



LINDSEY LODGE HOSPICE AND HEALTHCARE

CONSENT TO CARE AND TREATMENT POLICY

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INTRODUCTION

It is a general principle that valid consent must be obtained for a person before starting treatment or physical investigation, or providing personal care. This principle reflects people's right to determine what happens to their own bodies, and is a fundamental part of good practice.

For consent to be valid, it must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment.

The consent must be given by an appropriately informed person who has the capacity to consent to the intervention in question. This could include the patient, someone with parental responsibility, the court, someone authorised under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy.

There are situations such as in an emergency or when a person is unconscious, when consent cannot be obtained.

1. Types of consent

There are different types of consent in health care and social care settings. The Department of Health (DH) and professional bodies have produced comprehensive guidance about consent. The DH guidance includes information about what consent is, the different types of consent, when consent should be obtained, by whom and in what circumstances. This note reflects some of the key points from the DH guidance.

The validity of consent does not depend on the form in which it is given.

Written consent

Written consent merely serves as evidence of consent. It is valid if it is given voluntarily and appropriate information and capacity have been satisfied. A signature on a form will not make the consent valid.

It is good practice to use forms for written consent where an intervention such as surgery is to be undertaken. Most providers' consent policies will require written consent to be obtained in these circumstances. Most professional bodies and the guidance from DH also advise this as good practice. Details of the assessment of capacity, and the conclusion reached, should be recorded in the case notes.

It is hospice policy to obtain written consent to the sharing of information between hospice departments and with other providers, where it is relevant to the patient's care. Appendix A is the relevant consent form that should then be filed within the patient's record.

Verbal (explicit) and non-verbal (implied or implicit) consent

Sometimes verbal consent might be referred to as 'explicit' consent, and non-verbal may be referred to as 'implied' or 'implicit' consent. An example of non-verbal or implied consent would be where a person, after receiving appropriate information, holds out an arm for their blood pressure to be taken or opens their mouth for their teeth or throat to be examined.

However, the person must have understood what examination or treatment is intended, and why, for such consent to be valid. This could also apply for patient transport services. For example, when a person is called to get into an ambulance in order to be transported for treatment.

An example of verbal or explicit consent would be where a doctor carries out a rectal examination of a patient and tells the patient what they want to do and asks them if they agree to such an examination. If the patient agrees then this is explicit consent (verbal consent).

In all cases, staff should be aware of the different types of consent and the importance of ensuring that the person understands what is going to happen to them and what is involved. Staff should also be aware of and understand what to do if people refuse care or treatment or when consent is not valid or is no longer valid.

Treatments requiring special types of consent

Some procedures and treatments require special consent procedures to be followed. The following are examples of when special consent should be obtained:

- a) Before a person's gametes are used for the treatment of others, or to create an embryo in vitro.
- b) Before donation from living people of solid organs, bone marrow and peripheral blood stem cells for transplantation into others.
- c) Before research is carried out.

2. Refusal of consent

If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment, this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983 (see reference section for further detail).

This is the case even where this may result in the death of the person and/or the death of an unborn child, whatever the stage of the pregnancy.

3. Advance decisions

Please see the hospice guidance document on Advanced Decisions to Refuse Treatment

4. Withdrawal of consent

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. They should 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 rather than withdrawal of consent. 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.

5. Mental capacity

Where a person lacks the mental capacity to make a decision for themselves, and there is no appointed Lasting Power of Attorney or relevant Advanced Decision to Refuse Treatment (ADRT), any decision must be made in that person’s best interests. The Mental Capacity Act (MCA) (2005) set out the duties that providers should follow, in cases when serious medical treatment decisions are made for a person who lacks mental capacity to make such a decision for themselves.

REFERENCES: CQC Supporting note: Consent to Care and Treatment Mental Capacity Act (2005); www.legislation.gov.uk/ukpga/2005/9/contents Lindsey Lodge Hospice Policy: Advanced Decisions to Refuse Treatment				
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Appendix A - Consent to information sharing

At Lindsey Lodge Hospice and Healthcare, we aim to provide you with the highest quality of care. To do this, we keep records about you, your health and the care we provide for you or plan to offer you. We may also need to access health records held by other professionals that is helpful to the care we plan to offer you here.

We have a legal duty under the Data Protection Act 1998 and General Data Protection Regulations 2018 to keep information about you confidential and secure and to only share this information with those who you give consent to.

We would like to confirm as to whether you consent to us sharing appropriate information in the following ways (tick all that you are in agreement with):

Tick box

- Your relatives, partners or friends who act as a carer for you.
 - Sharing information with other health professionals that are involved in your individual care, such as GP, hospital doctors, community nursing teams. This includes the use of shared electronic records where applicable.
 - Sharing information with the wider multi-disciplinary team that meet every week at the hospice to discuss those patients under the care of the Locality Specialist Palliative Care Team. This wider team includes doctors, nurses, Macmillan social worker, therapists (occupational therapy/physiotherapy), family support team and health psychology.
 - Only where it is relevant to your care, sharing information with social services and local authority (these organisations are also bound by a legal duty to keep information confidential and secure).
 - Consent for clinical staff to view information held in your NHS Summary Care Record
 - Storage of non-clinical information (e.g. name, address) onto the internal hospice wide electronic system in the event that there is future engagement with our other departments within the organisation. We will only contact you, with your permission, by completing one of our Keep in Touch cards.
- I understand that where I have given my consent to share/view information, I have the right to withdraw my consent at any time in the future without detriment to my care.

Signed..... Name (print).....
Date.....

For patients who lack capacity to consent to information sharing, consent may be taken by the named NOK or carer, in the patient's best interests:

Signed..... Name (print)

Relationship to patient..... Date.....

In the event that the patient/carer is unable to give written consent, verbal consents may be taken by a member of staff and documented on this form. Where consent was taken from relative/carer, complete above the name of the carer who gave verbal consent. Verbal consent obtained by:

Signed..... Name (print)