| **This is an official Northern Trust policy and should not be edited in any way** |

| **Consent for Examination, Treatment or Care** |

| **Reference Number:** |
| **NHSCT/10/332** |

| **Target audience:** |
| All health and social care staff involved in delivering clinical or personal care |

| **Sources of advice in relation to this document:** |
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| **Replaces (if appropriate):** |
| Previous Northern Trust policy on Consent to Examination, Treatment or Care (NHSCT-09-128) |

| **Type of Document:** Trust Wide |

| **Approved by:** Policy, Standards and Guidelines Committee |

| **Date Approved:** 27 January 2010 |

| **Date Issued by Policy Unit:** 14 September 2010 |

| **NHSCT Mission Statement** |
| To provide for all the quality of services we would expect for our families and ourselves |
Policy on Consent for Examination, Treatment or Care

April 2010
Northern Health and Social Care Trust

Policy on Consent for Examination, Treatment or Care

1.0 Introduction

1.1 The DHSSPS developed guidance on Good Practice in Consent, March 2003. This was implemented within the service in April 2004.

1.2 This policy has been developed to standardise consent policy and practice across the Northern Trust and defines accountability for ensuring that the organisation meets its responsibilities for obtaining valid consent.

2.0 Policy Statement

2.1 The Northern Trust recognises the right of every individual receiving Trust services to be given appropriate information to help them to make informed choices about their care and treatment.

2.2 This policy seeks to ensure that practice in obtaining valid consent is consistent with best practice guidelines and is regularly audited.

3.0 Scope of the Policy

3.1 The consent policy applies to every situation in which a member of Trust staff:

- interacts with a patient/client and that interaction results in a decision about an examination, treatment or care;
- undertakes an intervention with or to an individual or group of patients or clients.

4.0 What is Consent?

4.1 ‘Consent’ is a patient’s agreement for a health professional to provide care. Patients or clients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the person must:

- be competent to take the particular decision;
- have received sufficient and appropriate information to take it;
- not be acting under duress.

4.2 Where an adult lacks the capacity (either temporarily or permanently) to give or withhold consent for themselves, no one else can give consent on their behalf. However, an intervention may proceed if it is in the person’s ‘best interests’, as long as it is the least restrictive option available and it has not been refused in advance in a valid and applicable advance directive. For further details on advance directives
see the DHSSPS Reference Guide to Consent for Examination, Treatment or Care (chapter 1, paragraph 16).

4.3 It is important that staff involved in providing or managing health and social care know the main points of law regarding consent. These can be found at Appendix 1.

4.4 Provisions must be made to ensure that patients and clients who have communication difficulties or whose first language is not English receive the information in an accessible format.

4.5.1 To book a face to face minority language interpreter, a sign language interpreter or to get written information translated, please contact the Equality Unit on 028 27661453. Alternatively, please contact the Big Word Telephone Interpreting Service on 0800 321 3050 for immediate telephone interpreting.

5.0 Children and Young People

5.1 All children should be involved in decisions about their treatment or care as their understanding allows.

5.1.1 Those aged 16 years or over are presumed to be capable of giving consent for themselves - as are younger children who are deemed to have sufficient understanding and intelligence to enable him or her to understand fully what is proposed (sometimes known as Gillick or Fraser competence).

5.1.2 Decisions on behalf of all other children should be made by someone with parental responsibility (unless, in an emergency, no such can be traced).

5.1.3 Persons with parental responsibility should be involved even when a child can provide his/her own consent (unless the child specifically objects to this).

5.1.4 A person with parental responsibility cannot over-ride the decision of a child with capacity to consent to an intervention, but may provide consent for a child with capacity who refuses an intervention.

6.0 Documenting Consent

6.1 For significant procedures, it is essential for health and social care professionals to document clearly both a person's agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the person's notes if necessary), or through documenting in the person's notes that they have given oral consent.

6.1.1 When a competent adult refuses or withdraws consent to a proposed examination, treatment or care, this should also be clearly documented in the patient/client records.

6.2 Written consent, using the appropriate form, should be obtained when;

- the treatment or procedure is complex, or involves significant risks (the term ‘risk’ is used throughout to refer to any adverse outcome, including those which some health professionals would describe as ‘side-effects’ or ‘complications’);
the procedure involves general/regional anaesthesia or sedation;

- providing clinical care is not the primary purpose of the procedure e.g. clinical photographs or video clip to be used in Training;

- there may be significant consequences for the patient's employment, social or personal life;

- the treatment is part of a project or programme of research approved by this Trust.

6.2.1 The DHSSPS consent forms in use in the Trust are found at Appendix 2 and are obtained from Regional Supplies: (Each form is available in a range of languages on the DHSSPS website)

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Consent for examination, treatment or care (adult)</td>
</tr>
<tr>
<td>2</td>
<td>Parental agreement to examination, treatment or care for a child or young person</td>
</tr>
<tr>
<td>3</td>
<td>Consent for examination, treatment or care (procedures where consciousness is not impaired)</td>
</tr>
<tr>
<td>4</td>
<td>Adults who are unable to consent to examination, treatment or care</td>
</tr>
</tbody>
</table>

6.2.2 The top white copy of the completed DHSSPS consent form should be offered to the patient and this action recorded.

6.2.3 A number of services have consent forms specific to their treatments/interventions. These should be approved by the Directorate Governance Team to ensure they meet DHSSPS standards.

6.2.4 Clinical staff should adhere to Human Tissue Authority Codes of Practice with regard to Consent for the Removal, Storage and Disposal of Human Organs and Tissue.

6.3 For elective interventions, the consent process will normally start in an outpatient consultation with confirmation of the patient’s agreement to treatment at pre-assessment clinics or on admission.

6.3.1 Patients and clients should be given the DHSSPS leaflet ‘Consent. It’s up to you’.

6.3.2 Written information on the condition, treatment options, risks and benefits will normally be given at the first stage of the consent process.

6.4 Patients and clients may, if they wish, withdraw consent even after they have signed a consent form.

6.5 Completed consent forms should be filed in the patient’s or client's chart.

6.6 In emergency situations, obtaining valid consent will often have to be a more rapid process.

6.7 In complex situations, legal advice may be required from the Trust legal advisers. Should this be the case, the out-of-hours duty solicitor’s contact number can be obtained from the Senior Manager on call.
7.0 Guidelines

7.1 This policy endorses the DHSSPS guidelines on consent for use in the Northern Trust. These can be accessed on the Trust Intranet or the DHSSPS web site as follows:

7.1.1 Good Practice in Consent for Examination, Treatment or Care (March 2003) www.dhsspsni.gov.uk

7.1.2 The DHSSPS Reference Guide to Consent for Examination, Treatment or Care (March 2003) www.dhsspsni.gov.uk

7.2 The DHSSPS Reference Guide to Consent for Examination, Treatment or Care (March 2003) provides comprehensive guidance on the law concerning consent. Appendix 1 of this policy summarises the main points of the law in Northern Ireland. The full document is available on the intranet.

