionals

An IMCA must be instructed by the decision maker where there are safeguarding concerns or serious medical treatment or long term care is proposed, and there are no appropriate families or friends who are willing and able to be consulted with and involved in determining Best Interests.

Details of appropriate IMCA services can be seen here

5.9 Withdrawing and withholding life-sustaining treatment

When treating a patient who has reached the end of life, clear communication and collective decision making are important. A healthcare professional's legal duty is to care for a patient and to

take reasonable steps to prolong their life. Although there is a strong presumption in favour of providing life-sustaining treatment, there are circumstances when continuing or providing life-sustaining treatment stops providing a benefit to a patient and is not clinically indicated. There is no legal distinction between withdrawing and withholding life-sustaining treatment.

A person with capacity may decide either contemporaneously or by a valid and applicable advance decision that they have reached a stage where they no longer wish treatment to continue.

If a person lacks capacity, this decision must be taken in their best interests and in a way that reflects their wishes (if these are known). A second opinion should be sought from an independent clinician who should reach their own conclusion in this matter and on whether life-sustaining treatment should be withdrawn / withheld. When families and doctors are in agreement and believe it is in the patient's best interests, medical staff are able to remove feeding apparatus without applying to the Court of Protection. However where there is disagreement legal advice should be accessed.

5.10 Covert Administration of Medicines (Disguising Medication)

As a general principle, a patient lacking capacity cannot with-hold consent. Administering covert medication, by disguising medication in food or drink, the patient or client is being led to believe that they are not receiving medication, when in fact they are. Where the patient lacks capacity, the registered professional must ensure that the capacity assessment is competed, that the patient does lack capacity and complete the best interest process in relation to medicines.

Administering medicines covertly to patients should be carefully considered and there should be adherence to this Policy. The decision to use covert medication must be made by the multidisciplinary team (ideally including the presence of the pharmacist) including the views of relatives and carers and any advanced statement or directive made by the patient.

If, following completion of the capacity assessment, it is clear that the patient has capacity and they refuse medication **it cannot** then be given covertly.

5.11 Ensuring consent remains valid

In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient and consent being given by the patient. For example, during an on-going 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. As long as there are no doubts about the patient's ability to give their consent; 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. Where consent is being sought at the point the care or procedure will be carried out, this will normally most naturally be done by the health professional responsible.

With regard to patients who lack capacity, the two stage test should be repeated in relation to care and treatment when it appears that there has been a noted change in the patient's condition-particularly where there has been improvement.

5.12 Written Consent: Persons with capacity to consent

In most cases where a consent form signed by the patient is required. Treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital out-patient clinic), 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: the first being the provision of information, discussion of options and initial decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as

well as the confirmation stage.

Patients receiving elective treatment or investigations for which a consent form signed by the patient is required 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. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before a patient arrives for treatment, however, a member of the healthcare team must check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

In situations where consent may be sought and documented in two stages (initial confirmation and reaffirming at the time of the procedure), at least one of the health care professional signatures needs to be undertaken by a care professional who is able to undertake the procedure or has the appropriate delegated authority to seek consent for the procedure. It may be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves and the first signature is made by a care professional who is able to undertake the procedure.

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

Clearly in urgent situations, the 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.

Although in most situations it will be clear who has responsibility for ensuring the lawful authority for examination, care or treatment is in place, all health care professionals provide information and advice which the patient may incorporate into their decision-making process and should therefore be aware of how they are delivering and providing information.

5.13 Refusal and Withdrawal of Consent

A patient who lacks capacity cannot "refuse" treatment found to be in their best interest. Where a level of restraint or sedation goes beyond that that would be given to a patient with capacity in order to ensure treatment is provided, discussion should be had with Legal Services who will advise on whether specialist legal advice needs to be obtained and approach made to the Court of Protection. A Deprivation of Liberty Authorisation should also be considered and discussion had with the Safeguarding Team.

If the patient has capacity and the process of seeking consent is to be meaningful, a refusal must

be one of the patient's options. If a patient refuses, objects to or resists proposed examination or treatment, health care professionals should try to determine the specifics and cause of this refusal. It may be the case that providing the examination, care or treatment in a slightly different way will remove the obstacle objected to. If, however, an adult with capacity continues to make a voluntary and appropriately informed decision to refuse treatment (whether contemporaneously or in advance), this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983. This is the case even where this may result in the death of the person (although legal advice should be sought as appropriate and if in any doubt). If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. Try to establish why the patient has refused to give their consent and if there are any practicable steps that can be taken to make the care or treatment options acceptable to the patient.

If the patient has already signed a consent form, but then changes their mind, this should be noted on the form. Where a patient has refused a particular intervention, any other appropriate care to which they have consented must be continue to be provided. The patient must be made to realise 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, the healthcare professional 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.

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

Patients with capacity do have the right to refuse life-sustaining treatment (other than treatment for mental disorder under the Mental Health Act 1983) – both at the time it is offered and in the future. Making a decision which, if followed, may result in death does not necessarily mean that a person lacks capacity. However, if the person is clearly suicidal, this may raise questions about their capacity to make the decision. If a patient with capacity has harmed themselves, a prompt psychosocial assessment of their needs should be offered. However, if the person refuses treatment and use of the Mental Health Act 1983 is not appropriate, then their refusal must be respected. Similarly, if practitioners have good reason to believe that a patient genuinely intended to end their life and had capacity when they took that decision, and are satisfied that the Mental Health Act is not applicable, then treatment should not be forced upon the person, although clear recorded attempts should of course be made to encourage them to accept help.

5.14 Documenting the Lawful Authority for undertaking examination, care or treatment; The patient with capacity

Healthcare documentation serves several purposes: it facilitates communication between healthcare professionals, aiding the continuity of care; it evidences what action has been taken; and it evidences why particular action has been taken.

Documentation that appropriately serves all three of these purposes will protect both individual health professionals and the organisations that are vicariously liable for them from unfounded accusations and resulting reputational damage. The process of considering what needs documenting also helps focus health professionals' minds on what they have done and why and provides them with an opportunity to identify if there are further steps they should be taking.

