

Church Street Practice

Consent Policy

Introduction

The purpose of this protocol is to set out the approach of Church Street Practice 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, immunisation 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 give 'Informed Consent'.

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 what he / she 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 16 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 "Expressed Consent" will be obtained in all cases (see below).

Expressed Consent

Expressed 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 will be used for the patient to express consent and is included within the templates for the following processes:

Minor Surgery, including joint injections and contraceptive implants and Cryotherapy

Obtaining Consent

- Consent (Implied or Expressed) 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.

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- 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 present family members etc.).
- 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.
- The practice acknowledges the patient's right to have an advocate assist them in any decision making regarding the giving of consent.

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

Immunisations & Consent

(Refer to the Dept of Health website and on line current publication of "The Green Book")

There is no legal requirement for consent to immunisation to be in writing and a signature on a consent form is not conclusive proof that consent has been given, but serves to record the decision and the discussions that have taken place with the patient or the person giving consent on a child's behalf.

The giving and obtaining of consent is viewed as a process, not a one-off event. Consent obtained before the occasion upon which a child is brought for immunisation is only an agreement for the child to be included in the immunisation programme and does not mean that consent is in place for each future immunisation. Consent should still be sought on the occasion of each immunisation visit.

Consent must be given voluntarily and freely. The individual must be informed about the process, benefits and risks of immunisation and be able to communicate their decision. Information given should be relevant to the individual patient, properly explained and questions should be answered fully

For travel immunisations we ask for a travel form to be signed during the consultation. (Refer to our current "Immunisation Childhood and Babies Protocol" & "Travel Health Protocol")

What information should be provided?

Individuals, or those giving consent on their behalf, must be given enough information to enable them to make a decision before they can give consent.

This should include information about the process, benefits and risks of immunisation.

Written or verbal information should be available in a form that can be easily understood by the individual who will be giving the consent. Where English is not the first language, translations and properly recognised interpreters should be used.

Health professionals should ensure that the individual (or those giving consent on their behalf) fully understands which immunisation(s) are to be administered; the disease(s)

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against which they protect; the risks of not proceeding; the side effects that may occur and how these should be dealt with; and any follow up action required.

In line with current data protection and Caldecott guidelines, individuals should also be informed about how data on immunisation will be stored, who will be able to access that information and how that data may be used. It is important to emphasise that such information is used to monitor the safety and efficacy of current vaccination programmes.

How should consent be sought?

The health professional providing the immunisation should ensure that consent is in place. It is good practice to check that the person still consents to your providing each immunisation before it is given.

The NMC Code of Professional Conduct (2004) states that 'You are personally accountable for your practice.' This means that you are answerable for your actions and omissions, regardless of advice or directions from another professional.' Giving an immunisation without consent could leave the health professional vulnerable to legal action and action by their regulatory body.

Adults are those aged 18 or over. An adult must consent to their own treatment under English Law; no one is able to give consent on behalf of an adult unable to give consent for examination or treatment him or herself. The Mental Capacity Act sets out how treatment decisions should be made for people of 16 years of age or older who do not have the capacity to make such decisions.

If an adult has refused immunisation before losing the capacity to make a decision, this decision will be legally binding provided it remains valid & applicable to the circumstances. If an adult has clearly refused the treatment before losing the capacity to make such a decision, you will be able to treat an adult who is unable to consent if the treatment would be in their best interest, e.g. in a nursing home situation where the risk of influenza could compromise the individuals health. This decision would be made by the patient's doctor in discussion with those close to the patient.

Immunisation of younger children:

For young children not competent to give or withhold consent, such consent can be given by a person with parental responsibility, provided that person is capable of consenting to the immunisation in question and is able to communicate their decision. Where this person brings the child in response to an invitation for immunisation and, following an appropriate consultation, presents the child for that immunisation, these actions may be considered evidence of consent.

The person with parental responsibility does not necessarily need to be present at the time the immunisation is given. Although a person may not abdicate or transfer parental responsibility, they may arrange for some or all of it to be met by one or more persons acting on their behalf (Section 2(9) of the Children Act 1989).

There is no requirement for such arrangements to be made in writing. Children may be brought for immunisation by a person without parental responsibility, for example, a grandparent or childminder. Where a child is brought for immunisation by someone who does not have parental responsibility the health professional would need to be satisfied that: The person with parental responsibility has consented in advance to the immunisation (i.e. they received all the relevant information in advance and arranged for the other person to bring the child to the appointment) or

The person with parental responsibility has arranged for this other person to provide the necessary consent (i.e. they asked the other person to take the child to the appointment, to consider any further information given by the health professional, and then agree to immunisation if appropriate).