7.3 Comprehensive Trust guidance on consent and capacity is provided at Appendix 3.

7.4 The Human Tissue Authority has developed codes of practice on consent for post mortem examinations and donation of organs, tissue etc. These can be accessed at www.hta.gov.uk

8.0 Accountabilities

8.1 Medical Director

The Medical Director is accountable for ensuring that the consent policy and guidelines are fit for purpose and their effectiveness evaluated.

He will seek assurance from Directors that the policy is implemented and practice is consistent with policy.

8.2 Directors (or their nominated lead)

Directors with responsibility for clinical or social care services will be accountable for ensuring:

- that the policy and guidelines are implemented in all services provided;
- that directorate audit plans include consent audit and audit findings are actioned;
- when the need for consent training is identified, it is resourced;
- there is a mechanism in the directorate for monitoring incidents related to consent issues.
9.0 **General Managers (or equivalent)**

General Managers are responsible for ensuring that:

- an audit plan is developed which is tailored to their service (standardised audit tools are contained in the DHSSPS Regional Consent Audit Document, August 2007);
- information leaflets meet corporate standards and are procured;
- when appraisal and audits identify the need for training in consent, this is facilitated;
- failure to obtain consent is reported as a clinical incident or near miss;
- local operational procedures identify the situations in which written consent is required.

10.0 **Line Managers**

Line Managers are responsible for:

- considering consent practice in annual appraisals;
- releasing staff for training when there is an assessed need;
- ensuring that consent policy is part of the induction programme for new staff;
- ensuring easy access to consent policy, guidelines and consent documentation;
- maintaining a supply of information leaflets.

11.0 **Clinical and Care Staff**

All staff are individually responsible for ensuring that:

- their practice is consistent with the law, the DHSSPS consent guidelines and Trust policy;
- a record of the consent process is made when appropriate;
- the correct documentation is used for written consent (Appendix 2);
- lack of capacity is documented;
- their own training needs in consent practice are met;
- patients and clients are given consent information and, when appropriate, written information on the procedure/intervention they may be consenting to in a format/language as appropriate;
• Seeking consent is only ever delegated to a colleague who is knowledgeable in the process and proposed intervention.

12.0 This policy will be reviewed one year post-implementation and thereafter two-yearly.
Twelve Key Points on Consent

The Law in Northern Ireland

When do you need consent?

- Before you examine, treat or care for competent adults
- Adults assumed to be competent unless demonstrated otherwise i.e. need to be able to understand and weigh up the information needed to make this decision.
- Adults may be competent to make some decisions even if they are not competent to make others
- Giving and obtaining consent is a process, not a one-off event. Patients/service users can change their minds and withdraw consent at any time. If any doubt, check they still consent

Can children give consent for themselves?

- Before you examine, treat or care for a child, you must also seek consent
- Young adults aged 16-17 can give consent. Younger children who fully understand what is involved can also give consent (although their parents should ideally be involved)
- In other cases, someone with parental responsibility must give consent on the child’s behalf, unless they cannot be reached in an emergency
- If a competent child consents, a parent cannot over-ride that consent. If a competent child refuses, legally a parent can give consent, but it is likely that such a serious step will be rare

Who is the right person to seek consent?

- It is best for the person actually treating the person to seek consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure or have been specially trained to seek consent for that procedure

What information should be provided when seeking consent?

- People need sufficient information e.g. about benefits and risks and appropriate alternatives
- If not offered as much information as they reasonably need to reach an informed decision, and in a form they can understand, their consent may not be valid
**Is the consent voluntary?**

- Consent must be given voluntarily: not under any form of duress or undue influence from health/social care professionals, family or friends

**Does it matter how consent is given?**

- Consent can be written, oral or non-verbal
- Signature on form does not itself prove that consent is valid – the point of the form is to record the decision and the discussions that have taken place

**Refusals of examination, treatment or care**

- Competent adults have the right to refuse, even where it would clearly benefit them
- Competent pregnant women may refuse any treatment, even if this would be detrimental to the foetus

**Mental Health Legislation**

- Mental health legislation provides the possibility of treatment for a person’s mental disorder or its complications without their consent
- Does not give power to treat unrelated physical illness without consent

**Adults who are not competent to give consent**

- No-one can give consent on behalf of adults who are not deemed competent. However, you may still treat them if it would be in their best interests
- Best interests include factors such as their wishes and beliefs when competent, their current wishes, general well-being and spiritual and religious welfare
- People close to them may be able to give you information on some of these/advise on their needs and preferences
- If people no longer have capacity but have clearly indicated in the past that they would wish to refuse such treatment in the circumstances in which they now find themselves (an advance directive), the refusal must be accepted.
## FORM 1 -- CONSENT FOR EXAMINATION, TREATMENT OR CARE

### Personal details (or pre-printed label)

<table>
<thead>
<tr>
<th>Surname/family name</th>
<th>First names</th>
<th>Date of Birth</th>
<th>Male</th>
<th>Female</th>
<th>H+C No.</th>
<th>Special requirements</th>
</tr>
</thead>
</table>

### Statement of healthcare professional

Responsible healthcare professional: 

Name of proposed procedure or course of treatment: 

I have explained the procedure. In particular, I have explained:

The intended benefits:

Serious or frequently occurring risks:

Possible additional procedures which may become necessary during the procedure:

- Blood transfusion
- Other procedure (please specify)

This procedure will involve:

- General and/or regional anaesthesia
- Local anaesthesia
- Sedation

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this individual.

- The following leaflet/tape has been provided:

Signed: 

Name (Print): 

Job Title: 

Contact details (if patient wishes to discuss options later):

### Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed:

Name (Print):

### Copy accepted by person giving consent

Yes/No (please circle)
Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

*I agree that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. *You may remove this sentence without affecting your care.

Signature ..............................................................Date ..............................................

Name (Print) ........................................................................................................................................

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature ..............................................................Date ..............................................

Name (Print) ........................................................................................................................................

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature ..............................................................Date ..............................................

Name (Print) ..............................................................Job Title ..............................................

Important notes: (tick if applicable)

- See also advance directive/living will (eg Jehovah’s Witness form)
- Person has withdrawn consent ..................................................Date..............................

