



**London Ambulance Service
NHS Trust
DRAFT 040805
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 (DoH 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
- Appendix 1 - contains copies the various consent forms used by the LAS
- Appendix 2 - Seeking Consent: remembering the patient's perspective

Objectives

1. To set out and explain the requirements laid down by the Department of Health 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.

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.

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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 LAS NHS Trust Assignment Record and Clinical Record (PRF LA4); For example the administration of activated charcoal whilst it is still part of a clinical trial. The three requisite forms, (LA5, LA5A & LA5B) are detailed in Appendix 1. 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 Department of Health.

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.

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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. No: 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.

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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.

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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 of 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.

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.

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,

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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.

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

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.

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 Central Ambulance Control (CAC) 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.

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- 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 CAC. 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.

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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 London Ambulance Service (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

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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 London Ambulance Service 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

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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

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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’s solicitors on seeking directions from the Court.

Availability of forms (LA5)

15. An LA5 – see Appendix 1 - 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.

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

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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?"

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

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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

23. 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.
24. 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.
25. 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

26. 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.
27. It is not appropriate to use children to interpret for family members who do

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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

28. 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?

29. **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.**
30. Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally 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

31. The PRF and the LA5 both 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.
32. 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.
33. If you feel that you are being pressurised to seek consent when you do not feel competent to do so, seek advice from Central Ambulance Control.

Refusal of Treatment

34. 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

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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 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.
- 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

35. 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.
36. 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 37 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.
37. 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

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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.

38. 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.
39. 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.
40. 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 (aka 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)

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Authorised By: Chief Executive Officer	Reviewed By: Senior Clinical Advisor
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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:

**Peter Bradley CBE
Chief Executive Officer.**

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LONDON AMBULANCE SERVICE NHS TRUST

**ASSESSMENT OF CAPACITY AND FORM FOR ADULTS WHO ARE UNABLE TO
CONSENT TO INVESTIGATION OR TREATMENT**

PRF No:.....CAD No:.....

Patient details (or pre printed label)	
Patient's surname / family name	
Patient's first names	
Date of birth	
Responsible health professional	
Job title	
NHS number (or other identifier) -----	
<input type="checkbox"/> Male	<input type="checkbox"/> Female
Special requirements <i>(eg other languages / other communication method)</i>	

To be retained with Assessment Record & Clinical Record (LA4)

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Assessment of Capacity

Voluntariness	Do you feel that the patient is free from external pressure to make their own decisions?	
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Yes <input style="width: 40px; height: 20px;" type="checkbox"/></td> <td style="width: 50%; border: none;">No <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/></td> </tr> </table>	Yes <input style="width: 40px; height: 20px;" type="checkbox"/>
Yes <input style="width: 40px; height: 20px;" type="checkbox"/>	No <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/>	

Information	Has sufficient information been passed to the patient to inform them fully of the clinical importance of seeking immediate treatment?	
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Yes <input style="width: 40px; height: 20px;" type="checkbox"/></td> <td style="width: 50%; border: none;">No <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/></td> </tr> </table>	Yes <input style="width: 40px; height: 20px;" type="checkbox"/>
Yes <input style="width: 40px; height: 20px;" type="checkbox"/>	No <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/>	

Capacity	Do you feel that the patient understands in simple language what is proposed and why it is being proposed?	Yes <input style="width: 40px; height: 20px;" type="checkbox"/>	No <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/>
	Do you feel that the patient is able to understand the principal risks and benefits of what is proposed?	Yes <input style="width: 40px; height: 20px;" type="checkbox"/>	No <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/>
	Does the patient understand the consequences of not receiving the proposed treatment?	Yes <input style="width: 40px; height: 20px;" type="checkbox"/>	No <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/>
	Can the patient retain the information long enough to make an effective decision?	Yes <input style="width: 40px; height: 20px;" type="checkbox"/>	No <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/>

Reasons for "NO" answers

If there are still concerns that the patient lacks capacity, irrespective of the above assessment, additional advice should be sought from a LAS officer or the GP. Staff should leave patients with serious illnesses or injuries only if they have no doubt that the patient has capacity to refuse treatment and has received full information about the consequences of their refusal. This must be recorded in writing, including the detail of the information given and the patient's response.

