	**London Ambulance Service NHS Trust** **Policy for Consent to Examination or Treatment** **For Use By: All A&E staff**

Introduction

This policy is for all staff who provide care to patients, irrespective of the route by which they came into contact with them. This policy is based on the Department of Health guidance on consent to examination or treatment of patients (DH 2001), and is in four parts.

- Part A provides a summary of the 12 key points on consent as applicable to ambulance staff.
- Part B contains guidance for ambulance staff
- Part C contains the full consent policy

Objectives

1. To set out and explain the requirements laid down by the Department of Health (DoH) with respect to 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 that decisions regarding consent must be documented using the appropriate LAS forms.

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 must decision be documented on the PRF, and if appropriate on an LA5, LA5a or LA5b. Given the comprehensive nature of this policy it is strongly advised that staff contact the Clinical Support Desk in EOC for guidance.

Monitoring compliance with this policy

The adherence of staff to this policy as a whole, and to the JRCALC Clinical Guidelines in respect of consent and patient treatment documentation, will be primarily carried out through Clinical Performance Indicator checks (CPIs).

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

The basic tenets of "Consent"

The terms "capacity" and "competence" are used throughout this document. Each term is used where it is felt to be most appropriate. Capacity is assessed by deciding whether you can answer "yes" to the following questions;

- Do you feel the patient is able to communicate a decision effectively?
- Do you feel the patient understands in simple language what is proposed and why it is being proposed?
- Do you feel that the patient is able to understand the principal risks and benefits of what is proposed?
- Does the patient understand the consequences of not receiving the proposed treatment?
- Can the patient retain the information long enough to make an effective decision?

If the answers to all of the above are "**YES**", staff should consider that the patient has **capacity** and able to make **competent** decisions.

PART A – 12 Key Points on Consent

When do ambulance staff need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent. You may wish / need to document this in more detail than is available on the London Ambulance Service (LAS) NHS Trust Assignment Record and Clinical Record (PRF LA4); for example the administration of a treatment or drug whilst it is part of a clinical trial. The three requisite forms are LA5, LA5a & LA5b. You must be guided by the circumstances existing at the time when deciding which form, if any to use. 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.

Please note that Form LA5 is specifically designed as an assessment of capacity tool as well as being for patients who are unable to consent to treatment for themselves, or for whom treatment is required without their consent.

The forms used by the LAS are either wholly, or substantially, based on the forms recommended by the DH.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient understand and weigh up the information needed to make this decision?" Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. 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.

Can children consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence 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 competent child consents to treatment, a parent **cannot** override that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. 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.

What information should be provided to the patient?

7. 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.

Is the patient's consent voluntary?

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

Does it matter *how* the patient gives consent?

9. 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.

Refusals of treatment

10. Competent adult patients 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 competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

Adults who are not competent to give consent

11. **No one** can give consent on behalf of an adult who lacks capacity. 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 the wishes and beliefs of the patient with capacity, their current wishes, 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 never had capacity, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

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

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.

Documentation of decisions regarding consent

Staff must ensure that decisions regarding consent must be documented using the appropriate LAS form. Explanations of which form is to be used in which scenario is explained further in this document. Also the PRF User Guide gives further explanation of the "Consent Obtained" tick box on the PRF.

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

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 a PRF and an 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.

Gaining Consent

"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.

Gaining the consent of a patient to examination and treatment will most often happen as a natural progression of the interaction of staff with their 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.

Actions to take if consent to examination or treatment is refused

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 moral duty and legal responsibility for ambulance staff to provide further care.

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

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 PRF LA4, all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative or friend, or an LAS Officer. Staff should notify the Emergency Operations Centre (EOC) of their actions, a timed recording will then be available should one be required.

Where a patient is deemed to **have capacity**, 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.

Where a patient who **does not have capacity** is refusing treatment, the crew must consider the consequences of the patient not receiving treatment. If the crew believes that the patient needs treatment, they should act in the patient's best interests. Crew and patient safety must be paramount in this decision.

In these circumstances they must document carefully both on the LA5 and PRF LA4, all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative or friend, or an LAS Officer. However, 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'.

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.

<u>Assessment of capacity/assessment for treatment without consent form (Form LA5)</u>

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 must receive treatment for life threatening illness or injury. 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, it is beholden on the staff member to be able to justify **all** their reasoning, actions and treatments. Crew and patient safety should be a consideration at all times.

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.

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 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 Emergency Operations Centre (EOC) to facilitate the contacting of other agencies.

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

The pink copy of form PRF 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 the LA5 copy is to be left with the pink copy of the PRF at the treatment centre.

Advanced Directives

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

- At the time it was made the patient had the necessary mental capacity to make it.
- At the time it was made the patient fully understood the consequences of his/her decision.
- The circumstances that have arisen are the circumstances that were contemplated when the advance directive was made.
- At the time the advance directive was made, there was no duress on the patient.

