London Ambulance Service NHS Trust

Policy for Consent to Examination or Treatment

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To set out and explain the requirements for seeking consent for the examination and treatment of a patient.

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Links to Related documents or references providing additional information		
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OP/028.	LAS Procedure for Specific Named Patient Protocols and No Resuscitation Orders / Advance Decisions	
TP/024	LAS Managing Patient Confidentiality When dealing with the Media	
	DH Good Practice in Consent Implementation Guide	
LA4	PRF LAS Trust Assignment Record and Clinical Record	
LA5	Assessment of Capacity and for adults who are unable to consent to investigation or treatment	
LA52	Accident / Incident Report Form	
OP14	Managing the Conveyance of patients policy and procedure	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

The Department of Health has issued a range of guidance documents on consent, and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in the LAS which aim to ensure that health professionals are able to comply with the guidance.

This policy is for all staff who provide care to patients, irrespective of the route by which they came into contact with them.

- Part A provides, in the form of Frequently Asked Questions a summary of the key points on consent as applicable to ambulance staff.
- Part B contains guidance for ambulance staff
- Part C contains the full consent policy

2. Scope

This policy defines the standards and procedures that LAS staff should follow when gaining patient consent for examination and treatment. The content of this policy applies to all staff who provide care to patients, irrespective of the route by which they come into contact with them. This policy does not address patient consent in relation to media.

3. Objectives

1. To set out and explain the requirements for seeking consent for examination and treatment of a patient.
2. To provide comprehensive information on gaining consent to examination or treatment.
3. To provide guidance for staff in specific circumstances.
4. To ensure staff realise the importance of decisions regarding consent that must be documented using the appropriate LAS forms.

4. Responsibilities

4.1 Health Professional

- The Healthcare professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is

being done: It is they who will be held responsible in law if this is challenged later.

- Accurately documenting the consent process where necessary, e.g., through PRF and / or LA5.

- Be aware of any guidance on consent issued by their own regulatory bodies

4.2 **Operational Manager/ Team leaders**

- It is the responsibility of all Operational Managers, from Team Leaders upwards, to ensure that this procedure is adhered to by the staff under their management.

5. Definitions

5.1 Mental capacity

Is, broadly speaking, the ability of an individual to make decisions regarding specific elements of their life. It is also sometimes referred to as 'competence'.

5.2 Capacity

Is not an absolute concept. Different degrees of capacity are required for different decisions, with the level of competence required increasing with the complexity of the decision.

5.3 Consent

Is the voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of the purpose, nature and likely effects and risks of that intervention; including the likelihood of its success and any alternatives to it. Permission given under any undue or unfair pressure is not consent.

Since October 2007, "Personal Welfare" Lasting Powers of Attorney will enable appointed attorneys to make a number of decisions about a person's life, when that person looses capacity to do so. This may include the power to give or refuse consent to medical examination and / or treatment. Form LA68 is a checklist that allows staff to check whether a Lasting Power of Attorney they are presented with is valid.

6. Deviation from the advice and guidance given within this policy

Should there be a need to deviate from the guidance contained in this policy then that decision must be documented on the London Ambulance Service

(LAS) NHS Trust Assignment Record and Clinical Record (LA4 PRF) and, if appropriate, on an LA5. Given the comprehensive nature of this policy it is strongly advised that staff contact the Clinical Support Desk in EOC if further guidance is required.

All decisions must be clearly recorded on the LA4 PRF and the LA5 as appropriate.

7. The five principles of the Mental Capacity Act 2005

7.1 Assumption of capacity

A person must be assumed to have capacity unless it is established that they lack capacity.

7.2 Assisted decision making

A person is not treated as unable to make a decision unless all practical steps to help them to do so have been taken without success.

7.3 Unwise decisions

A person is not to be treated as unable to make a decision merely because they make an unwise decision.

7.4 Best interests

An act done, or a decision made under the Mental Capacity Act 2005 for or on behalf of a person who lacks capacity must be done or made in their best interests.

7.5 Least restrictive alternative

Before the decision is made, regard must be taken as to whether there is an alternative which is least restrictive.

8. Assessing the Capacity to Consent

Capacity is assessed by using a two stage test:

8.1 First Stage:

- Is there any evidence that the patient has; ‘an impairment of, or a disturbance in the functioning of, the mind or brain ‘?