Documentation of the lawful authority to provide examination, care or treatment will, in most cases, be contained within the patient's narrative running record or within care plans / evaluations. The amount of documentation required about the examination, care or treatment undertaken and the rationale for this should be proportionate to the risks posed to the patient, the seriousness of the decision (objectively or subjectively for the patient) and the potential for challenge of the care given or its lawful authority at a later point.

As part of the documentation of lawful authority it should be recorded what information was provided to the patient about risks, benefits, alternatives etc. This should include whether any standard information leaflets were provided. Where leaflets are provided to patients, ideally a copy of these will be held on their patient records for future reference.

Examination, care or treatment that poses a significant risk of harm (medical, psychological, emotional or social) to the patient is more likely to be the subject of future challenge or scrutiny. It is therefore expected that the documentation around the discussions and decision-making process leading up to these procedures will be more thorough and comprehensive.

Recent changes in medical law "Montgomery's case" now requires an explanation of all material risks to a patient. A risk is said to be material if it is one to which the patient is likely to attach significance. This means that when you are consenting a patient you must consider their individual circumstances and explore with them what risk are significant to them personally. (See Consent legal brief Appendix 4)

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 have not signed a form is no bar to treatment. In addition, 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. It is therefore important that the process of discussion and agreement is recorded on the form.

The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. At least one of the health care professional signatures needs to be undertaken by a care professional who is able to undertake the procedure or has the appropriate delegated authority to seek consent for the procedure. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves and the first signature is made by a care professional who is able to undertake the procedure

5.15 Cross-site Consent:

The Trust is a multi-sited Trust. Therefore there are circumstances whereby a patient will be consented for a procedure, e.g. at Queens Hospital, that is due to be carried out at another site, e.g. Royal Derby Hospital.

In this event the consent form can be completed at Queens Hospital with the following advice:

- The consent form is scanned into Meditech V6 for the Royal Derby Hospital clinician to review pre-procedure. Confirmation of consent can then occur which must be documented in the patient record.
- The notes, containing the hard copy of the consent form, follow the patient to the procedure site for the clinician to complete the requisite confirmation of consent.
- In exceptional circumstances the consent form can be given to the patient and they can give this to the clinician at the procedure site for confirmation of consent.
- In situations where it is appropriate to formally record the capacity assessment undertaken but use of a 'consent form 4' is not required, the Trust request that staff use the mental capacity assessment form to record the capacity assessment and the outcome; see here.

5.16 Lawful authority for undertaking examination, care or treatment for 16-17 year olds

The situation in relation to 16 and 17 year olds is generally now the same as for adults.

- The Mental Capacity Act applies to all individuals aged 16 and over. 16 and 17 year olds are therefore assumed to have the capacity to make all decisions regarding their examination, care or treatment; unless for particular decisions it is shown that they lack capacity.
- Where 16 or 17 year olds have capacity to give or withhold consent (which will be assumed until demonstrated otherwise) their refusal should be respected. Parental wishes for the examination, care or treatment to go ahead should not be relied upon as sufficient lawful authority. If in any doubt seek legal advice regarding whether an application to the Court of Protection is required.
- Where 16 or 17 years olds are found to lack capacity because of an impairment of or disturbance in the functioning of the mind or brain that prevents them from understanding, retaining, weighing up or communicating information relating to the decision, the Mental Capacity Act and Trust templates for recording this must be followed as for adults.
- To lack capacity to make a decision as per the two-stage test of the Mental Capacity Act, an individual must have an impairment of or a disturbance in the functioning of the mind or brain. It is, however, possible that a 16 or 17 year old may be unable to make a decision simply because of the immaturity of their understanding. For decisions where a 16 or 17 year old falls into this category the Mental Capacity Act

would not be applied and the situation is as for under 16s.

5.17 Lawful authority for undertaking examination, care or treatment for children under 16 (See Appendix 3)

- Children under 16 are generally assumed to be unable to make complex decisions regarding examination, care or treatment. However, dependent on the complexity of the decision and the stage of development and maturity of the child, the child may have the capacity to make the decision for themselves. This is called Gillick competence and related to Fraser guidelines and relates to a specific decision (i.e. we would say that a child is Gillick competent to make ***X*** decision at the time of assessment). This ability would be assessed by determining whether the child can:
    - Understand the decision they need to make, why they need to make it and the information about the different options available?
    - Retain the information long enough to make a decision or choice?
    - Weigh up the consequences, benefits, risks and impact of choosing different options (or of not making a decision at all)?
    - Communicate the outcome of their decision by any means (i.e. speech, sign language).

- Where children do have capacity to give or withhold consent their valid, informed consent provides sufficient lawful authority to provide examination, care or treatment.

- Where children do have capacity to give or withhold consent their refusal should be respected. Parental wishes for the examination, care or treatment to go ahead should not be relied upon as sufficient lawful authority. If in any doubt seek legal advice.

- Where children do not have the ability to give or withhold consent someone with PR is able to give consent on their behalf (See Appendix 2 for detail on who can provide PR as not all parents do).

- When babies or young children are being cared for in hospital, it will not usually seem practicable to seek a parent's consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you should remember that, in law, such consent is required. Where a child is admitted, you should therefore discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

5.18 Lawful Authority for Undertaking a Hospital Post Mortem

- In most circumstances a post mortem examination is carried out at the request of the coroner in these circumstances consent from the family is not required. See the Trust's Policy and Procedures Relating to the Death of an Adult Patient for more information.
- Post mortem examinations are sometimes requested by hospital doctors or a relative of the deceased, these are called Hospital Post mortem examinations and they require consent to be obtained and this should follow the same principles as obtaining consent for examination, care or treatment.
- A Consultant ,Speciality Registrar or Speciality Doctor who has a) received appropriate training and b) previously witnessed post-mortem examination should be identified to discuss the possibility of a post-mortem with the family of the deceased patient.