(ask person to sign/date here)
FORM 2
PARENTAL AGREEMENT TO EXAMINATION, TREATMENT OR CARE FOR A CHILD OR YOUNG PERSON

Personal details (or pre-printed label)
Surname/family name ................................................................................................................
First names ................................................................................................................................
Date of Birth ...............................................................................................................................
o Male o Female  H+C No. (or other identifier) ..............................................................................
Special requirements (language or other) ........................................................................................

Statement of healthcare professional
Responsible healthcare professional .......................................Job Title........................................
Name of proposed procedure or course of treatment (include side of body or site and brief explanation if medical term not clear)
......................................................................................................................................................
......................................................................................................................................................
I have explained the procedure. In particular, I have explained:
......................................................................................................................................................
......................................................................................................................................................
The intended benefits ........................................................................................................
......................................................................................................................................................
......................................................................................................................................................
Serious or frequently occurring risks ...........................................................................................
......................................................................................................................................................
......................................................................................................................................................
Possible additional procedures which may become necessary during the procedure.
☐ Blood transfusion ☐ other procedure (please specify)................................................................
This procedure will involve:
☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation
I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this child and his or her parents.

☐ The following leaflet/tape has been provided............................................................................

Signed ...........................................................................................Date ......................................
Name (Print) ................................................................................................................................
Job Title .................................................................................................
Contact details (if patient wishes to discuss options later) .............................................................

Statement of interpreter (where appropriate)
I have interpreted the information above to the child and his or her parents to the best of my ability and in a way which I believe they can understand.

Signed ...........................................................................................Date ......................................
Name (Print) ................................................................................................................................

Copy accepted by child/parent Yes/ No (please circle)
### Statement of parent

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you and your child. You have the right to change your mind at any time, including after you have signed the form.

I **agree** to the procedure or course of treatment described on this form and **I confirm** that I have ‘parental responsibility’ for this child.

I **understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I **understand** that my child and I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of the situation prevents this. (This only applies to children having general or regional anaesthesia).

I **understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

I **have been told** about possible additional procedures which may become necessary during my child’s treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

<table>
<thead>
<tr>
<th>Description of procedure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>..........................................................</td>
<td></td>
</tr>
<tr>
<td>..........................................................</td>
<td></td>
</tr>
</tbody>
</table>

*I agree* that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my child’s care. *You may remove this sentence without affecting your child’s care.*

Signature ..........................................................Date ....................................

Name (Print) ..........................................................Relationship to child ..........................

**Child’s agreement (if child wishes to sign)**

I agree to have the treatment I have been told about.

Signature ..........................................................Date ....................................

Name (Print) ..........................................................

**Confirmation of consent** (to be completed by a healthcare professional when the child is admitted for the procedure, if parent/child has signed the form in advance). I have confirmed with the child/parent that they have no further questions and wish the procedure to go ahead.

Signature ..........................................................Date ....................................

Name (Print) ..........................................................Job Title ..........................

**Important notes:** (tick if applicable)

- [ ] See also advance directive/living will (eg Jehovah’s Witness form)
- [ ] Parent has withdrawn consent ..........................................................Date..........................

(ask parent to sign/date here)
Appendix 2: Sample Forms

FORM 3
CONSENT FOR EXAMINATION, TREATMENT OR CARE
(Procedures where consciousness not impaired)

WHEN COMPLETING THIS FORM
PLEASE ENSURE THAT IT IS OPEN FLAT ON A HARD SURFACE
PRESS FIRMLY WITH BALLPOINT PEN ONLY

Guidance to healthcare professionals

What a consent form is for
This form documents the person’s agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver - if individuals, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. They are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire, by providing a check-list of the kind of information which should be offered, and by enabling the person to have a written record of the main points discussed. In no way, however, should the written information provided be regarded as a substitute for face-to-face discussions.

The law on Consent
See the Department of Health, Social Services and Public Safety publication Reference Guide to Consent for Examination, Treatment or Care for a comprehensive summary of the law on consent (also available at www.dhsspsni.gov.uk).

Who can give consent
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”, then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf and a separate form (Form 2) is available for this purpose. Even when a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child’s care, unless the child specifically asks you not to do so. If an individual is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that s/he has given consent orally or non-verbally.

When NOT to use this form
If the person is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A person will not be legally competent to give consent if:

• s/he is unable to comprehend and retain information material to the decision and/or
• s/he is unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support an individual in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information
Information about what treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for people when making up their minds. The courts have stated that patients should be told about ‘significant risks which would affect the judgement of a reasonable patient’. ‘Significant’ has not been legally defined, but the GMC requires doctors to tell patients about ‘serious or frequently occurring’ risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, people may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that they receive at least very basic information about what is proposed. Where information is refused, you should document this on the form and in the case notes.
### FORM 3 -- CONSENT FOR EXAMINATION, TREATMENT OR CARE
(Procedures where consciousness not impaired)

#### Personal details (or pre-printed label)
- Surname/family name: 
- First names: 
- Date of Birth: 
- Gender: Male/Female  
- H+C No. (or other identifier): 
- Special requirements (language or other): 

#### Statement of healthcare professional
- Responsible healthcare professional: 
- Name of proposed procedure or course of treatment: (include side of body or site and brief explanation if medical term not clear) 
- I have explained the procedure. In particular, I have explained: 
- The intended benefits: 
- Serious or frequently occurring risks: 
- I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples that may be taken and any particular concerns of those involved. 
- O The following leaflet/tape has been provided: 
- Signed:  
- Name (PRINT): 

#### Statement of interpreter (where appropriate)
- I have interpreted the information above to the best of my ability and in a way which I believe [s/he] they can understand. 
- Signed: 
- Name (PRINT): 

#### Statement of person giving consent or with parental responsibility for child
- I agree to the procedure or course of treatment described above. 
- I understand that you cannot give me a guarantee that a particular person will perform the procedure. 
- The person will, however, have appropriate experience. 
- I understand that the procedure will/will not involve local anaesthesia. 
- Signature: 
- Name (PRINT): 

Copy accepted Yes/No (please circle)
FORM 4
ADULTS WHO ARE UNABLE TO CONSENT
TO EXAMINATION, TREATMENT OR CARE

WHEN COMPLETING THIS FORM
PLEASE ENSURE THAT IT IS OPEN FLAT ON A HARD SURFACE
PRESS FIRMLY WITH BALLPOINT PEN ONLY

Guidance to healthcare professionals

This form
This form should only be used where it would be usual to seek written consent but an adult (18 or over) lacks capacity to give or withhold consent to treatment. If an adult has capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the Mental Health (Northern Ireland) Order 1986, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or ‘living will’), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health, Social Services and Public Safety Reference Guide to Consent for Examination, Treatment or Care (www.dhsspsni.gov.uk).