8.2 Second Stage:

- Do you feel the patient is able to communicate a decision effectively?
- Has the patient been given sufficient information, in a way they can understand, to inform them of the decision they now need to make about treatment?
- Do you feel that the patient is able to understand the principal risks and benefits of what is proposed?
- Does the patient, therefore, understand the reasonably foreseeable consequences of receiving, or not receiving, the proposed treatment?
- Can the patient retain the information long enough to make a valid decision?
- Is the patient free from external pressure or coercion?
- If the answers to all of the above are "**YES**", staff should consider that the patient has **capacity** and is able to consent to, or refuse, the proposed treatment or course of action.

PART A – Frequently Asked Questions (Key Points on Consent)

1. When do ambulance staff need consent from patients?

1.1. Before you examine, treat or care for capacitant patients you must obtain their consent unless they lack the capacity to consent to the proposed course of action. You may wish / need to document this in more detail than is available on the LA4; for example the administration of a treatment or drug whilst it is part of a clinical trial. Form LA5, is available for this purpose. You must be guided by the circumstances existing at the time when deciding which form, if any to use.

1.2. A consideration that must be taken into account is the time taken to explain and complete the form(s), against the imperative for examination, treatment or action existing at the time.

1.3. Form LA5 is specifically designed to aid the assessment of a patient's capacity and also as a record that a comprehensive capacity assessment has been undertaken. The form should be completed where the attending ambulance professional has any doubt about a patient's capacity to consent or refuse. The form should also be used to guide the assessment of capacity, and to document any intervention that is taken in the patients best interests if they are deemed to lack capacity. It is also recommended that the form is completed for patients who have capacity but are refusing

treatment against advice with the potential outcome having a detrimental affect of their health.

1.4. Adults are always assumed to have capacity unless demonstrated otherwise. If you have doubts about their capacity, the question to ask is: "can this patient understand and weigh up the information needed to make this specific decision?" Unconventional decisions, or decisions that may appear unwise to others, do not prove that the patient lacks capacity, but may indicate a need for further information or explanation.

1.5. Patients may have capacity to make some health care decisions, even if they lack it to make others.

1.6. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

2. Can children consent for themselves?

2.1 Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the capacity to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will 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 child with capacity consents to treatment, a parent cannot override that consent. Legally, a parent can consent if a child refuses, but it is likely that taking such a serious step will be rare.

3. Who is the right person to seek consent?

3.1. It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

4. What information should be provided to the patient?

4.1. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

5. Is the patient's consent voluntary?

5.1. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

6. Does it matter how the patient gives consent?

6.1. Consent can be written, oral or non- verbal. A signature itself does not prove the consent is valid – the most important point is to record the patient's decision and the discussions that have taken place.

7. Who can refuse consent to treatment?

7.1. Adult patients with capacity are entitled to refuse treatment, even where the treatment would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. For example a pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

8. What about adults who lack capacity to give consent?

8.1. **No one** can give consent on behalf of an adult who lacks capacity, unless that person holds a valid "Personal Welfare" Lasting Power of Attorney or has been appointed as a deputy by the Court of Protection and has been given the authority to make that specific decision. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' are wider than best medical interests and includes factors such as their past and present wishes and beliefs, their general wellbeing and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has an enduring condition that may have prevented them from expressing their own wishes and feelings relatives, carers and friends may be best placed to advise on the patient's needs and preferences and should be consulted, if practical and appropriate.

8.2. If a patient who lacks capacity has clearly indicated in the past, while they had capacity, that they would refuse treatment in certain circumstances (an 'advance decision'), and those circumstances arise, you must abide by that refusal.

8.3. This summary does not cover all situations. For more detail, consult the full London Ambulance Service NHS Trust policy on consent for examination and treatment in Part C of this document.

9. How do we record decisions regarding consent?

9.1. Staff must ensure that decisions regarding consent are documented using the appropriate LAS form. Explanations of which form is to be used in which scenario are explained later in this document. Also the LA4 User

Guide gives further explanation of the “Consent Obtained” tick box on the LA4.

9.2. It cannot be stressed enough that where consent to treatment is withheld or subsequently withdrawn, having been previously given, that this must be documented on both form LA5 and the LA4.

9.3. All staff must ensure that they have with them at all times whilst on duty the requisite forms to document consent decisions. This means that they must have as a minimum an LA4, LA5, LA5a and LA5b available for completion as dictated by the circumstances and patient.