- The Consultant ,Speciality Registrar or Speciality Doctor , along with an appropriate member of the Bereavement service (who is trained to provide support during post-mortem consent), should discuss the reasons for suggesting a post-mortem and the potential value with the Next of Kin and any other relevant family members
- Where agreement to post mortem is received this should be documented on Consent Form 1, which the Next of Kin should be asked to sign.
- The family must be informed of the date and time of the post-mortem and advised of the Bereavement Service number in case they have any queries or wish to stop the post-mortem before it takes place.
- The family must be allowed a cooling off period (at least overnight)
- If the family refuses to consent to a post-mortem they should not be pressurised into it and the threat of referral to the Coroner should NEVER be used in an attempt to persuade the family to give consent.
- The family's refusal should be documented in the deceased person's medical records.
- Post-mortem staff in the bereavement service will receive additional training in relation to the Human Tissue Act recommendations surrounding hospital post- mortem examinations, to ensure all requirements are met.

5.19 Lawful Authority for the use of Tissue

- Explicit consent is not necessary for the use of tissue removed from patients during surgical procedures for public health surveillance purposes, provided the data makes use of the unlinked anonymous method. However, this Trust requires that patients should be given the opportunity to refuse permission.
- Similarly, tissue samples may be used for quality assurance purposes without requiring specific patient consent provided there is an active Policy of informing patient of such use and allowing for opt-out.
- The Trust requires that patients should be given the opportunity to refuse permission for tissue taken from them during surgery or other procedures to be used for education or research purposes.
- The duty to provide patients with information about the opt-out option can be fulfilled through the provision of the patient information leaflet "About your consent form".
- Where patients identify they do not wish their tissue to be used for such purposes a note will be made on any request forms and subsequently noted within the pathology systems.
- Wherever possible, samples of tissue used in any of these ways should be anonymised or pseudo-anonymised.

5.20 Clinical Photography

- Lawful authority should be obtained for any visual or audio recording including photographs or other visual images in the same way as obtaining lawful authority for the provision of examination, care or treatment. The purpose and possible future use of the recording must be clearly explained to the person before their consent is sought for the recording to be made.

- 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.

- Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care without the

express consent of the patient or, where the patient is under 16 and is not Gillick competent, a person with parental responsibility for the patient.

- If photographic or video recordings are requested to be used for teaching, audit or research, people must be aware that they can refuse without their care being compromised and that when required or appropriate it can be anonymised.

- General Medical Council (GMC) guidance gives more detailed advice, including situations when permission is not required and about obtaining consent to use recordings as part of the assessment or treatment of patients and for training or research.

5.21 Research

- Participation in research or clinical trials generally requires the valid, informed consent of the patient. Research involving or in relation to a person lacking capacity may be lawfully carried out if an 'appropriate body' (normally a NHS Research Ethics Committee) agrees that the research is safe, relates to the person's condition and cannot be done as effectively using people who have mental capacity. The research must produce a benefit to the person that outweighs any risk or burden. Alternatively if it is to derive new scientific knowledge it must be of minimal risk to the person and be carried out with minimal intrusion or interference of their rights.
- Carers or nominated third parties must be consulted and agree that the person would want to join an approved research project. If the person shows any signs of resistance or indicates in any way that he or she does not wish to take part, the person must be withdrawn from the project immediately.
- Staff who may have queries regarding research projects that include patients who may lack the capacity to consent to take part should contact the Research and Development Department.

6. Training Requirements

- All clinical staff should be confident and have received training or guidance on obtaining consent and assessing capacity to consent in respect of the examinations, care, treatments and procedures they undertake or perform.

- There is specific mandatory training on Treatment with Lawful Consent for all staff who are required to undertake shared decision-making discussions regarding treatment or procedures (See My Learning Passport). Additionally, all staff are required to undertake mandatory Safeguarding Level 3 training which gives compliance with MCA.

- Staff who seek and document lawful authority in respect of procedures requiring completion of a 'consent form' must also attend specific training in relation to the procedures for which they are to seek consent (where the staff member is able to undertake the procedure themselves; this will be assumed to have occurred during their training on undertaking the procedure).

- Procedure specific consent training packages developed by the specialties or divisions must be approved by the relevant Divisional Governance Meeting. A register will be maintained of the approved training packages, the procedures they cover and the date for reviewing the approval

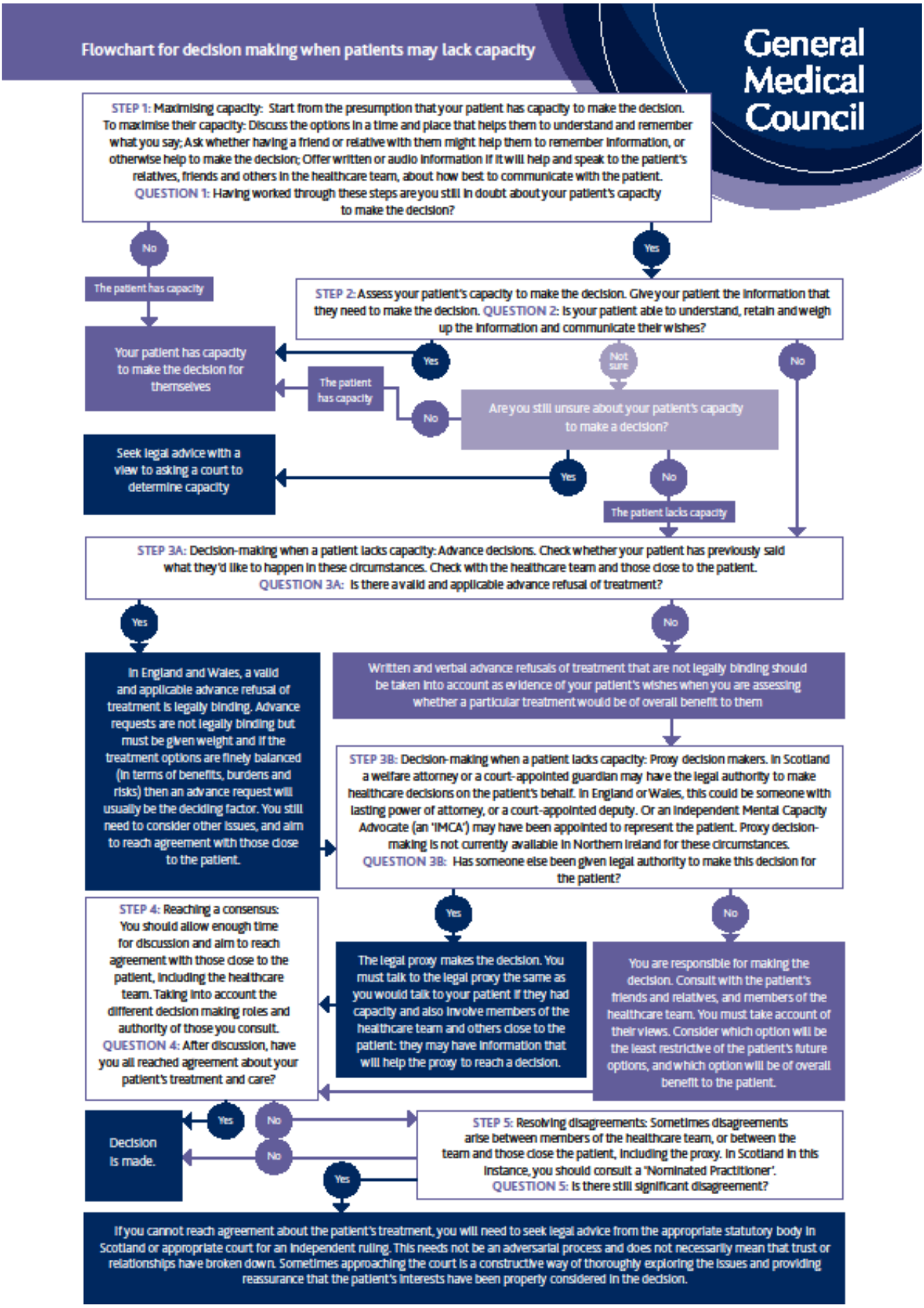
- Up-to-date registers of all staff members who have completed the necessary training which