When treatment can be given to an adult who is unable to consent
For treatment to be given to an adult who is unable to consent, the following must apply:

- the adult must lack the capacity (‘competence’) to give or withhold consent to this procedure
- AND the procedure must be in his/her best interests.

Capacity
An adult will lack capacity to consent to a particular intervention if he or she is:

- unable to comprehend and retain information material to this decision, especially as to the consequences of having, or not having, the intervention in question; and/or
- unable to use and weigh this information in the decision-making process.

Before making a judgement that an adult lacks capacity you must take all steps reasonable in the circumstances to assist him/her in taking their own decisions (this will clearly not apply if the patient is unconscious). This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate.

People close to the person (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates or supporters.

Capacity is ‘decision-specific’: an adult may lack capacity to take a particular complex decision, but be quite able to take other more straightforward decisions or parts of decisions.

Best interests
An adult’s best interests are not limited to their best medical interests. Other factors which form part of the best interests decision include:

- the wishes and beliefs of the adult when competent
- their current wishes
- their general well-being
- their spiritual and religious welfare

Two incapacitated individuals whose physical condition is identical, may therefore have different best interests. Unless the person has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, you attempt to involve people close to the adult (spouse/partner, family and friends, carer, supporter or advocate) in the decision-making process. Those close to the person cannot require you to provide particular treatment which you do not believe to be clinically appropriate. However they will know the person much better than you do, and therefore are likely to be able to provide valuable information about their wishes and values.

Second opinions and court involvement
Where treatment is complex and/or people close to the person express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient’s condition prevents this. Donation of regenerative tissue such as bone marrow, sterilisation for contraceptive purposes and withdrawal of artificial nutrition or hydration from a patient in PVS must never be undertaken without prior High Court approval. High Court approval can also be sought where there are doubts about the person’s capacity or best interests.
<table>
<thead>
<tr>
<th>FORM 4 -- ADULTS WHO ARE UNABLE TO CONSENT TO EXAMINATION, TREATMENT OR CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal details (or pre-printed label)</strong></td>
</tr>
<tr>
<td>Surname/family name ................................................................................................................</td>
</tr>
<tr>
<td>First names ................................................................................................................................</td>
</tr>
<tr>
<td>Date of Birth .............................................................................................................................</td>
</tr>
<tr>
<td>□ Male □ Female H+C No. (or other identifier) ........................................................................</td>
</tr>
<tr>
<td>Special requirements (language or other) ................................................................................</td>
</tr>
</tbody>
</table>

**Statement of healthcare professional**

| Responsible healthcare professional ..............................................Job Title................................ |
| Name of proposed procedure or course of treatment *(include side of body or site and brief explanation if medical term not clear)* |

B. **Assessment of adult’s capacity**

I confirm that the person named above lacks capacity to give or withhold consent to this procedure or course of treatment or care because he or she:

- □ is unable to comprehend and retain information material to the decision ; and/or
- □ is unable to use and weigh this information in the decision-making process; or
- □ is unconscious

Further details (excluding where patient unconscious); for example how above judgements reached; which colleagues consulted; what attempts made to assist the individual make his or her own decision and why these were not successful.

C. **Assessment of best interests**

To the best of my knowledge, the person named above has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to him/her; and I believe the procedure to be in his/her interests because:

(Where incapacity is likely to be temporary, for example if patient unconscious, or where he/she has fluctuating capacity)

The treatment cannot wait until he/she recovers capacity because:
Appendix 2: Sample Forms

D. Involvement of the family and others close to him/her

The final responsibility for determining whether a procedure is in an incapacitated person’s best interests, lies with the healthcare professional performing the procedure. However, it is good practice to consult with those close to the person (e.g. spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that he/she would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. “Best interests” go far wider than “best medical practice”, and include factors such as their wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

<table>
<thead>
<tr>
<th>(to be signed by a person or persons close to the individual, if they wish)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I/we have been involved in a discussion with the relevant healthcare professionals over the care and treatment of ...................................................(name). I/we understand that he/she is unable to give his/her consent, based on the criteria set out in this form. I/we also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.</td>
</tr>
<tr>
<td>Any other comments (including any concerns about decision).................................................................</td>
</tr>
<tr>
<td>Name..................................................................................Relationship to person .................................</td>
</tr>
<tr>
<td>Address (if not the same as above)............................................................................................................</td>
</tr>
<tr>
<td>Signature .............................................................................Date .....................................................</td>
</tr>
</tbody>
</table>

If a person close to the individual was not available in person, has this matter been discussed in any other way (e.g. over the telephone) □ Yes □ No

Details:............................................................................................................................................

<table>
<thead>
<tr>
<th>Signature of healthcare professional proposing treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The above procedure is, in my professional judgement, in the best interests of the person named above, who lacks capacity to consent for himself or herself. Where possible and appropriate, I have discussed his/her condition with those close to him or her, and taken their knowledge of his/her views and beliefs into account in determining his or her best interests.</td>
</tr>
<tr>
<td>I have/have not sought a second opinion.</td>
</tr>
<tr>
<td>Signature .............................................................................Date .....................................................</td>
</tr>
<tr>
<td>Name (PRINT) ..................................................................................Job Title ........................................</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where second opinion sought, he/she should sign below to confirm agreement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature .............................................................................Date .....................................................</td>
</tr>
<tr>
<td>Name (PRINT) ..................................................................................Job Title ........................................</td>
</tr>
</tbody>
</table>


Consent and Capacity in the Examination, Treatment or Care of Patients and Clients