Part B – Guidance for ambulance staff

This guidance is designed to clarify roles and responsibilities of ambulance staff in relation to consent or refusal to examination or treatment.

1. Gaining Consent

1.1. “Consent” is a patient’s agreement for a health professional to provide care. Patients 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 patient must be competent to take the particular decision, have received sufficient information to take it and not be acting under duress.

1.2. Gaining the consent of a patient to examination and treatment will most often happen as a natural progression of the interaction of staff with the patient. However, staff must never assume that the patient will consent to examination and treatment, even if they have called for our assistance. Staff must ensure a full **discussion** takes place with the patient, a course of action is **agreed** and that these decisions and actions are fully **documented.** The staff must respect the patient’s wishes and needs throughout this process and always bear in mind that the patient is entitled to withdraw consent at any time.

2. Actions to take if consent to examination or treatment is refused

2.1. It is not uncommon in pre-hospital situations for patients to refuse care or treatment. Although patients may refuse, there is still, in certain circumstances, an ongoing duty of care and therefore a legal responsibility for ambulance staff to try and provide further care. This may be via friends / relatives or carers, or via other agencies such as Social Services.

2.2. If a patient refuses examination or treatment against the advice of ambulance staff, the staff need to use form LA5 to assess whether the patient has capacity

2.3. If a patient **with capacity** is refusing treatment, the crew may be acting unlawfully if they treat them against their wishes. In these circumstances they must document carefully both on the LA5 and LA4, all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative or friend, the Clinical Support Desk, or their Team Leader / manager. Staff should notify the Emergency Operations Centre (EOC) of their actions. EOC staff must record this in the relevant electronic call log.

2.4. Where a patient who **does not have capacity** is refusing treatment, the crew must consider the consequences of the patient not receiving treatment and must consider the least restrictive approach to meeting the assessed need. If the crew believes that the patient needs urgent or life saving treatment, they should act in the patient's best interests. Crew and patient safety must be paramount in this decision. Occasionally the police may be of assistance. However, remember that the police cannot restrain or forcibly remove the patient unless a breach of the peace, or other unlawful act, is likely to take place

2.5. In these circumstances they must document fully and carefully both on the LA5 and LA4, all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative or friend, Clinical Support desk or Team Leader / manager. Unless the patient has appointed a personal welfare lasting power of attorney, or the Court has appointed a personal welfare deputy who has the authority to consent to the specific treatment proposed, no-one else can give consent on behalf of such a patient. They may only be treated if that treatment is believed to be in their 'best interests'.

2.6. Where a patient is deemed **not to have capacity**, the police may also be of assistance if a breach of the peace, or other unlawful act, is likely to take place. However, in these cases all parties on scene have a duty to ensure the patient receives the best possible care and treatment. Consideration must be given as to whether the proposed treatment or course of action could be carried out as effectively in a way that is less restrictive of the patient's rights and freedom of action.

3. Assessment of capacity/assessment for treatment without consent form (Form LA5)

3.1. This form is intended to be used where a patient is refusing to be treated, but in the opinion of the member of staff, the patient is in need of urgent treatment. This will therefore mean that the staff member will be treating the patient without their explicit consent. Whilst this is in fact permissible in certain circumstances, the staff member must be able to justify **all** their reasoning, actions and treatments. Crew and patient safety should be a consideration at all times.

3.2. The form LA5 has been devised to assist staff in both the reasoning process and the need to document decisions and actions in these difficult circumstances. It is understood that staff may not be able to complete the form as the process develops, but, it must be completed as soon as is practically possible.

3.3. To reach a decision on whether you will need to treat a patient without their consent you must first decide if the patient has capacity. Form LA5 has an 'Assessment of Capacity' tool for this purpose. The remaining sections of the form are used to guide staff in making the decision to treat a patient without their consent. It also prompts staff to explore alternative treatments and care pathways. Staff are encouraged to use the EOC to facilitate the contacting of other agencies.

3.4. A completed copy of the form LA5 is to be retained and handed in with the LA4.

3.5. A copy of form LA4, appropriately completed at section 11, must be given / offered to the patient, if they are not conveyed to a treatment centre. If the patient is conveyed to a treatment centre, a copy of the LA5 is to be left with a copy of the LA4 at the treatment centre.

