



## Seeking Consent Policy

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## **1. Statement of Aims and Objectives**

- 1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to treat all patients with dignity, equality and with regard for their feelings and wishes surrounding choices and treatment options, by adhering to the principles of informed consent.
- 1.2. Consent to treatment is the principle that a person must give permission before they receive any type of medical treatment, test, or examination.
- 1.3. Consent from a patient is needed regardless of the procedure – such as a physical examination, taking observations or providing medication. The principle of consent is an important part of medical ethics and international human rights law.
- 1.4. Accurate and comprehensive documentation is required to evidence the clinical care carried out by SECAMB. Patient clinical records (PCRs) provide details of effective and informed patient care and consent. They are used to determine accountability, support effective clinical judgement and show how decisions were reached.

## **2. Principles of consent**

- 2.1. For consent to be valid, it must be voluntary and informed and the person consenting must have the capacity to make the decision (see Trust Mental Capacity Act (MCA) Policy).
- 2.2. Voluntary – the decision to either consent or not to consent to treatment must be made by the person themselves and must not be influenced by pressure from Trust staff, friends or family.
- 2.3. Informed - the person must be given all of the information to explain steps taken to determine the diagnosis, nature of the proposed treatment, including the benefits and risks. The patient should be informed whether there are reasonable alternative treatments (including no active treatment) and the consequence if the patient were to decline or refuse treatment.
- 2.4. Capacity – the person must be competent to give consent, which means they understand the information given to them, and they can use it to make an informed decision.
- 2.5. All practicable steps must be made to ensure that information is given to patients in a way that means they are able to understand it.

- 2.6. The use of Language Line must be considered for patients for whom English is not their first language. This must be used in preference to family members, where time allows, to ensure clarity and maintain patient confidentiality.
- 2.7. Communication tools may be utilised to ensure patients who may have difficulty understanding the spoken word, or who are non-verbal themselves are supported in expressing their own decisions and choices.
- 2.8. If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected. This is still the case even if refusing treatment would result in their death, or the death of their unborn child (see 12.5). In these cases, collaborative decision making is strongly advised.
- 2.9. If a person over the age of 16 lacks the capacity to make a decision about their treatment, the healthcare professionals can make a decision to provide treatment in the person's best interest (MCA policy refers). This should be clearly documented within the patient care record.
- 2.10. Clinicians must take reasonable steps to seek advice from anyone with an interest in the patient's wellbeing, including friends, relatives, or any Advance care planning documentation, before making these decisions if time and urgency of the situation allows.

### **3. Giving Consent**

- 3.1. Consent can be given in the following ways:
  - Verbally – for example, by saying they're happy to have an ECG/blood pressure taken.
  - Non-verbally - if they understand the treatment or examination about to take place – for example, holding out an arm for a blood pressure to be taken.
- 3.2. If the patient changes their mind at any point before the procedure is commenced the person is entitled to withdraw their previous consent. They may also withdraw consent during a procedure, and this should be respected and ceased as soon as possible.
- 3.3. Nobody can consent on behalf of a person over 16 unless they hold court appointed deputyship or Lasting Power of Attorney for health and welfare (LPA) appropriate to the decision.

## 4. Consent from children and young people

### 4.1. Children and young people under 16years

- Children aged 0 to 13 – consent would usually be given by someone with parental responsibility for the child.
- Children aged 13-15 may be deemed ‘Gillick Competent’ – that is, the professional providing treatment assesses the child to be competent to consent to their own treatment. Should a child be ‘Gillick Competent’ their consent to treatment cannot be overridden by someone with parental responsibility.
- Children aged 13-15 cannot refuse treatment, should that treatment be necessary to prevent serious harm (including psychological harm). In this circumstance, their refusal can be overridden by somebody with parental responsibility.
- Parental responsibility is held by – the birthing parent, (usually the mother) the non-birthing parent (usually the father) IF the parents were married at the time of the birth, or the non-birthing parent is recorded on the birth certificate, and anyone appointed parental responsibility by a court. It is not held by stepparents, siblings, foster carers etc.
- Wherever possible (i.e., if the situation is not time critical, the information is available) input from the person with parental responsibility must be sought as part of the best interest decision making process.

### 4.2. Young people 16-17 years

- Young people aged 16-17 are presumed to have competency to consent under the *Family Law Reform Act 1969* and thus parental consent does not have to be sought for a 16–17-year-old. They can be assessed using the *Mental Capacity Act 2005*.
- Someone with parental responsibility can override a 16–17-year-olds refusal of treatment, although this should be considered mainly in cases where refusal of treatment would cause serious harm (including psychological harm).
- In the case of a 16 – 17 year-old with capacity making an ‘unwise decision’, e.g. to refuse treatment when the likely outcome would be serious harm (including psychological harm) or death, consider shared /

supported decision making with colleagues such as senior clinicians and the safeguarding on call team.