Guidance for Staff
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Introduction and aims of this guidance</td>
<td>3</td>
</tr>
<tr>
<td>2 Consent</td>
<td>4</td>
</tr>
<tr>
<td>2.1 Providing valid consent</td>
<td>4</td>
</tr>
<tr>
<td>2.2 Refusing or providing only partial consent</td>
<td>4</td>
</tr>
<tr>
<td>3 Adults with capacity to consent</td>
<td>5</td>
</tr>
<tr>
<td>4 Children and young people</td>
<td>6</td>
</tr>
<tr>
<td>5 Persons with a mental disorder</td>
<td>6</td>
</tr>
<tr>
<td>6 Adults without capacity to consent</td>
<td>7</td>
</tr>
<tr>
<td>6.1 The principles underlying capacity</td>
<td>7</td>
</tr>
<tr>
<td>6.2 Suspecting that a person may lack capacity</td>
<td>8</td>
</tr>
<tr>
<td>6.3 Assessing capacity</td>
<td>8</td>
</tr>
<tr>
<td>6.4 Determining a person’s ‘best interests’</td>
<td>10</td>
</tr>
<tr>
<td>6.5 The least restrictive alternative</td>
<td>11</td>
</tr>
<tr>
<td>6.6 Objecting to examination, treatment or care</td>
<td>11</td>
</tr>
<tr>
<td>7 Emergency situations</td>
<td>11</td>
</tr>
<tr>
<td>8 The Court as ultimate authority</td>
<td>11</td>
</tr>
<tr>
<td>9 Documentation</td>
<td>12</td>
</tr>
<tr>
<td>10 Capacity flow-charts</td>
<td>12</td>
</tr>
<tr>
<td><strong>Flow-chart 1</strong> - Actions when it is Proposed to Provide an Examination, Treatment or Care for an Adult and there is No Valid Advance Refusal</td>
<td>14</td>
</tr>
<tr>
<td><strong>Flow-chart 2</strong> - Actions when it is Proposed to Provide an Examination, Treatment or Care for a Child (under the age of 18 years)</td>
<td>14</td>
</tr>
</tbody>
</table>
1 Introduction and aims of this guidance

Consent remains one of the most misunderstood legal and professional issues facing health and social care workers, who are often unclear as to the legality of their actions in securing consent from patients or clients for the examinations, treatment or care they provide.

This is especially so when an individual appears unable to provide meaningful consent to a proposed examination, treatment or care, or where he/she has a mental disorder (such as a learning disability, dementia, or a mental illness).

The government has sought over recent years to bring clarity to the area. In Northern Ireland, for example, the Department of Health, Social Services and Public Safety (DHSSPS) between 2003 and 2004 issued not only general consent guidance for both the health and social care sectors, but also more specific guidance on matters of consent for children and for adults with a learning disability.

The Mental Capacity Act 2005 came into effect in England and Wales in 2007, and Northern Ireland is due to have capacity legislation by 2014. In the meantime, the Mental Capacity Act should be seen as dictating good practice here as well.

The Northern HSC Trust has recently adopted its own Policy on Consent, and this guidance has been drawn up to assist staff in operating that policy. It aims to help all health and social care staff within the Trust, both qualified and unqualified, in their understanding and application of a range of issues on consent and capacity, including:-

- legal aspects of capacity and consent, both for adults and for children;
- obtaining consent, both for day-to-day interventions (such as personal care acts, venepuncture and other relatively low-level interventions) and for more complex or invasive procedures (such as general or specialist surgery);
- determining whether a person has the capacity to make a decision with regard to a proposed examination, treatment or care for him/herself;
- maximising the capacity of individuals to make their own decisions about their treatment or care; and
- determining the ‘best interests’ of an individual who does not have the capacity to make a decision for him/herself.

The guidance accords with the Human Rights Act 1998, the Mental Capacity Act 2005 and the Mental Health (N Ireland) Order 1986, as well as the following documents:-

- Good Practice in Consent – Consent for Examination, Treatment or Care: A Handbook for the HPSS (DHSSPS, 2003)
- Policy on Consent (Northern HSC Trust, 2008)
- The Mental Capacity Act 2005 Code of Practice (Department of Constitutional Affairs, 2007).
2 Consent

2.1 Providing valid consent

Consent is a process – and while the end-product of that process might be a person’s signature on a consent-form, such a signature does not necessarily mean that the person has given their valid and legal consent to a proposed examination, treatment or care.

For a person’s consent to be legal and valid, he/she must:-

- be provided with sufficient (and appropriate) information to make the decision;
- be able to reach a decision free from undue influence or coercion; and
- have the capacity to make the decision.

Information should generally be given through face-to-face discussion, supplemented where necessary by whatever means (e.g. written or pictorial) that is most appropriate for the person concerned. It should include details of what the proposed examination, treatment or care will involve, its benefits and risks (including any significant side-effects and/or complications, and the implications of not receiving it) as well as any possible alternative procedures.

It is the responsibility of the professional who will provide the examination, treatment or care to ensure that valid consent is obtained. However, a colleague may be delegated the task of seeking consent - provided he/she is suitably trained and qualified and has sufficient knowledge of the proposed intervention and its risks to provide the person with appropriate information.

No-one else may provide consent on behalf of any other adult. This applies even to adults who do not have the capacity to provide consent for themselves.

2.2 Refusing or providing only partial consent

Also, if an adult who does have the capacity to make a decision about a proposed examination, treatment or care declines to accept that intervention – and this applies even in the case of a pregnant woman whose refusal to accept treatment may be detrimental to her foetus – his/her decision must be respected and the intervention may not proceed: to do otherwise would be unlawful, and the person providing the examination, treatment or care could be liable to prosecution. (Note that there is one exception to this – see under ‘Persons with a mental disorder‘.) In cases where refusal is likely to lead to serious consequences for the person, professionals should convene a meeting of all relevant parties and consider referring the matter to their legal advisers who, in turn, may recommend that a declaration be sought from the Court.

When a person with capacity changes his/her decision about a particular examination, treatment or care, that change in decision must be respected.

Likewise, if a person consents to only part(s) of a proposed package of examination, treatment or care, that decision too must be respected.

Each of these situations should be fully documented in the person’s notes, preferably countersigned by the person him/herself.
3 Adults with capacity to consent

**Unless there is evidence to indicate otherwise, all adults should be presumed to have capacity to make their own decisions and give their own consent.**

And because it is unlawful to undertake any form of examination, treatment or care with someone in the absence of valid consent, it is essential that the professional responsible for the intervention ensures that any consent the person provides is valid before proceeding any further.

Four conditions (referred to as the ‘test of capacity’) must apply before a person can be said to have given valid consent to a proposed examination, treatment or care. He/she must be able to:-

- understand the information relevant to the decision that has to be made;
- retain that information;
- use or weigh the information as part of the process of making a decision; and
- communicate a decision (whether by talking, sign language or any other means).

A *functional* approach must be taken to capacity and consent. This means that no-one can be presumed to be unable to provide consent just because of a previous diagnosis (e.g. of learning disability). Nor may a person’s capacity be determined on the basis purely of their appearance or any other aspect of their behaviour, or of the apparent wisdom or lack of wisdom of any decision he/she may make. (An unwise decision might *suggest* that a person’s capacity is impaired; it should never be considered a sufficient indicator, however). Also, a person may be able to consent to *one* form of examination, treatment or care – or even just to one *aspect* of a proposed intervention – but not to others, or to consent *today* but not subsequently (i.e. capacity can fluctuate).