enables them to seek and document lawful authority for the specified procedures will be maintained at Divisional level. This will be updated following each new intake of medical staff, new appointments of staff already appropriately trained and on receipt of the necessary forms identified in Appendices 5,6 and 7 as appropriate.

7. Monitoring Compliance and Effectiveness

Monitoring Requirement :	Compliance with completion of relevant documentation
Monitoring Method:	Monthly case file audit
Reports Prepared by:	Quality and Safety Team and Safeguarding Team
Report presented to:	Quality Compliance Steering Group; QIG;QPC;PMM
Frequency of Report:	Monthly reports

Appendix 1MCA: overview of process



Appendix 2

Guidance re Lawful authority for undertaking examination, care or treatment for children: Parental Responsibility (PR)

1. **Births registered in England and Wales**
   - If the parents of a child are married when the child is born, or if they've jointly adopted a child, both have PR.
   - They both keep PR if they later divorce.

2. **Unmarried parents**

An unmarried father can acquire PR for his child in 1 of 3 ways:

- Jointly registering the birth of the child with the mother (from 1 December 2003)
- Getting a PR agreement with the mother

(A PR Agreement under the Children Act 1989 is an agreement to which all other people with PR consent. This is a formal document which needs to be signed by all the parties and then registered at court).

- Getting a PR order from a court

(A PR Order is an order under the Children Act 1989, which unmarried fathers can apply for when the mother refuses to allow the father to be registered or re-registered on the birth certificate, or refuses to sign a PR Agreement with him).

You must ask for evidence of any of the above in the event that an unmarried father attends with the child on his own.

3. **Step-Parents**

A step-parent can only acquire PR for a child in very specific circumstances including:

- When the court makes a Child Arrangements Order that the child lives with the step-parent either on their own or with another person.
- When the step-parent adopts a child which puts him / her in the same position as a birth parent.
- Through the signing of a PR Agreement to which all other people with PR consent. This is a formal document which needs to be signed by all the parties and then registered at court.
- When the court has made a PR Order following an application by the step-parent.

On acquiring PR, a step-parent has the same duties and responsibilities as a natural parent. In all cases you should ask for evidence of any of the above in the event a step-father attends with a child and consent to treatment is required.

4. **Same-sex parents**

Civil partners

- Same-sex partners will both have PR if they were civil partners at the time of the
- treatment, e.g. donor insemination or fertility treatment.

5. Non-civil partners

For same-sex partners who aren't civil partners, the second parent can get PR in the following circumstances:

- If a PR Agreement was made. (This would be with the mother's agreement and evidenced in the form of an Order from the Court.)
- Becoming a civil partner of the other parent and making a PR Agreement or jointly registering the birth.

6. Legal Order Guidance

6.1 Private Fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) is placed for 28 days or more in the care of someone who is not the child's parent(s) or a 'connected person' (someone who has a pre-existing relationship with the child, for example, a teacher who knows the child in a professional capacity). Those caring for a child(ren) under these arrangements will not have PR for the child(ren), therefore consent from the person with PR is required.

6.2 Section 20 Children Act 1989

The Local Authority (LA) does NOT have PR for a child subject to section 20 care provision.

6.3 Interim Care Order (section 38 Children Act 1989)

This is an interim order prior to the final Care Order being made and gives the Local Authority (LA) PR for a child. However, the LA MUST consult with and inform other PR holders about important decisions they make for the child.

6.4 Care Order (section 31 Children Act 1989)

A Care Order gives the LA PR for a child (the LA MUST consult with and inform other PR holders about important decisions they make for the child i.e. medical treatment).

6.5 Emergency Protection Order

Gives the LA PR for the child while at the same time does not remove it from anyone else who has PR in respect of the child.

6.6 Supervision Order (section 35 Children Act 1989)

Does not give the LA PR for a child; PR remains with the parent(s).

6.7 Child Arrangement Order (section 8 Children Act 1989)

If a child arrangements order states that the child will live with a person, that person will have parental responsibility for that child until the order ceases. The parent(s) also retain PR as stated above under PR guidance.

6.8 Special Guardianship Order (Adoption and Children Act 2002)

This order discharges any existing care order and grants PR to the Special Guardian(s). Although parents do not lose their right to PR, the Special Guardians will have a higher level of PR than the birth parent(s) should conflict arise.

6.9 Placement Order (Adoption and Children Act 2002)

Prospective adopters will acquire PR for the child as soon as the child is placed with them, to be shared with the birth parents and the adoption agency making the placement (i.e. this could be the LA).

