

CREST FAMILY PRACTICE

CONSENT POLICY

Introduction

The purpose of this protocol is to set out the Practice's approach to consent and the way in which the principles of consent will be put into practice. It is not a detailed legal or procedural resource due to the complexity and nature of the issues surrounding consent.

Where possible, a clinician must be satisfied that a patient understands and consents to a proposed treatment or investigation. This will include the nature, purpose, and risks of the procedure, if necessary by the use of drawings, interpreters, videos or other means to ensure that the patient understands, and has enough information to make an "informed choice".

Implied Consent

Implied consent will be assumed for many routine physical contacts with patients. Where implied consent is to be assumed by the clinician, in all cases, the following will apply:

- An explanation will be given to the patient about what the clinician is about to do, and why.
- The explanation will be sufficient for the patient to understand the procedure.
- In all cases where the patient is under 18 years of age a verbal confirmation of consent will be obtained and briefly entered into the medical record.
- Where there is a significant risk to the patient an "Express Consent" will be obtained in all cases (see below).

Express Consent

Express consent (written or verbal) will be obtained for any procedure which carries a risk that the patient is likely to consider as being substantial. A note will be made in the medical record detailing the discussion about the consent and the risks. A Consent Form may be used for the patient to express consent.

Obtaining Consent

- Consent (Implied or Express) will be obtained prior to the procedure, and prior to any form of sedation.
- The clinician will ensure that the patient is competent to provide a consent (16 years or over) or has "Gillick Competence" if under 16 years. Further information about Gillick Competence and obtaining consent for children is set out below.

- Consent will include the provision of all information relevant to the treatment.
- Questions posed by the patient will be answered honestly, and information necessary for the informed decision will not be withheld unless there is a specific reason to withhold. In all cases where information is withheld then the decision will be recorded in the clinical record.
- The person who obtains the consent will be the person who carries out the procedure (i.e. a nurse carrying out a procedure will not rely on a consent obtained by a doctor unless the nurse was present at the time of the consent).
- The person obtaining consent will be fully qualified and will be knowledgeable about the procedure and the associated risks.
- The scope of the authority provided by the patient will not be exceeded unless in an emergency.
- The Practice acknowledges the right of the patient to refuse consent, delay the consent, seek further information, limit the consent, or ask for a chaperone.
- Clinicians will use a Consent Form where procedures carry a degree of risk or where, for other reasons, they consider it appropriate to do so (e.g. malicious patients).
- No alterations will be made to a Consent Form once it has been signed by a patient.
- Clinicians will ensure that consents are freely given and not under duress (e.g. under pressure from other family members).
- If a patient is mentally competent to give consent but is physically unable to sign the Consent Form, the clinician should complete the Form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

Other aspects which may be explained by the clinician include:

- Details of the diagnosis, prognosis, and implications if the condition is left untreated
- Options for treatment, including the option not to treat.
- Details of any subsidiary treatments (e.g. pain relief)
- Patient experiences during and after the treatment, including common or potential side effects and the recovery process.
- Probability of success and the possibility of further treatments.
- The option of a second opinion

Consent for children

Everyone aged 16 or over 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/her to understand fully what is proposed” (known as Gillick Competence), then he/she will be competent to give consent for him/herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign a Consent Form for themselves, but may like a parent to countersign as well.

For children under 16 (except for those who have Gillick Competence as noted above), someone with parental responsibility should give consent on the child’s behalf by signing accordingly on the Consent Form. Mothers automatically have parental consent, fathers have parental responsibility if they are married to the mother, or after 2003 if they are named on the child’s birth certificate, or they may be granted a parental responsibility order by a court. Normally the consent of one person with parental responsibility is adequate even if the other parent disagrees, but this is not the case with immunisation.

If consent is refused or withdrawn

If an adult with the capacity to consent makes an informed decision to refuse consent, this decision will be respected, however serious the consequences may be for the patient. Consent may be withdrawn by the patient at any time, in which case the doctor or nurse will explain the consequences of not completing the procedure and will assess the risks to the patient before deciding on further action.

More detailed information on consent, including legal case summaries, can be found in the Department of Health Reference Guide to Consent for Examination or Treatment:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653_1.pdf

November 2014
Review date November 2015