In other words, capacity and consent are both decision-specific and time-specific. The key question is whether a person can make *this* decision, at *this* point in time – and for that reason it is always advisable for any decisions to be taken as close to the proposed intervention as possible. (Where consent was given some time previously, the professional involved should ensure that the person is still consenting immediately before the examination, treatment or care is administered - especially if new information about the intervention and/or the person’s circumstances have come to light in the interim.) Also, the only basis on which to determine whether a person can consent to any intervention is the test of capacity outlined above.

The professional responsible for the proposed examination, treatment or care will generally be able to determine a person’s capacity informally, directly with the individual. Complex cases, however (e.g. if the person has a severe learning disability or mental illness), may be referred for a specialist psychological or psychiatric opinion. Even when that is done, though, it remains the responsibility of the professional providing the intervention to be satisfied that valid consent has been given before proceeding further.

The professional must record in the person’s notes whether he/she has the capacity to make the decision at hand and only then should the person be asked to confirm their consent to the proposed examination, treatment or care.
The way in which the person’s consent is provided should be recorded too. For serious or invasive procedures, such as surgery, this will generally involve the person signing a Trust Consent Form. For lower-level interventions, however, such as venepuncture or attendance at a day centre, it may involve the person either giving verbal consent or simply complying with, or at least not objecting to, a procedure (e.g. extending his/her arm to facilitate the taking of blood, or not objecting to a personal care procedure).

4 Children and young people

Irrespective of a child or young person’s age, he/she should be as fully involved as his/her level of understanding allows in the making of any decisions about his/her examination, treatment or care.

Young persons aged 16 and 17 years are presumed to have the capacity to give their own consent for examination, treatment or care unless there is evidence to indicate otherwise.

So too are even younger children – provided they are able to understand fully the proposed intervention (i.e. provided they are ‘Gillick competent’ on the matter).

Consent on behalf of all other children should be given by someone who has parental responsibility for them. The only exception is in an emergency when no-one with parental responsibility can be contacted; then the intervention may proceed on the basis of the child’s ‘best interests’ or ‘welfare’.

Indeed, even when a child is able to provide his/her own consent to a proposed examination, treatment or care, the health or social care professional involved should involve the person(s) with parental responsibility for the child’s care, unless the child specifically requests that this not be done. (In such a situation, especially if there are ongoing implications, as in the long-term use of contraceptives, for example, the child should be encouraged to accept the support of some other adult instead.)

However, if a child who has capacity accepts and gives his/her consent to a proposed examination, treatment or care, no person with parental responsibility may over-ride that decision.

But if a child with capacity refuses to accept a proposed intervention, someone with parental responsibility may provide consent in his/her stead. It is likely that such cases will be rare, however, and they are likely to be referred to the Court.

Indeed, the rights and powers of a person with parental responsibility are never absolute: he/she must at all times act in the best interests and welfare of the child concerned.

In the event of a disagreement between those with parental responsibility for a child and the health and social care professional(s) involved, and that disagreement cannot be resolved, the Court may be asked to make a declaration.

5 Persons with a mental disorder

Although many persons with a mental disorder may not have the capacity to make a decision about their examination, treatment or care, this will not always be the case.
Indeed, the presumption should always be that an adult with a mental disorder, just as with any other adult, has capacity unless there is evidence to the contrary.

Even then, each person should be supported to the fullest reasonable extent to reach a decision about each aspect of any examination, treatment or care that is being proposed.

Traditionally, health and social care professionals have adopted a paternalistic approach to adults with a mental disorder, providing examinations, treatment or care in what they (perhaps in conjunction with what the adult’s spouse or next-of-kin) consider to be in the adult’s best interests – even, at times, if the adult shows a clear unwillingness to accept or comply with the intervention. Even though well-intentioned, this approach is, as has been indicated above, highly unlikely to be legally sustainable.

Persons with a mental disorder should generally, therefore, be considered in relation to capacity and consent in exactly the same way as persons without a mental disorder.

The only exception is for people with a mental disorder who have the capacity to consent (or otherwise) to a proposed examination, treatment or care and who are subject to the Mental Health (N Ireland) Order 1986. Such persons can be required to receive treatment – even treatment to which they object – although only insofar as it is directly related to their mental disorder. (They may not be treated compulsorily and against their wishes for any other condition they may have.)

6 Adults without capacity to consent

No-one else can consent for an adult who is unable to consent for him/herself.

Even so, it is still possible for an examination, treatment or care to be given to such adults – although only provided the remainder of this guidance is complied with. It is the responsibility of the member of staff who will provide the intervention to ensure that it is.

6.1 The principles underlying capacity

The Mental Capacity Act is based on 5 key principles:-

- a person must be presumed to have the capacity to make a decision on a particular matter until it is established that he/she does not have that capacity;
- a person should not be considered as unable to make a decision unless all practicable steps to assist him/her to do so have been taken without success;
- a person should not be considered as unable to make a decision merely because he/she chooses to make what may appear to be an unwise decision;
- when a decision is being made on behalf of someone who is deemed to lack capacity, that decision must be made in the person’s ‘best interests’; and
- when a decision is being made on behalf of someone who is deemed to lack capacity, consideration must be given to the ‘least restrictive option’ available (i.e. the option which is the least restrictive in terms of the person’s rights and freedom of action) – although only if it is also in the person’s best interests.
These principles should underpin all aspects of the examination, treatment or care of adults across the Northern Trust who do not have the capacity to consent for themselves.

6.2 Suspecting that a person may lack capacity

Unless there is evidence to indicate otherwise, all adults should be presumed to have capacity to make their own decisions and provide their own consent.

Factors which might cause a health or social care professional to suspect that a person might not have the capacity to decide on a particular matter include the following:

- the person's behaviour or circumstances;
- the person having already been shown to lack capacity in other areas of his/her life; and
- someone else expressing concern about the person's capacity.

If a person is suspecting of lacking capacity, then his/her capacity must be assessed before the proposed examination, treatment or care can be provided.

Before any assessment, however, all reasonable steps must be taken to support the person to reach his/her own decision, and/or it must be determined that the intervention cannot be delayed until such time as the person may be able to demonstrate capacity.

Notwithstanding this, if a treatment must be given in order to preserve the person's life or prevent a rapid deterioration in his/her condition, it may proceed, even without a capacity assessment, under the common law doctrine of necessity.