6.10 Adoption Order (Adoption and Children Act 2002)

When a child is adopted, the PR of their biological (birth) parents as well as any other person who holds PR will end. PR will be held solely by the adopter/s.

7. Looked After Children

When children and young people become accommodated by the LA, parents are asked to sign a Placement Plan which also has Consent to Medical Treatment section (NB: this does not give authority to anaesthetics).

Social Workers should contact parent(s) when children and young people are required to undergo routine examination or treatment. They should involve the parent(s) in discussion regarding the examination or treatment prior to consent being given.

Where a child is in need of surgery, a general anaesthetic or other specific medical treatment, the child's Social Worker should actively seek to involve the parent(s) with PR.

- Consent should be given in writing by the parent and the local authority delegated person as above (but is equally valid if given verbally, provided it was informed and freely given).
- Children's wishes and feelings where possible should be obtained, considered and accounted for.
- If a Looked After child under 16, who is subject to a Care or Interim Care Order, the Team Manager should give consent if the parent(s) are unable or unwilling to do so.
- If a Looked After child requires serious medical treatment, this should be brought to the attention of the LA senior management, who can then give consent and delegate a Social Worker or Team Manager to attend the hospital, discuss the surgery, anaesthetic and risks with the doctor(s).
- In a 'life or limb' situation, a Doctor must act in the child's best interest and may proceed without consent.
- Children receiving medical treatment who are Looked After by another LA should follow the same process as Looked After children locally.

8. What happens when those with PR disagree?

Disputes between parents can be difficult for everybody involved in the child's care. Health professionals must take care to concern themselves only with the welfare of the child and to avoid being drawn into extraneous matters such as marital disputes.

Generally, the law only requires doctors to have consent from one person in order lawfully to provide treatment. However, doctors may feel reluctant to override the dissenting parent's strongly held views, particularly where the benefits and burdens of the treatment are finely balanced and it is not clear what is best for the child. If the dispute is over a controversial and elective procedure (for example: male infant circumcision for religious purposes), doctors must not proceed without the authority of a court judgement in the case.

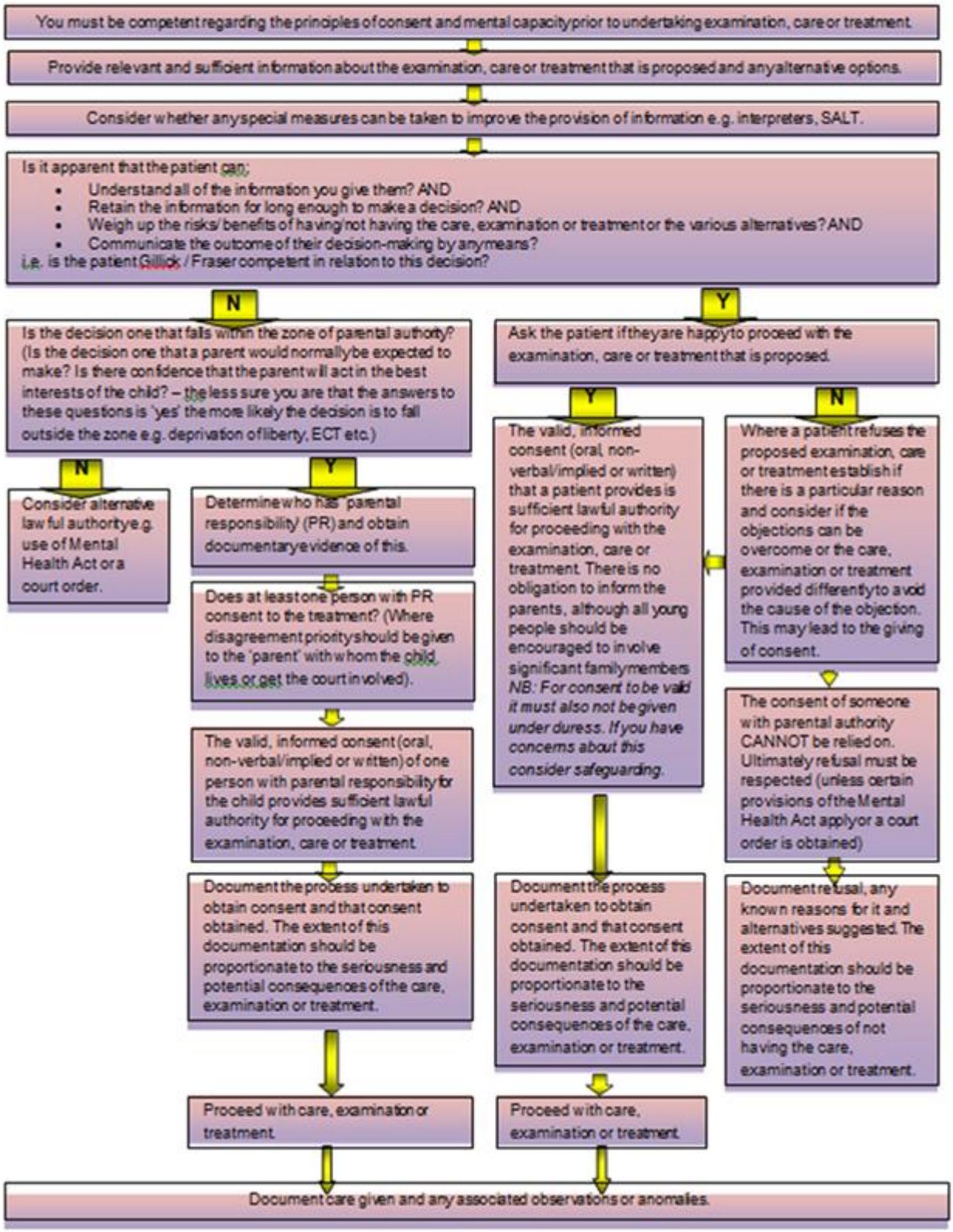
In other cases, discussion aimed at reaching consensus should be attempted. If this fails, a decision must be made by the clinician in charge whether to go ahead despite the disagreement. The onus is then on the dissenting parent to take steps to reverse the doctor's decision.