Patient identifier/label

All sections to be completed by health professional proposing the procedure

A Details of procedure or course of treatment proposed

(NB see guidance to health professionals overleaf for details of situations where court approval must first be sought)

B Assessment of patient's capacity

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because:

- the patient is unable to comprehend and retain information material to the decision; and/or
- the patient is unable to use and weigh this information in the decision-making process; or
- the patient is unconscious

Further details (excluding where patient unconscious): for example how above judgements reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful.

C Assessment of patient's best interests

To the best of my knowledge, the patient has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the procedure to be in the patient's best interests because:

(Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)

The treatment cannot wait until the patient recovers capacity because:

D Involvement of the patient's family and others close to the patient

The final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (eg spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical interests", and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

(to be signed by a person or persons close to the patient, if they wish)

I/We have been involved in a discussion with the relevant health professionals over the treatment of _____ (patient's name). I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form. I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision)

Name _____ Relationship to patient _____

Address (if not the same as patient) _____

Signature _____ Date _____

If a person close to the patient was not available in person, has this matter been discussed in any other way (eg over the telephone?)

Yes No

Details:

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature _____ Date _____

Name (PRINT) _____ Job title _____

Where second opinion sought, s/he should sign below to confirm agreement:

Signature _____ Date _____

Name (PRINT) _____ Job title _____

Guidance to health professionals (to be read in conjunction with consent policy)

This form should only be used where it would be usual to seek written consent but an adult patient (18 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the *Mental Health Act 1983*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or 'living will'), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health's *Reference guide to consent for examination or treatment* (www.doh.gov.uk/consent).

When treatment can be given to a patient who is unable to consent

For treatment to be given to a patient who is unable to consent, the following **must** apply:

- the patient must lack the capacity ('competence') to give or withhold consent to this procedure AND
- the procedure must be in the patient's best interests.

Capacity

A patient will lack capacity to consent to a particular intervention if he or she is:

- unable to comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question; and/or
- unable to use and weigh this information in the decision-making process.

Before making a judgement that a patient lacks capacity you must take all steps reasonable in the circumstances to assist the patient in taking their own decisions (this will clearly not apply if the patient is unconscious). This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates or supporters.

Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be quite able to take other more straight-forward decisions or parts of decisions.

Best interests

A patient's best interests are not limited to their best medical interests. Other factors which form part of the best interests decision include:

- the wishes and beliefs of the patient when competent
- their current wishes
- their general well-being
- their spiritual and religious welfare

Two incapacitated patients, whose *physical* condition is identical, may therefore have different best interests.

Unless the patient has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, you should attempt to involve people close to the patient (spouse/partner, family and friends, carer, supporter or advocate) in the decision-making process. Those close to the patient cannot require you to provide particular treatment which you do not believe to be clinically appropriate. However they will know the patient much better than you do, and therefore are likely to be able to provide valuable information about the patient's wishes and values.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. Donation of regenerative tissue such as bone marrow, sterilisation for contraceptive purposes and withdrawal of artificial nutrition or hydration from a patient in PVS must never be undertaken without prior High Court approval. High Court approval can also be sought where there are doubts about the patient's capacity or best interests.

LONDON AMBULANCE SERVICE NHS TRUST

CONSENT FORM 1

PATIENT AGREEMENT TO INVESTIGATION OR TREATMENT

PRF No:.....CAD No:.....

Patient details (or pre printed label)

Patient's surname / family name

Patient's first names

Date of birth

Responsible health professional

Job title

NHS number (or other identifier) -----

Male

Female

Special requirements
(eg other languages / other communication method)

To be retained in patient's notes

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Patient identifier/label

Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear) _____

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits _____

Serious or frequently occurring risks _____

Any extra procedures which may become necessary during the procedure

blood transfusion _____

other procedure (please specify) _____

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided _____

This procedure will involve:

general and/or regional anaesthesia

local anaesthesia

sedation

Signed _____ Date _____

Name (PRINT) _____ Job title _____

Contact details (if patient wishes to discuss options later) _____

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed _____ Date _____

Name (PRINT) _____

Top copy accepted by patient: yes/no (please ring)

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

Patient's signature _____ Date _____

Name (PRINT) _____

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signed _____ Date _____

Name (PRINT) _____

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed _____ Date _____

Name (PRINT) _____ Job title _____

Important notes: (tick if applicable)

See also advance directive/living will (eg Jehovah's Witness form)

Patient has withdrawn consent (ask patient to sign/date here) _____

Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- they are unable to comprehend and retain information material to the decision and/or
- they are unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.