4. Advance Decisions

4.1. An Advance Decision is an oral or written decision made by an adult with capacity to do so, that if:

4.1.1 At a later time in specified circumstances a specified treatment is proposed by a health professional;

And

4.1.2 The patient lacks capacity to consent to the carrying out of that treatment;

4.2. If an advanced decision is in place and valid the specified treatment is not carried out or continued. Where the Advance Decision relates to life sustaining treatment then specific criteria must be met as set out in Form LA67. A copy of form LA67 is appended to this policy (Appendix A)

4.3. Advance Decisions must be respected – see Procedure for Specific Named Patient Protocols and No Resuscitation Orders / Advance Decisions (OP/028). An advance refusal of treatment will be binding where:

4.4. At the time it was made the patient had the capacity to make it.

4.5. The circumstances that have arisen are the circumstances that were

contemplated when the advance decision was made.

4.6. At the time the advance decision was made, there was no duress on the patient.

4.7. In order to ascertain the validity of an advance decision, clarification may need to be sought from either the patient's GP, the clinician involved in that aspect of the patient's care, or any person (if any) named in the decision, which may include the patient's solicitor. Where there is real doubt over the validity of an advance decision and any delay in treating and/or transferring the patient is likely to lead to a significant or irreversible deterioration on health, then staff should do what is practicable in order to treat/transfer the patient having consulted with EOC. Where doubt exists as to the validity of an advance decision, treatment must be continued until the patient is able to discuss their current treatment wishes. However, only that treatment, which is immediately necessary and in the patient's best interests should be provided.

Part C – Full LAS policy on consent to examination or treatment.

1. Why consent is crucial

1.1. Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. It should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind.

2. What consent is – and isn't

2.1. "Consent" is a patient's agreement for a health professional to provide care. Patients 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 patient must:

2.1.1. have capacity to take the particular decision;

2.1.2. have received sufficient information to take it; and

2.1.3. not be acting under duress.

2.2. The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the

patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

2.3. Where an adult patient lacks the mental capacity to give or withhold consent for themselves at the time of contact with the LAS, unless the patient has appointed a personal welfare Lasting Power of Attorney, or the Court has appointed a personal welfare deputy who has the authority to consent to the specific treatment proposed, **no-one else can give consent on their behalf**. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance decision. For further details on advance decisions see the Department of Health's *Reference guide to consent for examination or treatment* (chapter 1, paragraphs 47 -52 19) and LAS Procedure for Patient Specific Protocols OP /028. Form LA68 (See appendix 2) contains a checklist for assessing Lasting Powers of Attorney.

3. Guidance on consent

3.1. The Department of Health has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies, (such as the Health Professions Council's Code of Conduct, Performance and Ethics).

3.2. Reference guide to consent for examination or treatment provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies are available on the internet at www.doh.gov.uk/consent

3.3. Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available on the internet at www.doh.gov.uk/consent.

4. Gaining, Recording and Documenting Consent

4.1. Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid consent. If a patient is rushed into signing a form,

on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal or implied consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract. It is vital, therefore that the process leading to the patient's consent or refusal should be carefully and fully recorded, including any advice given.

4.2. Whilst written consent will rarely be an absolute legal requirement it is good practice to do so especially if the treatment is part of a project or programme of research approved by the London Ambulance Service.

5. Refusal of Treatment

5.1. If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. An adult patient, who has capacity, is entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983*. The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults.

5.2. If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented on the LA4 and / or LA5. If the patient has already signed a consent form, but then changes their mind, you (and, where possible, the patient) should note this on the form.

5.3. Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

5.4. If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient's care to that health professional.

6. Procedures to follow when patients lack capacity to give or withhold consent

6.1. Considerations about a patient's capacity must be guided by the five basic

principles contained in the Mental Capacity Act 2005:

6.1.1. A person must be assumed to have capacity unless it is established that they lack capacity.

6.1.2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.

6.1.3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

6.1.4. An act done, or a decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

6.1.5. Before an act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

6.2. Any intervention must also depend on a physical assessment, which considers the likelihood of the imminent risk to the person of loss of life or limb. If it is felt that, without immediate treatment, there would be a significant or irreversible deterioration in health, the LAS has a duty to intervene safely and provide care in the person's best interests.

6.3. If the incident is less serious and patient care can be provided on scene by alternative measures, forced removal is inappropriate.

6.4. Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented on form LA5 - Capacity to Consent to Examination or Treatment. This will include an assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient.