If you are in any doubt about whether the person with the child has PR for that child, you must check. Others (such as adopted parents, step parents or the Local Authority) may acquire parental responsibility via specific legal processes.

When babies or young children are being cared for in hospital, it will not usually seem practicable to seek a parent's consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you must remember that, in law, such consent is required. Where a child is admitted, you must therefore discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

Appendix 3

Overview of Lawful Authority for Examination, Care or Treatment – Under 16s



Appendix 4

BRIEFING NOTE – CONSENT

One of the most controversial areas of medical law is the issue of how much information a patient should be given about the risks of a particular procedure during the consent process.

The recent decision in ***Montgomery v. Lanarkshire Health Board*** fundamentally alters the answer to that question.

The new test now requires an explanation of all **material risks** to a patient. A risk is said to be material if it is one to which **the patient is likely to attach significance**.

In this respect, the Judgment brings the law into line with current GMC guidance, as well as guidance provided by other bodies such as the AAGBI.

Mrs Montgomery's Case

Mrs Montgomery brought a claim on behalf of her son in respect of his birth in 1999.

As Mrs Montgomery suffered with diabetes, the pregnancy was deemed to be high risk, by virtue of the fact that diabetic mothers are likely to have babies that are larger than normal, with a particular concentration of weight around the shoulders. This creates a 9-10% risk that during delivery the shoulders are too wide to pass through the birth canal, leading to shoulder dystocia.

If this occurs there is a small risk (put at 0.1%) that the umbilical cord will become occluded, causing hypoxia and resulting in consequential cerebral palsy or death.

Mrs Montgomery was not informed of the risk of shoulder dystocia. She claimed that if she had been warned she would have opted for a delivery by caesarean section.

At birth, shoulder dystocia did occur and the cord became occluded, causing hypoxia and resulting in her son sustaining severe brain injury. A claim was brought against the health authority on the basis of the failure to explain the risk of shoulder dystocia.

BRIEFING NOTE – CONSENT

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The Obstetrician's Approach to Consent

The Obstetrician accepted in evidence that she had not warned Mrs Montgomery of the risk of shoulder dystocia. She said she had not done so because *"if you were to mention shoulder dystocia to every [diabetic] mother…then everyone would ask for a caesarean section and it is not in the maternal interests for women to have caesarean sections"*

The Trust in turn relied on expert opinion that there was a responsible body of obstetricians who would not have warned Mrs Montgomery of the risk.

The Law as it Stood

For the last 30 years lawyers and doctors have been taught that the decision in ***Sidaway v. Board of Governors of the Bethlem Hospital (1985)*** set out the law on consent. In Sidaway, the Court said that the issue was to be considered by reference to the famous "**Bolam**" test. In other words, was the consent process one which a responsible body of medical opinion would support? If the failure to warn was supported by a responsible body of opinion, then under the old law, the Trust would have a defence.

Applying that test, the lower courts had dismissed Mrs Montgomery's claim on the basis that the obstetrician was indeed supported by a responsible body of opinion.

The Appeal to the Supreme Court Judgment and the New Test for consent

The Supreme Court overturned Sidaway unanimously. The old "*responsible body of opinion"* test no longer applies to consent.

The test now to be applied in consent cases was outlined by Lord Reed:

1. In all adults of sound mind, there is a duty to take reasonable care to ensure that the patient is aware of any **material risks** involved in any recommended treatment.

2. A risk is material if it is one where, in the circumstances of the particular case, a **reasonable person in the patient's position would be likely to attach significance to the risk** or the particular individual patient has attached significance to a risk.

The patient is required to understand the seriousness of the risk and the anticipated benefits of the proposed treatment and reasonable alternatives.

Applying this new test, the Supreme Court held that Mrs Montgomery should have been warned of the risk of shoulder dystocia and offered a caesarean section. The Court pointed out that the risk must be regarded as one which would have been significant to Mrs Montgomery. Indeed, the very reason why she had not been told of the risk was that the obstetrician assumed that she would then have asked for a caesarean section.

It is important to remember that the new test only applies to consent. The Supreme Court made it clear that the Bolam test will still apply to the issue of whether the treatment itself was carried out to an appropriate standard.

Implications

This case has far reaching implications for your practice when consenting a patient.

1 In cases of informed consent, there is no longer a defence that you failed to explain a risk on the basis that a reasonable body of opinion would support that omission. The law now requires explanation of **all material risks**.

2 The law now requires that:
    - A patient should be told of all material risks
    - A risk is material if that patient would attach significance to it.

3. This means that when you are consenting your patient, you must consider their individual circumstances and explore with them what risks are of significance to them personally. It will not be enough on its own for you to rely on patient information leaflets or pre-printed consent forms.