6.3 Assessing capacity

The Mental Capacity Act specifies two criteria that must be fulfilled before a person can be determined as lacking capacity on a particular matter:

- criterion 1: the person must have 'an impairment of, or a disturbance in the functioning of, the mind or brain', which may be either permanent or temporary and may be evidenced through the person:
  - having a formal diagnosis of an established form of mental disorder (e.g. learning disability, dementia or mental illness); or
  - demonstrating signs of an abnormal mental state (e.g. delirium, a mood or anxiety disorder, or the result of drug or excessive alcohol intake);

- and criterion 2: because of that impairment or disturbance in the mind or brain, the person must be unable to make a decision on the matter at hand, i.e. he/she must be unable to:
  - understand the information relevant to the decision that must be made; or
  - retain that information; or
  - use or weigh that information when arriving at the decision; or
  - communicate the decision made (i.e. whether by talking, through the use of sign language or by any other means).
Note that a person can be considered to lack the capacity to make a decision about a particular examination, treatment or care only if both of these criteria apply and that, in turn, the latter will apply if the person is unable to do even just one of the four things listed.

Also note that it is for the individual who will provide any proposed examination, treatment or care to be satisfied as to whether or not the person concerned has the capacity to provide valid consent. Staff will generally be able to determine for themselves whether or not these conditions are fulfilled, but in cases of doubt they should seek a second opinion. For particularly complex cases, it may be advisable to request an assessment by an appropriate specialist healthcare professional (usually a psychiatrist or a psychologist).

In terms of the assessment itself, the person must be able to ‘broadly understand’ and ‘retain’ the information involved for long enough for a decision to be made. He/she may be assisted in this by providing the information in a non-verbal format (e.g. photographs or drawings) and/or by means of an augmentative communication system, such as Makaton. (A speech and language therapist may be able to advise on the most appropriate way to communicate with the person as part of the assessment.)

When determining if a person can ‘use or weigh’ information when arriving at the decision, the individual conducting the assessment should consider the following:-

- whether the person appreciates the wider consequences of the decision;
- whether the person employs reasoning processes;
- whether the person’s decision accords with any beliefs he/she has expressed;
- whether the person has weighed the risks and benefits of a range of options;
- whether the person may have been coerced into reaching the decision; and
- the importance to the person of any religious and/or cultural beliefs that may have influenced his/her decision, or that may account for the decision made.

**Generally speaking, the more serious the decision that has to be made, the greater should be the level of understanding that the person has to demonstrate.**

In any case, it must be seen as more likely than not (on the balance of probabilities) that the person either has or has not the capacity to make the decision at hand.

If the outcome of a capacity assessment is challenged, a resolved position might be achieved through any or all of the following:-

- the appointment of an independent advocate to represent the person;
- asking for a second opinion;
- a mediation process; or
- referral to the Court for a ruling.

A person’s capacity should be re-assessed regularly, and especially when a treatment or care plan is being developed or revised.

Both the outcome and how it is arrived at must be recorded in the person’s casenotes.
6.4 Determining a person’s ‘best interests’

Any form of examination, treatment or care provided to an adult who does not have the capacity to consent to that intervention must be in the person’s ‘best interests’. (‘Best interests’ include, but extend beyond, what is in the person’s best medical interests.)

It is the responsibility of the professional providing the proposed intervention to take steps to determine, insofar as possible, what the person’s ‘best interests’ are.

Normally, this will entail convening a meeting comprising of the multi-disciplinary team, the person’s main carer(s) and anyone else with a significant input in the person’s life.

Together, the participants in such a meeting will need to consider the following:-

- whether and/or when the person is likely to regain capacity, and whether the decision that requires to be taken can be postponed in the interim;
- how to encourage and maximise the participation of the person him/herself in reaching a decision;
- the past and present wishes, feelings, beliefs and values of the person, along with any other relevant factors; and
- the views of any other relevant people.

Other relevant factors requiring consideration include any ‘advance directive’ or ‘living will’ about how the person would want to be treated and/or the details of any treatment(s) the person does not wish to receive.

But whereas a statement about how a person may want to be treated is not binding (albeit it must be taken into consideration in determining the person's best interests), a valid advance refusal (detailing any treatments the person does not wish to receive) must be respected and acted upon.

To be valid, an advance refusal must have been drawn up voluntarily by an appropriately informed person who was at least 18 years old and had capacity at that time; it must also relate directly to the issue at hand and, if it relates to life-sustaining treatment, it must have been signed and witnessed as such.

Advance refusals will be rendered invalid if in the interim the person has done anything inconsistent with the decision and/or if there are reasonable grounds to believe that there are now circumstances which, had the person known about them at the time, he/she would not have made that decision.

In cases where a person’s capacity fluctuates, his/her views about any intervention that may become necessary during a period of incapacity should be ascertained at a time when he/she does have capacity, and those views should be recorded in his/her notes.

Provided agreement can be reached as to what action(s) are in the person’s best interests, the agreed examination, treatment or care should proceed on that basis.

Where agreement cannot be reached, however (even if there is just a single dissenter), a second professional opinion may be sought and/or the ‘best interests’ meeting may be re-convened. Ultimately, the Court may be asked to make a ruling on the matter.
6.5 The least restrictive alternative

When deciding upon the form of any examination, treatment or care to be given to a person who is unable to consent for him/herself, the professional concerned must consider the option which is likely to produce the desired outcome in the way that is the ‘least restrictive’ in terms of the person’s rights and freedom of action.

However, this requirement does not take precedence over ‘best interests’: the least restrictive option should be adopted only if it is also in the person’s best interests.

6.6 Objecting to examination, treatment or care

When a person without the capacity to consent to a particular examination, treatment or care which has been determined to be in his/her best interests objects when that intervention is applied, all reasonable steps should be taken - including enlisting the help of family, carers or others, as appropriate - to alleviate the person's concerns.

Ultimately, though, the examination, treatment or care may still proceed – provided the least possible amount of force is adopted and the health or social care professional concerned believes that such action is necessary to prevent harm to the person and that it is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm (cf., the Trust’s Policy on the Use of Restrictive Physical Interventions 2008 and the Mental Capacity Act 2005).

In serious or complex cases, or where doubt exists on the part of the heath or social care professional, consideration should be given to seeking legal advice, as appropriate.

7 Emergency situations

Where an emergency intervention is required, either to preserve a person's life or to prevent a rapid deterioration in his/her condition, and a person with capacity refuses that intervention, the person's decision should be respected. However, where at all possible a meeting of all relevant parties should be convened and/or consideration should be given to referring the matter to the Trust's legal advisers.

Where an emergency intervention is required for a person who does not have capacity, the intervention should proceed on the basis of it being in the person's 'best interests'.

And where an emergency intervention is required for a person whose capacity on the matter is unclear, the intervention should proceed on the basis of the common law doctrine of necessity.