6.5. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than a genuine lack of capacity. You should involve appropriate colleagues in making such assessments of capacity, such as specialist learning disability teams, speech and language therapists or translation and interpreting services unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

6.6. Occasionally, there will not be a consensus on whether a particular treatment is in the best interests of an adult lacking capacity. Where the

consequences of having, or not having, the treatment are potentially serious, a court declaration may be sought. The Head of Legal Services will obtain advice / assistance from the LAS solicitors on seeking directions from the Court.

7. Availability of forms (LA5)

7.1 The LA5 is to be used for patients who may be unable to consent for themselves. It can also be used patients with capacity who are refusing conveyance and / or treatment. These forms should be used in the same manner and in tandem with LA4.

8. Gaining consent in straightforward situations.

8.1 In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient and gaining their consent. If the patient is willing for the treatment to be provided, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

8.2 If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must consider whether the patient has had sufficient opportunity to absorb the information necessary for them to make their decision. As long as it is clear that the patient had capacity and consents, the health professional may then proceed. This simple process will be most applicable to Ambulance staff.

9. More complex discussions.

9.1 In more complex cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital out-patient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have involved at the provision of information, discussion of options and an initial (oral) decision, followed by a confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the whole process as well as the patient's confirmation. When confirming the patient's consent and understanding, it is advisable to use open questions which require more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

10. Emergencies

10.1 Clearly in emergencies, discussion of options and confirmation that the patient wishes to go ahead will follow straight on from each other, and it is appropriate to use the LA4 to document any discussion and the patient's

consent, The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.

11. Conveying patients:

11.1 LAS Operational Procedure OP14 (Managing the Conveyance of Patients Policy and Procedure) provides local guide lines on Consent to examination and treatment (S7.1), Assessment, Diagnosis and Treatment Regimes (S8) and Patients not conveyed to a treatment centre (S16).

12. Treatment of children

12.1 Only people with 'parental responsibility' are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children. If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

12.2 When babies or young children are being cared for, it will not usually seem practicable to seek their parents' consent for every routine intervention. However, you should remember that, in law, such consent is required. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

12.3 Critical situations involving children and young persons involving a life threatening emergency may arise when it is impossible to consult a person with parental responsibility, or if they refuse consent. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable for all carers to undertake treatment to preserve life or prevent serious damage to health.

12.4 Children under the age of 16, who can fully understand what is proposed, also have the capacity to consent to, or refuse, an intervention. This means that the level of capacity of children varies with the complexity of the treatment/refusal and its consequences. There is no particular age when a child gains capacity to consent or refusal. In some situations, although the consequences of non-treatment may be evident, these must be fully explained to ensure that the child fully understands the consequences of refusal.

12.5 As is the case where patients are giving consent for themselves, those giving consent on behalf of children must have the capacity to consent to the intervention in question, be acting voluntarily, and be appropriately informed and be acting in the best interests of the child. If neither the child nor the person with parental responsibility has capacity, ambulance staff must act in the child's best interests.

13. Provision of Information

13.1. The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen next.

13.2. Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

14. Provision for patients whose first language is not English

14.1. The London Ambulance Service NHS Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. All staff have access to interpreting services and multi-lingual phrasebooks. Other specific advice can be sought from the Diversity Team based at LAS HQ.

14.2. It is not appropriate to use children to interpret for family members who do not speak English, or for an adult family member to interpret for a child who does not speak English.

15. Access to more detailed or specialist information

15.1. Patients may sometimes request more detailed information about their condition. This information could be provided via Patient Experiences Dept, access to NHS Direct, NHS Direct Online, Clinical Support Desk or the Medical Directorate.

16. Who is responsible for seeking consent?

16.1. The member of staff carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

16.2. Where oral or non-verbal consent is being sought prior to the initiation of the procedure, naturally this will be done by the member of staff responsible. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

17. Completing consent forms

17.1. It is the member of staff's own responsibility to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and to work within their own competence and not to agree to perform tasks which exceed that competence.

17.2. If you feel that you are being pressurised to seek consent when you do not feel competent to do so, seek advice from Clinical Support Desk.

18. Clinical Photography and Conventional or Digital Video Recordings

18.1. Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, staff should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

18.2. Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient.

18.3. Photographic and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient, as long as this policy is well publicised. However, express consent must be sought for any form of publication – see also LAS Managing Patient Confidentiality when dealing with the Media – TP/024.