LONDON AMBULANCE SERVICE NHS TRUST

CONSENT FORM 2

**PARENTAL AGREEMENT TO INVESTIGATION OR TREATMENT FOR A
CHILD OR YOUNG PERSON**

PRF No:CAD No:.....

Patient details (or pre printed label)	
Patient's surname / family name	
Patient's first names	
Date of birth	
Responsible health professional	
Job title	
NHS number (or other identifier)	
<input type="checkbox"/> Male	<input type="checkbox"/> Female
Special requirements <i>(eg other languages / other communication method)</i>	

To be retained with Assessment Record and Clinical Record (LA4)

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Patient identifier/label**Name of proposed procedure or course of treatment**

(include brief explanation if medical term not clear) _____

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the child and his or her parent(s). In particular, I have explained:

The intended benefits _____

Serious or frequently occurring risks _____

Any extra procedures which may become necessary during the procedure

 blood transfusion _____ other procedure (please specify) _____

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient and his or her parents.

 The following leaflet/tape has been provided _____

This procedure will involve:

 general and/or regional anaesthesia local anaesthesia sedation

Signed _____ Date _____

Name (PRINT) _____ Job title _____

Contact details (if child/parent wish to discuss options later) _____**Statement of interpreter** (where appropriate)

I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe they can understand.

Signed _____ Date _____

Name (PRINT) _____

Top copy accepted by patient/parent: yes/no (please ring)

Statement of parent

Please read this form carefully. If the procedure has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form and **I confirm** that I have 'parental responsibility' for this child.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that my child and I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of the situation prevents this. (This only applies to children having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

I have been told about additional procedures which may become necessary during my child's treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

Signature _____ Date _____

Name (PRINT) _____ Relationship to child _____

Child's agreement to treatment (if child wishes to sign)

I agree to have the treatment I have been told about.

Name _____ Signature _____

Date _____

Confirmation of consent (to be completed by a health professional when the child is admitted for the procedure, if the parent/child have signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the child and his or her parent(s) that they have no further questions and wish the procedure to go ahead.

Signed _____ Date _____

Name (PRINT) _____ Job title _____

Important notes: (tick if applicable)

- See also advance directive/living will (eg Jehovah's Witness form)
- Parent has withdrawn consent (ask parent to sign/date here) _____

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form should be used to document consent to a child's treatment, where that consent is being given by a person with parental responsibility for the child. The term 'parent' has been used in this form as a shorthand for 'person with parental responsibility'. Where children are legally competent to consent for themselves (see below), they may sign the standard 'adult' consent form (form 1). There is space on that form for a parent to countersign if a competent child wishes them to do so.

Who can give consent?

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. The courts have stated that if a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. If children are not able to give consent for themselves, some-one with parental responsibility may do so on their behalf.

Although children acquire rights to give consent for themselves as they grow older, people with 'parental responsibility' for a child retain the right to give consent on the child's behalf until the child reaches the age of 18. Therefore, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child's treatment. In law, health professionals only need the consent of one appropriate person before providing treatment. This means that in theory it is lawful to provide treatment to a child under 18 which a person with parental responsibility has authorised, even if the child refuses. As a matter of good practice, however, you should always seek a competent child's consent before providing treatment unless any delay involved in doing so would put the child's life or health at risk. Younger children should also be as involved as possible in decisions about their healthcare. Further advice is given in the Department's guidance *Seeking consent: working with children*. Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the patient's notes.

Parental responsibility

The person(s) with parental responsibility will usually, but not invariably, be the child's birth parents. People with parental responsibility for a child include: the child's mother; the child's father if married to the mother at the child's conception, birth or later; a legally appointed guardian; the local authority if the child is on a care order; or a person named in a residence order in respect of the child. Fathers who have never been married to the child's mother will only have parental responsibility if they have acquired it through a court order or parental responsibility agreement (although this may change in the future).

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for children and their parents when making up their minds about treatment. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

Guidance on the law on consent

See the Department of Health publications *Reference guide to consent for examination or treatment* and *Seeking consent: working with children* for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Patient/parental agreement to investigation or treatment
(procedures where consciousness not impaired)

Name of procedure

(include brief explanation if medical term not clear) _____

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient/parent. In particular, I have explained:
The intended benefits _____

Serious or frequently occurring risks _____

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

The following leaflet/tape has been provided _____

Signed _____ Date _____

Name (PRINT) _____ Job title _____

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

Signed _____ Date _____ Name (PRINT) _____

Statement of patient/person with parental responsibility for patient

I agree to the procedure described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will/will not involve local anaesthesia.