In order to ascertain the validity of an advance directive, clarification should be sought from either the patient's GP, the clinician involved in that aspect of the patient's care, or another person named on the directive, which may include the patient's solicitor. Where there is real doubt over the validity of an advance directive and any delay in treating and/or transferring the patient is likely to lead to permanent physical or mental

harm, 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 Directive, treatment must be continued until the patient is stable and competent to discuss their current treatment wishes. However, only that treatment, which is immediately necessary and in the patient's best interest should be provided.

Part C – Full LAS policy on consent to examination or treatment. This policy is based substantially on the guidelines on consent issued by the Department of Health.

Why consent is crucial

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. Seeking consent is also a matter of common courtesy between health professionals and patients. 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.

This policy

2. 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. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

What consent is – and isn't

3. "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.

4. The context of consent can take many different forms, ranging from the active request by a patient of 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.

5. Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, **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 directive. For further details on advance directives see the Department of Health's *Reference guide to consent for examination or treatment* (chapter 1, paragraph 19) and LAS Procedure for Specific Named Patient Protocols and No Resuscitation Orders / Advanced Directives OP /028

Guidance on consent

6. 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).

    - *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.

    - *12 key points on consent: the law in England* summarises those aspects of the law on consent which arise on a daily basis and is provided in Part A of this document. Further copies are available from www.doh.gov.uk/consent.

    - 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.

7. For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's notes if necessary), or through documenting in the patient's notes that they have given oral consent. **Within the LAS this will mean that consent will be documented on the Patient Report Form (LA4 PRF).**

Written consent

8. 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 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.

9. It is rarely a legal requirement to seek written consent,* but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- the procedure involves general/regional anaesthesia or sedation
- providing clinical care is not the primary purpose of the procedure
- there may be significant consequences for the patient's employment, social or personal life
- the treatment is part of a project or programme of research approved by the London Ambulance Service NHS Trust.

* The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances.

10. Completed forms should be kept with the PRF. Any changes to a form, made after the form has been signed, should be initialled and dated by both patient and health professional.

11. It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be helpful to do so.

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

12. 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 - Assessment of Capacity and Refusal 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.

13. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. You should involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, 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.

14. Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. 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.

Availability of forms (LA5)

15. The LA5 is to be used for patients who may be unable to consent for themselves. These forms should be used in the same manner and in tandem with LA4 PRFs.

16. When a patient formally gives their consent to a particular intervention, this is only the *endpoint* of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking consent'. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient's condition

Single stage process.

17. In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

18. If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed. This single stage process will be most applicable to Ambulance services.

Two or more stage process

19. In most 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 at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires 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?" This process will be used more in the hospital environment.

Emergencies

20. Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.

Treatment of children

21. 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 (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

22. 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.

23. 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.

24. Children under the age of 16, who have sufficient understanding and intelligence to 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.

25. 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 interest.

Provision of Information

26. 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.

27. 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.

28. Patient information is available via the Patient Advice and Liaison Service (PALS) and the Professional Standards Unit (PSU). Both these services are available via the HQ Switchboard – 0207 921 5100 or via the London Ambulance Service website www.londonambulance.nhs.uk

Provision for patients whose first language is not English

29. 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 Language Line and multi-lingual phrasebooks. Other specific advice can be sought from the Diversity Team based at LAS HQ.

30. 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.

Access to more detailed or specialist information

31. Patients may sometimes request more detailed information about their condition. This information could be provided via PALS, access to NHS Direct, NHS Direct Online, Professional Standards Unit or the Medical Directorate.

Who is responsible for seeking consent?

32. **The health 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.**

33. Where oral or non-verbal consent is being sought prior to the initiation of the procedure, naturally this will be done by the health professional 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.

Completing consent forms

34. The PRF the LA5, and the LA5a and b all provide space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

35. It is a health professional'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.

36. If you feel that you are being pressurised to seek consent when you do not feel competent to do so, seek advice from EOC.

Refusal of Treatment

37. If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient 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.

    - If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented on the PRF and / or LA5a or b. 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.

    - 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.

- 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.

Clinical Photography and Conventional or Digital Video Recordings

38. 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, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

39. 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. The one exception to this principle is set out in paragraph 40 below. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed 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.

40. 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.

41. 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.

42. 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.

43. 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.

Training

Training in consent is provided by the Education and Development Department through both core courses and the Continuing Professional Development programme.

Current forms in use in this organisation

LAS Trust Assignment Record and Clinical Record (LA4, PRF)
Assessment of Capacity and for adults who are unable to consent to investigation or treatment (LA5)
Patient agreement to investigation or treatment (LA5a)
Parental agreement to investigation or treatment for a child or young person (LA5b)
Accident / Incident Report Form (LA52)

Useful contact details

PALS
PSU
NHS Direct
NHS Direct Online
Governance Development Unit
Medical Directorate
Legal Services

References: DoH Good Practice in Consent Implementation Guide.
LAS Procedure for Specific Named Patient Protocols and No Resuscitation Orders / Advanced Instructions – OP/028.
LAS Managing Patient Confidentiality When dealing with the Media – TP/024

Signature: Mike Dinan – Director of Finance.

On behalf of:

Peter Bradley CBE
Chief Executive Officer.