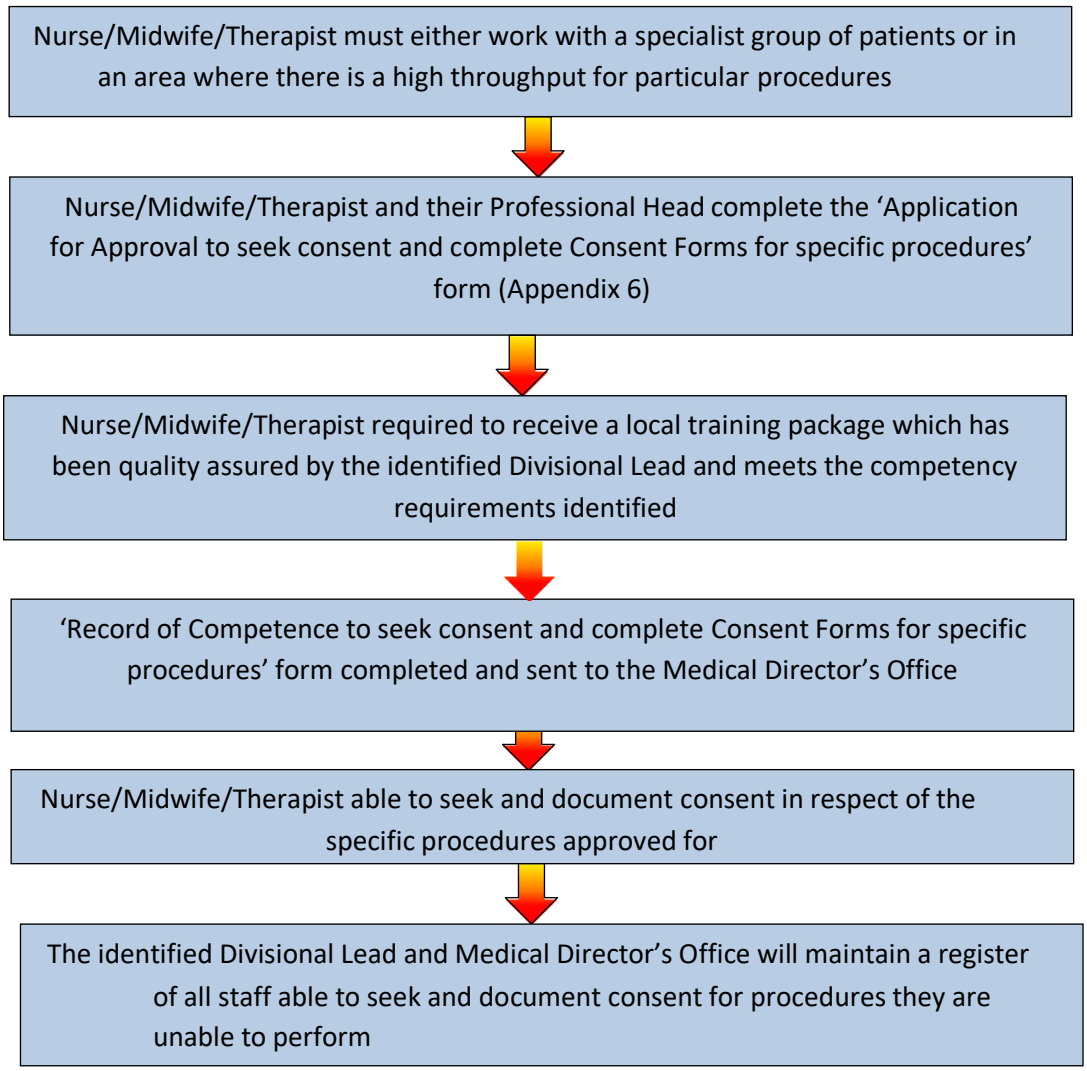
In practice, many legal cases are not about whether or not it was reasonable for a clinician not to warn of a particular risk. Instead, the dispute is usually about whether a particular complication was discussed at all, with a doctor who is adamant that the patient was told about a risk and a patient who is equally adamant that they were not.

These cases often boil down to what was written (or not written) in the medical records. If the records are silent as to whether the patient was warned of a complication of treatment it is likely that the Court will believe the patient, for whom the treatment is a once in a lifetime experience, rather than the Doctor, recalling one consultation, possibly many years later.

Experience within the Trust makes it clear that where a doctor has clearly and fully set out the risks in the records, and where there is clear evidence that information has been provided in well drafted information leaflets, we are much less likely to face these sorts of claims.

Appendix 5

Process for obtaining delegated authority for seeking consent and completing consent forms – Nurses and AHPs



Appendix 6

UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
Scope of Professional Practice

Application for Approval to seek consent and complete Consent Forms for specific procedures

This document should be used to apply for approval to seek consent and complete consent forms for specified procedures.

Name of registered nurse / midwife / therapist:	
Status:	
Directorate:	
Department:	

Please identify procedures for which consent would be sought and consent forms completed:

Please state supporting case for seeking consent and completing consent form for specified procedures: Where supporting case involves high throughput of procedure state numbers per month

I understand that should this application be approved I cannot commence seeking consent and completing consent forms until such time as I have successfully completed the related Scope of Professional Practice requirements

Applicant's Signature:	
Date of Application:	

Approval of Professional Head:
Status:
Date:

Appendix 7

UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
Scope of Professional Practice

Record of Competence to seek consent and complete Consent Forms for specific procedures

This document reflects the training received and systems in place to support registered nurses / midwifes in seeking consent and completing Consent Forms for procedures that they are not capable of undertaking.

Name of registered nurse / midwife / therapist:	
Status:	
Directorate:	
Department:	

Criteria	**Responsibility / Signature**	**Date achieved**
Principles of Consent	Trust Patient Safety and Risk Manager	
Quality Assurance of Consent Resource Package	Trust Patient Safety and Risk Manager	

Following the above criteria being fulfilled the assessor (Health Care Professional competent to undertake the procedure being consented for) must ensure understanding of the principles and witness the registered nurse / midwife / therapist seeking valid consent prior to deeming the registered nurse / midwife competent to seek consent and complete the Consent Form

Assessment of Competence	***Achieved Assessor's Signature***	***Date***
Knowledge of the key principles of valid consent.		
Knowledge of the information the patient requires in order to give valid consent.		
Knowledge of what must be routinely documented to provide evidence of valid consent.		
Knowledge of how to assess capacity.		
Knowledge of action to be taken where a patient lacks mental capacity.		
Clarity around the procedures a consent form should be completed for (after competence assessment).		
Practical observation of the registered nurse / midwife / therapist seeking consent and completing the consent form, applying the above knowledge appropriately.		

Assessor's Name:	
Assessor's Grade:	
Assessor's Signature:	
Date of Competence Assessment:	

1 x copy in consent resource pack, 1x copy to manager, 1x copy to registered nurse / midwife / therapist, 1x copy to Trust Patient Safety Lead

Appendix 8 - GUIDELINES FOR INTERPRETERS

Guidelines for Using Sign Language Interpreters

- Brief the interpreter before the appointment starts on the content of the conversation and what is expected from them in order to be of service to the patient and clinician
- Explain the interpreter's role – to convert exactly what is said by both parties Emphasise that the interpreter will respect confidentiality
- Emphasise the interpreter will not express an opinion or give advice to either parties.
- Always ask the person what is their preferred method of communication – British Sign Language (BSL); lip reading; (Note – lip readers only pick up on average 30% of words or clear speech
- Make sure the person is looking at you before you speak. If necessary, attract their attention by touching their arm or shoulder
- Ensure there is good lighting in the room. Ensure your face is well lit. Do not stand with your back to a bright source, such as a window or a lamp
- Try not to wear tops that are multi-coloured or have lots of patterns. Reduce background noise and visual disturbance as much as possible
- Look directly at the person. Speak clearly and at an even pace. Do not shout or exaggerate your lip movements. Use natural gestures and facial expressions to support what you are saying
- Check whether the person uses any specific signs. Stop talking if you have to turn away or write notes
- Allow time for the person to absorb what you have said and check that they have understood. If there seems to be any misunderstanding, relax, repeat what you have said, rephrase – use plain words – avoid jargon. Write things down if needed, but ask first.