Signature _____ Date _____

Name (PRINT) _____ Relationship to patient _____

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance)

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signature _____ Date _____

Name (PRINT) _____ Job title _____

Top copy accepted by patient/parent: yes/no (please ring)

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form documents the patient's agreement (or that of a person with parental responsibility for the patient) to go ahead with the investigation or treatment you have proposed. **It is only designed for procedures where the patient is expected to remain alert throughout and where an anaesthetist is not involved in their care: for example for drug therapy where written consent is deemed appropriate.** In other circumstances you should use either form 1 (for adults/competent children) or form 2 (parental consent for children/young people) as appropriate.

Consent forms are not legal waivers – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients also have every right to change their mind after signing the form.

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”, then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this form for themselves, if they wish. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form (see also ‘This form’ above)

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- they are unable to comprehend and retain information material to the decision and/or
- they are unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

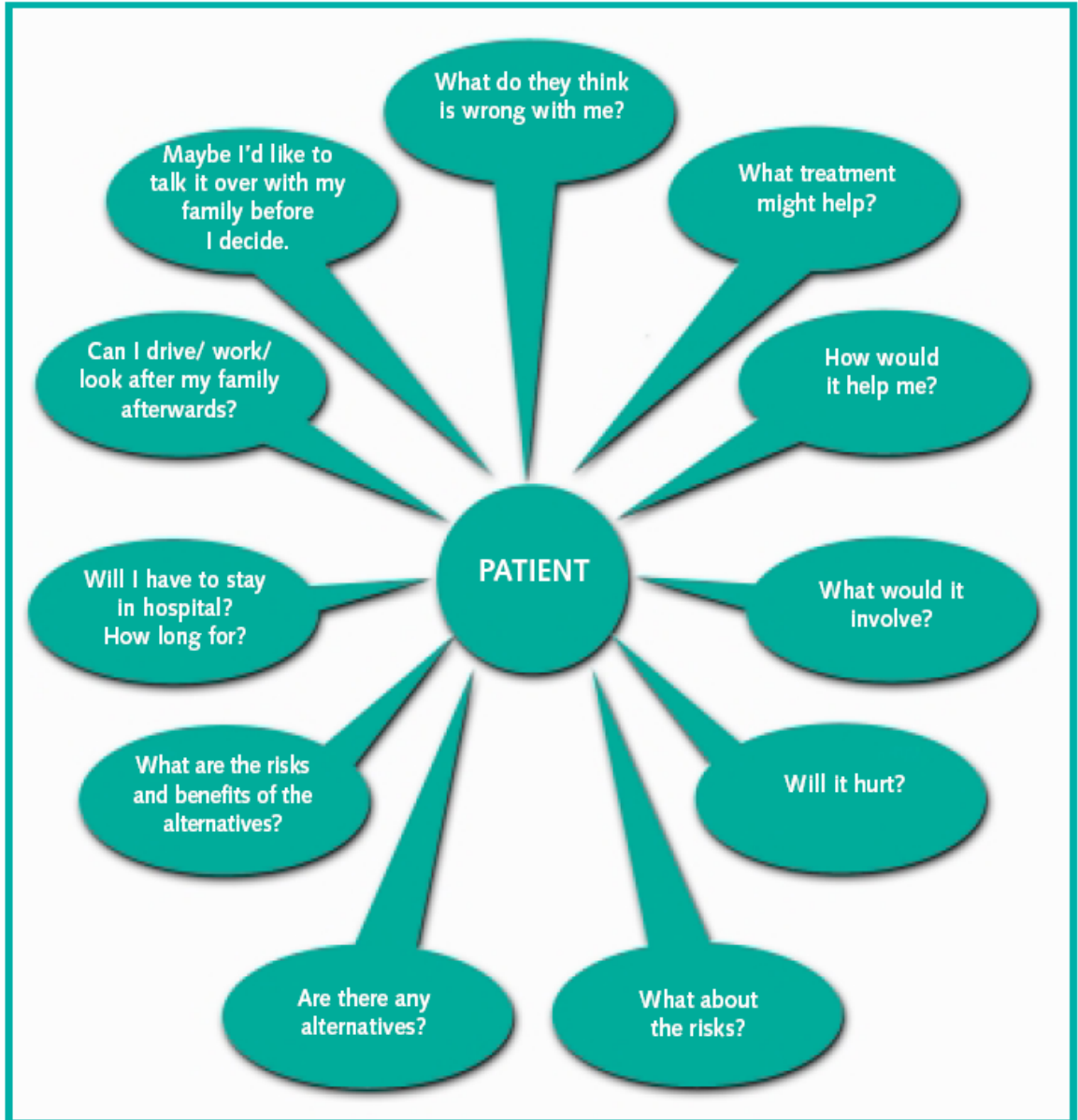
Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds about treatment. The courts have stated that patients should be told about ‘significant risks which would affect the judgement of a reasonable patient’. ‘Significant’ has not been legally defined, but the GMC requires doctors to tell patients about ‘serious or frequently occurring’ risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this overleaf or in the patient's notes.