18.4. If you wish to make a photographic or video recording of a patient specifically for education, publication or research purposes, you must first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it (see TP/024). Patients must know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive full

information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

18.5. The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

18.6. If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of someone close to the patient. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

19. Useful contacts

- Patient Experiences Department
- Clinical Support Desk
- NHS Direct
- NHS Direct Online
- Governance and Compliance team
- Medical Directorate
- Legal Services

IMPLEMENTATION PLAN				
Intended Audience	For all LAS staff			
Dissemination	Formal education during clinical training and CPD courses. Printed poster, Clinical Update, LAS News, RIB and availability to all staff on the Pulse.			
Communications	Revised Procedure to be announced in the RIB and a link provided to the document.			
Training	Training in consent is provided by the Education and Development Department through both core courses and the Continuing Professional Development programme. Also use of Team Leader updates and Clinical Updates.			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
JRCALC Clinical Guidelines in respect of consent and patient treatment documentation	Clinical Performance Indicator checks (CPIs)	Mental Health Committee	Clinical Quality Safety and Effectiveness Committee	Individual staff will be monitored via CPI checks and Station Management teams

Appendix 1

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MENTAL CAPACITY ACT 2005
Checklist for assessing "Advance Decisions" for patients aged 18 or above

Patient's Name:	Incident Date:
Date of Birth:	CAD:

An advance decision (AD) is an oral or written decision made by an adult (18 and +) with capacity to do so, that if:

(i) at a later time (in specified circumstances, if they are specified) a specified treatment is proposed by a health professional; and

(ii) the patient lacks capacity to consent to the carrying out of that treatment

Then the treatment is not carried out or continued. Where the AD relates to life sustaining treatment the specific criteria stated overleaf must be met. The decision may be expressed in layman's terms.

Please document clearly in the patient's records or overleaf your reason for answering **"Yes"** or **"No"** for any of the questions below. This form must be placed in the patient's records.

1. **Does the patient have capacity or may he/she have it at some time in the future when he/she could take the decision to consent to or refuse treatment for him/ herself?**

YES/NO

If **"Yes"** then the AD is not applicable and the patient's views should be obtained.

If **"No"** proceed to question 2.

2. **Has the AD been revoked or altered? This need not be in writing, unless it includes a provision about life-sustaining treatment. (NB - a previous AD refusing life-sustaining treatment may be revoked orally).**

YES/NO

If **"Yes"** the revocation or alteration should be followed, but see question 6 and the checklist to consider for life-sustaining treatment.

If **"No"** proceed to question 3.

3. If possible has the patient been asked whether they now wish to revoke or alter their previous AD?

YES/NO

If **"Yes"** and they have not changed their view proceed to question 4.

If **"No"** ask the patient if possible and if they wish to change their view legal advice should be sought. If there is no change in their view proceed to question 4.

4. Is the AD valid?

In answering this question please consider each of the following;

- Has the patient withdrawn the advance decision when he/she had capacity to do so?
- Has the patient done anything which is clearly inconsistent with the AD?
- Is there a person (donee) with a Lasting Power of Attorney, created after the AD was made, giving the donee authority to give or refuse consent to the treatment to which the AD relates?

If the answer to any question is **"Yes"** then the AD is not valid and is not binding.

5. Is the AD applicable to the treatment in question?

- Does the treatment in question fall outside of what is specified in the AD?
- Are any particular circumstances specified in the AD now absent?
- Are there reasonable grounds for believing that circumstances exist which the patient did not anticipate at the time of the AD and which would have altered his decision had he anticipated them?

If the answer to any question is **"Yes"** then the AD is not applicable and is not binding.

Life-sustaining treatment

6. Have the following conditions been satisfied for any AD which relates to life-sustaining treatment?

The AD is:

- Verified by a statement by the patient to the effect that it is to apply to that treatment even if life is at risk.
- In writing

- Signed by the patient or another person in the patient's presence and at the patient's direction

and

the signature is made or acknowledged by the patient in the presence of a witness

and

the witness signs or acknowledges his signature in the patient's presence.

If **all** the answers are **"Yes"** then the AD will apply to life-sustaining treatment but you **must** also follow the remainder of this checklist. (An AD refusing life-sustaining treatment may be revoked orally)

I confirm I have understood and reviewed this checklist in respect of the above-named patient.