Please also be aware that:

A sign language interpreter will ideally sit beside and slightly behind the person conducting the interview so that the patient can easily see both the interviewer and the interpreter's hands.

Guidelines for using Telephone Interpreting

When your Service User is with you – Phone 0845 310 9900

- The operator will ask you for your ID Code (this is available from your Lead Nurse / Manager / Matron / Site Co-ordinator. (Please note: this code is **confidential** to your department)
- Your organisation name (and department, where appropriate) Your initial and surname
- The language you require (say if you need a specific interpreter*) Your client's location, i.e. with you
- Stay on-line while the operator connects you to a trained interpreter (about 30 seconds)
- Note the interpreter's ID code, introduce yourself and brief the interpreter saying what phone you are using, e.g. single / dual handset, speaker phone or mobile
- Ask the interpreter to introduce you and themselves to your client and give the interpreter the first question or statement
- Give the interpreter time to interpret between you and your client. Continue the conversation
- Let your patient and the interpreter know when you have finished.

***Whenever possible the service provider will meet specific requests, e.g. for a female interpreter**

Guidelines for using Face-to-Face Interpreters

- Brief the interpreter before the appointment starts on the content of the conversation and what is expected from them in order to be of service to the patient and clinician.
- Explain the interpreter's role – to convert exactly what is said by both parties.
- Emphasise that the interpreter will respect confidentiality.
- Emphasise the interpreter will not express an opinion or give advice to either parties. Stop at intervals to give time for interpreting.
- Be aware of the safety of the interpreter, particularly when the patient is aggressive or difficult.
- Do **NOT** leave the patient or family/carer alone with the interpreter.
- Give the service user or family/carer and interpreter a break if the appointment is going to be longer than 45 minutes.

Interpreter Service Urgent Pager User Guide

- The Interpreter Service Urgent Pager system for both RDH and LRCH is provided by Vodafone paging service (Vodapage).

- There are two individual pager numbers you can call for urgent interpreter service enquiries during office hours (Monday to Friday – 09:00-17:00) – for urgent enquiries out of hours :- **076997 19510** or **076997 16680**

Raising an Urgent Page

There are two ways of raising an urgent Interpreter Service page:

- **Paging via a telephone:**

Dial **076997 19510** or **076997 16680**from any phone (using 9 to obtain an outside line from the Trust desk phone). You will speak to a person at the Vodapage Bureau:

Ensure you;

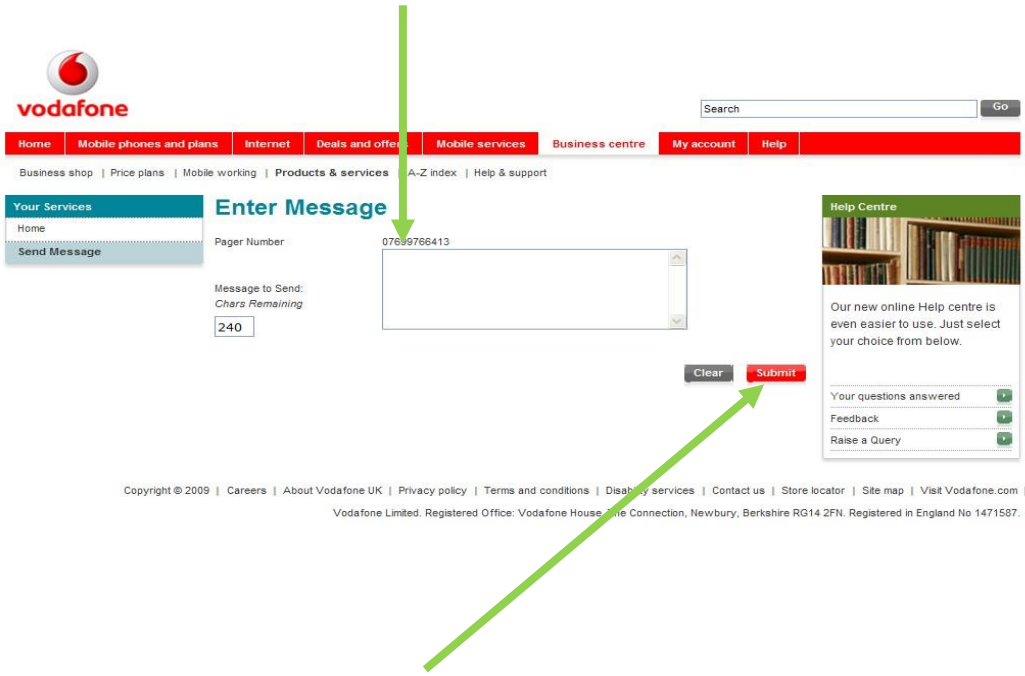
- State the telephone extension number of the department to be contacted (If necessary you can also request a short text message be sent)
- Be sure operator confirms the correct extension number to be contacted

- **Paging via the internet:**

This can be done from any PC with an internet connection; NB; if you get the Websense window, press cancel to clear and continue.

Browse to http://www.paging.vodafone.net/login.jsp?refresh=true (a shortcut can be placed on relevant PCs for this). Type the pager number **07699719510** or **07699716680** in the following box and click on the 'Go' button…

Type your alphanumeric pager message in this window
eg: please call ext 12345



Click on the ‘Submit’ button

You should see a ‘Message successfully sent’ screen. The window can now be closed and the page will be received shortly afterwards. If you see ‘sorry, invalid pager number’ the number may have been mistyped, start again and retype the number.