The law on consent

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Seeking Consent: remembering the patient's perspective



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Information for Patients

Before a doctor or other health professional, (including a member of the London Ambulance Service NHS Trust), examines or treats you, they need your consent. Sometimes you can simply tell them whether you agree with their suggestions. However, sometimes a written record of your decision is helpful and you may be asked to sign a consent form. If you later change your mind, you're entitled to withdraw consent – even after signing.

What should I know before deciding?

Health professionals must ensure you know enough to enable you to decide about treatment. They'll write information on the consent form and offer you a copy to keep as well as discussing the choices of treatment with you. Although they may well recommend a particular option, you're free to choose another. People's attitudes vary on things like the amount of risk or pain they're prepared to accept. That goes for the amount of information, too. If you'd rather not know about certain aspects, discuss your worries with whoever is treating you.

Should I ask questions?

Always ask anything you want. As a reminder, you may wish to write your questions down. The person you ask should do his or her best to answer, but if they don't know they should find some-one else who is able to discuss your concerns. You might want to ask a friend or relative to support you in asking any questions. Ask if you'd like someone independent to speak up for you.

Is there anything I should tell people?

If there's any procedure you **don't** want to happen, you should tell the people treating you. It's also important for them to know about any illnesses or allergies which you may have suffered from in the past.

Can I find out more about giving consent?

The Department of Health leaflet *Consent – what you have a right to expect* is a detailed guide on consent in versions for adults, children, parents, carers / relatives and people with learning difficulties. Ask for one from your clinic or hospital, order one from the NHS Publications Order Line (08701 555 455) or read it on the web site www.dh.gov.uk./consent.

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Who is treating me?

You will be offered advice / care / treatment by healthcare staff who have been educated and trained appropriately for the role in which they have come into contact with you. At times some of these staff will be in training. Where staff are in training they will be supervised by a more senior member of staff who will be qualified for that role.

Photographs and videos

As part of your treatment some kind of photographic record may be made – for example X-rays, clinical photographs or sometimes a video. You will always be told if this is going to happen. The photograph or recording will be kept with your notes and will be held in confidence as part of your medical record. This means that it will normally be seen only by those involved in providing you with care or those who need to check the quality of care you have received. The use of photographs and recordings is also extremely important for other NHS work, such as teaching or medical research. However, we will not use yours in a way that might allow you to be identified or recognised without your express permission.

What if things don't go as expected?

The London Ambulance Service attends approximately one million calls every year and sometimes things don't go as they should. Although the staff involved in your care should inform you and your family, often the patient is the first to notice something amiss. If you're worried about any aspect of your care which you cannot resolve immediately with our staff, speak to your GP, or contact our PALS Office 0207 887 6678 or pals@lond-amb.mhs.uk

What are the key things to remember?

It's your decision! It's up to you to choose whether or not to consent to what's being proposed. Ask as many questions as you like, and remember to tell the team about anything that concerns you or about any medication, allergies or past history which might affect your general health.

Questions to ask health professionals

As well as giving you information health professionals must listen and do their best to answer your questions, which may include:

- What are the main treatment options?
- What are the benefits of each of the options?
- What are the risks, if any, of each option?

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- What are the risks if I decide to do nothing for the time being?
- How can I expect to feel after the procedure?

Health care professionals should welcome your views and discuss any issues so they can work in partnership with you for the best outcome.

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