_____	_____	_____
Signature of Health Professional	Date	Name and position of Health Professional

This checklist is only intended to provide guidance and a framework when considering an advance decision. Where there are any doubts concerning the validity or applicability of an advance decision further medical and/or legal advice should be sought.

Notes:

Appendix 2

MENTAL CAPACITY ACT 2005
Checklist for assessing "Lasting Powers of Attorney" for patients aged 18 or above

Patient's Name:	Incident Date:
Date of Birth:	CAD:

Under a Lasting Power of Attorney (LPA) the donor (the patient) confers upon individuals named in the document known as the "donee", or "donees" if more than one, authority to make decisions about the donor's personal welfare, or specified matters concerning those.

This includes authority to make decisions when the donor no longer has capacity. However the following conditions must be satisfied for a valid LPA to be created:

- The donor must be 18 years old or above and have capacity when executing an LPA
- The donee must be at least 18 years old
- The instrument conferring authority (LPA) must be in specific terms and have been registered with the Office of the Public Guardian

Where the LPA allows decisions to be made and these decisions concern life-sustaining treatment a donee cannot refuse life-sustaining treatment unless the LPA expressly allows for this.

Where there is any doubt as to the validity of a LPA, or whether a donee under a LPA is acting in the best interests of the donor, legal advice should be sought and an application can be made to the Court of Protection if necessary.

Any decision in relation to powers conferred on a donee of a Lasting Power of Attorney should be considered with reference to the principles in section 1 of the Act and section 4 "best interests" provisions in the Act.

Please document clearly in the patient's records or on this form your reasons for answering **"Yes"** or **"No"** for any of the questions below. This form must be placed in the patient's records.

1. **Have you seen the LPA and is it registered at the Office of the Public Guardian?**

YES/NO

If **"Yes"** proceed to question 2

If **"No"** the LPA is not valid and the views and wishes of the donee do not have to be followed.

2. **Does the donor / patient have capacity?**

YES/NO

If **"Yes"** the patient can make the decision. If **"No"** proceed to question 3.

3. **Has the patient made any subsequent advance decision that is valid and applicable to this decision?**

YES/NO

If **"Yes"** follow the advance decision.

If **"No"** proceed to question

4. **Does the LPA cover the patient's property and affairs only?**

YES/NO

If **"Yes"** the donee does not have power to make decisions regarding the patient's welfare.

If **"No"** and it is clear that it covers welfare issues also proceed to question 5.

5. **Does the Lasting Power of Attorney allow for a second donee and if so have they been consulted?**

YES/NO

If **"Yes"** and the document states that the donees have "joint and several" responsibility then either donee may give the necessary authority. If it is only "joint" then both must agree to the proposed management.

If **"No"** then proceed with the relevant authority from the single donee.

6. **Has the donee been fully informed of the nature, risks and consequences of the treatment being proposed as well as the consequences of accepting or refusing the treatment on behalf of the patient?**

YES/NO

If **"Yes"** proceed to question 7.

If **"No"** you must do so before the donee or donees take any decision.
Does the decision of the donee conflict with the views of health professionals looking after the patient or do you believe that the patient's best interests have not been properly considered (see the Best Interests checklist)?

YES/NO

If **"Yes"** consideration should be given to referring the matter to the Court of Protection and the case should be reported to senior staff in order to obtain legal advice in the first instance.

If **"No"** then proceed in accordance with the wishes of the "donee".

Life-sustaining treatment

8. **Does the Lasting Power of Attorney contain express provision authorising the donee to give or to refuse consent to the carrying out or continuation of life sustaining-treatment?**

   YES/NO

   If **"Yes"** then this is valid but consider question 9 also. If **"No"** and life-sustaining treatment is necessary then it must be given.
   Where there is any dispute with the health professional about the assessment of the patient's capacity which remains unresolved legal advice should be sought in order that the matter can be referred to the Court of Protection.

9. **Do all relatives and carers agree with the proposed management and the wishes of the donee?**

   YES/NO

If **"Yes"** then proceed as planned. If **"No"** then this presents a potential risk and further advice should be sought.

I confirm I have understood and reviewed this checklist in respect of the above-named patient.

_____	_____	_____
Signature of Health Professional	Date	Name and position of Health Professional

This checklist is only intended to provide guidance and a framework when considering a lasting power of attorney. Where there are any doubts concerning the validity or applicability of a lasting power of attorney further medical and/or legal advice should be sought.