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If there is any evidence that the person with parental responsibility:

- May not have agreed to the immunisation (e.g. the notes indicate that the parent(s) may have negative views on immunisation), or
- May not have agreed that the person bringing the child could give the necessary consent (e.g. suggestion of disagreements between the parents on medical matters) then the person with parental responsibility should be contacted for their consent. If there is a disagreement between the people with parental responsibility for the child, then immunisation should not be carried out until their dispute is resolved.

A person giving consent on behalf of a child may change his or her mind and withdraw consent at any time. Where consent is either refused or withdrawn, this decision should be documented.

It is the duty of each healthcare professional to communicate effectively and share such knowledge and information with other members of the primary healthcare team.

Recording Consent:

It is important that the healthcare record for each child – Personal Child Health Record & GP computer record is an accurate account of care planning & delivery. It is good practice for proper records of any discussions to be recorded and completed with the parent or guardian.

Training

The doctors take part in the training of 5th year medical students and nurses. On some occasions a student will be sitting with them during consultations. At other times their surgeries will be dedicated training sessions, when a medical student will see the patient first, prior to the patient seeing their own doctor. Reception staff will inform patients that a medical student will be present allowing opportunity for the patient to book with another doctor and a notice will be placed on Reception. If a patient does not wish to see a medical student, or for one to be present during their consultation then they can also inform the receptionist on the day.

Consent For Inclusion In Health And Care-Related Research

Expressed written consent will be sought in all cases where a patient is invited to participate in health or care related research by the practice and will be identified individually. Where anonymised, aggregated information from patient records is used for research purposes, consent will not be sought – see patient information disclosure policy for full details.

Consent For Children

In UK law, a person's 18th birthday draws the line between childhood and adulthood (Children Act 1989 s105) which in health care matters an 18 year old enjoys as much autonomy as any adult.

To a more limited extent, 16 and 17 year-olds can also take medical decisions independently of their parents. The right of younger children to provide independent consent is proportionate to their competence. It is therefore presumed that everyone aged 16 or more is 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" including the risks and alternative courses of actions (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 ^[1] for themselves, but may ask a parent to countersign as well.

The "Gillick Test" known after a 1983 judgement in the High Court laid down criteria for establishing whether a child had the capacity to provide valid consent to treatment in

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specified circumstances irrespective of their age. This was approved 2 years later in the House of Lords and helps clinicians to identify younger children aged under 16 who have legal capacity to consent to medical examination and treatment.

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.

Fraser Guidelines – Lord Fraser was one of the Law Lords responsible for the Gillick Judgement and he specifically addressed the dilemma of providing contraceptive advice to girls without the knowledge of their parents. He was particularly concerned with the welfare of girls who would not abstain from intercourse whether they were given contraception or not. The summary of his judgement referring to the provision of contraceptive advice was presented as the “Fraser guidelines” which relate specifically to contraception.

Lord Fraser stated that a doctor could proceed to give advice and treatment:

- "provided he is satisfied in the following criteria:
- that the girl (although under the age of 16 years of age) will understand his advice;
- that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;
- that she is very likely to continue having sexual intercourse with or without contraceptive treatment;
- that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;
- that her best interests require him to give her contraceptive advice, treatment or both without the parental consent." ([Gillick v West Norfolk, 1985](#))

To determine who has parental responsibility, refer to the following extract from the government's Directgov website (refer to the full website for more information):

Who Has Parental Responsibility?

A mother automatically has parental responsibility for her child from birth. However, the conditions for fathers gaining parental responsibility vary throughout the UK.

For births registered in England and Wales

In England and Wales, if the parents of a child are married to each other at the time of the birth, or if they have jointly adopted a child, then they both have parental responsibility. Parents do not lose parental responsibility if they divorce, and this applies to both the resident and the non-resident parent.

This is not automatically the case for unmarried parents. According to current law, a mother always has parental responsibility for her child. A father, however, has this responsibility only if he is married to the mother when the child is born or has acquired legal responsibility for his child through one of these three routes:

1. (From 1 December 2003) by jointly registering the birth of the child with the mother
2. By a parental responsibility agreement with the mother
3. By a parental responsibility order, made by a court

Living with the mother, even for a long time, does not give a father parental responsibility and if the parents are not married, parental responsibility does not always pass to the natural father if the mother dies.

All parents (including adoptive parents) have a legal duty to financially support their child, whether they have parental responsibility or not.

- Refer to GMC publications “0-18 years: guidance for all doctors” and “Consent: patients and doctors making decisions together” [*]
- Mental Capacity Act 2005 – website extracts