#### 4.3. **Refusal of treatment**

- Should a child under the age of 16 require immediate, lifesaving treatment and consent for treatment is being withheld by the child and those with parental responsibility, the child should be conveyed to hospital. If this is also refused, consider contacting the police. A police officer can, under s46 of the *Children Act 1989*, remove a child to suitable accommodation (although they do not assume parental responsibility, nor can they consent to treatment). This is an emergency power and is known as police protection. If a child can be removed to hospital, this may allow time for medical staff to make an emergency application for an order from the Court of Protection, who have 24/7 availability for such decisions.
- Should a child under the age of 16 require treatment that is not immediately lifesaving but is necessary to prevent significant harm, and consent for treatment is being withheld by the child and those with parental responsibility, consider making an urgent referral to children's social care or contacting the police. Always follow up with a safeguarding referral if contact has been made with social care or the police directly.
- Consider shared/supported decision making with colleagues such as senior clinicians and the safeguarding on call team.

### 5. **When consent isn't needed**

5.1. It may not be necessary to obtain consent if a person:

- Requires emergency treatment to save their life, but they're incapacitated (for example, they're unconscious) – the reasons why treatment was necessary should be fully explained identifying that decisions were taken in the patient's best interest.
- When a patient is receiving treatment for their mental health condition under the *Mental Health Act 1983* – however, in these cases, treatment for a physical health condition still requires consent, or application of the mental capacity and best interest process which the patient may be able to provide, despite their mental illness; if they are unable to consent then MCA should be followed.

- Is a risk to public health for example, notifiable diseases.
- When a patient is deemed to lack capacity (following completion of an assessment) and best interest decision principles are applied.

## 6. Consent and life-sustaining treatments

- 6.1. All best efforts should be made to prolong a patient's life, unless there is a clear advance decision to refuse treatment, or end of life care plan.
- 6.2. To help reach a decision, the healthcare professionals responsible for the person's care must discuss the decision, with anyone who has an interest in the patient's welfare wherever possible.
- 6.3. Any Advance care planning, documenting the patient's priorities for care should be sought and taken into consideration.
- 6.4. They should consider, among other things:
  - What the person's quality of life will be if treatment is continued.
  - How long the person may live if treatment is continued.
  - Whether there's any chance of the person recovering.
  - Treatment can be withdrawn if there's an agreement that continuing treatment isn't in the person's best interests.

## 7. Responsibilities

- 7.1. The **Chief Executive Officer** has overall responsibility for ensuring compliance with the principles of consent contained within this policy.
- 7.2. The Trust's **Director of Nursing & Quality** will be the Executive Director with responsibility for implementing this policy.
- 7.3. The Trust's **Safeguarding Lead** will be the lead manager with delegated responsibility for the Mental Capacity Act (and areas of consent included in this policy) across the organisation.
- 7.4. **All Trust Employees** are responsible for understanding the principles of informed consent contained within this policy.

## 8. Competence

- 8.1. All staff must complete training regarding the application of the Mental Capacity Act and consent in line with the Trust Training Needs Analysis (TNA).

- 8.2. Training levels and competencies may vary depending on organisational role. These will also be identified with the TNA.

## **9. Monitoring**

- 9.1. This policy will be monitored by the as per the Trust's internal governance structures.
- 9.2. Day to day policy issues will be managed by the lead manager for safeguarding.
- 9.3. Any contravention or deviation from the policy must be reported. Any staff member or external partner agency may report contraventions or deviations as they are noted. Reporting should be completed using the Trust's untoward incident reporting process (IWR-1 (Incident Web Report)).

## **10. Audit and Review**

- 10.1. The policy document will be reviewed annually by the Lead Manager to ensure continued compliance including incorporating any changes in legislation, codes of practice or national standards; a full review will take place every three years within the agreed governance arrangements.

## **11. References**

- Human Rights Act 1998  
(<https://www.legislation.gov.uk/ukpga/1998/42/schedule/1/part/I/chapter/7>)
- Mental Capacity Act 2005
- The Care Act (2014)
- The Children Act (1989 updated 2004)
- Safeguarding vulnerable groups Act 2006
- <http://www.birthrights.org.uk/library/factsheets/Human-Rights-in-Maternity-Care.pdf>
- <https://www.nhs.uk/conditions/consent-to-treatment/children/>
- [https://www.nhs.uk/nhsengland/aboutnhservices/documents/consent\\_%20aguideforparentsdh\\_4117353.pdf](https://www.nhs.uk/nhsengland/aboutnhservices/documents/consent_%20aguideforparentsdh_4117353.pdf)