8 The Court as ultimate authority

The Court is the ultimate authority on all aspects of a person’s examination, treatment or care, including issues of capacity and consent. As such, it may be approached when there are doubts about a person’s capacity or where there is a dispute over whether a particular intervention is in a person's best interests.
In addition, there are several matters which must be referred to the Court before a proposed intervention can proceed, including the non-therapeutic sterilisation (e.g. for contraceptive reasons) of a woman without capacity and the withdrawal of artificial nutrition or hydration from a patient in a 'persistent vegetative state' (PVS).

9 Documentation

It is essential for health and social care professionals to document clearly both the nature and the outcome of a person's decision to consent to any form of examination, treatment or care which is significant. This may be done either through the use of a consent form (with further detail in the person's notes if necessary) or by means of an entry in the person's notes that they have provided consent by some other (non-written) means.

In particular, written consent should be sought when the proposed intervention is complex and/or involves significant risk. This may be provided through completion of one of the four HPSS Consent Forms (2003):

- Form 1: Consent For Examination, Treatment or Care;
- Form 2: Parental Agreement to Examination, Treatment or Care for a Child or Young Person;
- Form 3: Consent for Examination, Treatment or Care (Procedures where Consciousness Not Impaired); and
- Form 4: Adults Who are Unable to Consent to Examination, Treatment or Care.

Full details should also be documented - preferably countersigned by the person him/herself - in the notes of any person with capacity who refuses to consent to a particular intervention.

And finally, any decision about a person's examination, treatment or care that has involved a consideration of his/her capacity must be fully documented in his/her notes also. This should include details of how the person's capacity was assessed, the outcome of the assessment, and how any 'best interests' decisions were reached.

10 Capacity flow-charts

Two flow-charts, one for adults and the other for children, are presented on the following two pages. They summarise the key issues and steps to be taken when a health or social care professional proposes an examination, treatment or care for a patient or client.
Appendix 3

Flowchart 1: - Actions when it is Proposed to Provide an Examination, Treatment or Care for an Adult and there is No Valid Advance Refusal

(Note: Where a valid advance refusal exists, it must be respected and acted upon – see section 6.4 of the Guidance for Staff, above)

Does the person have the capacity to consent to the proposed examination, treatment or care?
(i.e. can he/she (i) understand the information relevant to the decision to be made; (ii) retain that information; (iii) use or weigh that information as part of the process of making the decision; and (iv) communicate the decision made, whether by talking, sign language or any other means)

No

Is the treatment/care life-saving or is it needed urgently to prevent deterioration or serious harm?

Yes

Does the person consent to the proposed treatment/care?

No

Provide the treatment/care

Yes

Is the person likely to have the capacity to consent to the treatment/care in the future?

No

Is there unanimous agreement that the proposed treatment/care is in the person’s best interests?

Yes

Either provide or do not provide the treatment/care, according to the agreement on ‘best interests’

No

Seek a further opinion (possibly from the Court), until a resolved position on ‘best interests’ is achieved

Postpone the treatment/care until the person has the capacity to consent

Consider using the Mental Health Order to provide the treatment/care

No

Consider using the Mental Health Order to provide the treatment/care (but consider alternatives to which the person may consent)

Do not provide the treatment/care

Yes

Convene a multi-disciplinary meeting, and/or consider referral to the Courts

Is the person likely to have the capacity to consent to the treatment/care in the future?

Yes

Either provide or do not provide the treatment/care, according to the agreed ‘best interests’ decision

No

Seek a further opinion (possibly from the Courts), until a resolved position on ‘best interests’ is achieved

Unclear

Is the treatment/care life-saving or is it needed urgently to prevent deterioration or serious harm?

Yes

Provide the treatment/care

No

Is the person likely to have the capacity to consent to the treatment/care in the future?

Is the treatment/care for the person’s mental disorder?

Consider using the Mental Health Order to provide the treatment/care

Is the treatment/care life-saving or is it needed urgently to prevent deterioration or serious harm?

Does the person have a mental disorder?

Yes

Provide the treatment/care

No

Is the treatment/care for the person’s mental disorder?

Consider using the Mental Health Order to provide the treatment/care

Is the person likely to have the capacity to consent to the treatment/care in the future?

Postpone the treatment/care until the person has the capacity to consent

Seek a further opinion (possibly from the Courts), until a resolved position on ‘best interests’ is achieved
Flow-chart 2 - Actions when it is Proposed to Provide an Examination, Treatment or Care for a Child (under the age of 18 years)

(Notes: All children should be as involved in decisions about their treatment/care as their understanding allows; 16 and 17 year-olds, plus younger children who are ‘Gillick competent’, are presumed to have capacity; decisions on behalf of all other children should be made by someone with parental responsibility unless, in an emergency, no such person can be traced; persons with parental responsibility should be involved even when a child can provide his/her own consent - unless the child asks that this not be done)

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**Does the child have the capacity to consent to the proposed examination, treatment or care?**

For 16-17 year-olds: can he/she (i) understand the information relevant to the decision to be made; (ii) retain that information; (iii) use or weigh that information as part of the process of making the decision; and (iv) communicate the decision made, whether by talking, sign language or any other means?

For younger children: has he/she achieved sufficient understanding and intelligence to understand fully what is proposed?

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**Does the child consent to the proposed treatment/care?**

- Yes: Provide the treatment/care
- No: Consider using the Mental Health Order

**Is the treatment/care in relation to a mental disorder?**

- Yes: Consider alternatives the child might consent to
- No: Provide the treatment/care

**Is the treatment/care life-saving or needed urgently to prevent deterioration or serious harm?**

- Yes: Is a person with parental responsibility available and willing to provide valid consent?
  - Yes: Provide the treatment/care
  - No: Postpone the treatment/care until the child can consent
- No: Consider alternatives that the child or a person with parental responsibility might consent to, and/or a referral to the Court

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**Is the treatment/care life-saving or is it needed urgently to prevent deterioration or serious harm?**

- Yes: Is a person with parental responsibility available and willing to provide valid consent?
  - Yes: Provide the treatment/care
  - No: Postpone the treatment/care until the child can consent
- No: Consider alternatives the child might consent to

**Is the treatment/care for the person’s mental disorder?**

- Yes: Is the child likely to have the capacity to consent to the treatment/care in the near future?
  - Yes: Consider using the Mental Health Order
  - No: Does a person with parental responsibility consent?
    - No: Postpone the treatment/care until the child can consent
    - Yes: Provide the treatment/care
- No: Consider alternatives that the child or a person with parental responsibility might consent to, and/or a referral to the Court