

CONSENT GUIDANCE DOCUMENT

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Simply Teeth will audit the consent policy and working document intermittently as part of the Clinical Audit Programme.

ALL personnel employed by the Practice involved in the process of obtaining consent to examination and/or treatment, are expected at all times to work in accordance with their respective professional codes of conduct and scope of practice guidelines.

Introduction

It is the law that a competent adult patient may give or withhold consent to examination, investigation or treatment.

In law, any examination, treatment or investigation carried out without obtaining informed consent may result in the patient taking action, claiming battery. This in turn could lead to payment of damages or even criminal proceedings.

Failure to obtain informed consent is taken very seriously by professional registration bodies.

Patients usually give consent on the understanding that all healthcare professionals involved in their care will uphold. All healthcare professionals have a duty to maintain confidentiality of any patient information held in any format and to ensure that access to any such information is strictly controlled.

The Human Rights Act (1988), which came into force in October 2000, will give added strength to an individual who believes proper consent for examination or treatment was not sought and or his/her right to confidentiality was broken.

Patients may give limited consent dependant upon their religious beliefs. This must be respected by the health professional.

Against this background this document has been developed to give guidance on the most important issues in obtaining consent. It is the Practices intention that this document and the consent policy will ensure that all healthcare professionals are aware of the law regarding consent, and are enabled to adopt practices which aim to ensure the understanding and support of the patient, thus minimising the risk of legal challenge.

These documents are not exhaustive and where necessary a legal opinion should be sought from the professional legal advisors via the line manger and then the local NHS Caldicott Guardian if appropriate.

It is also realised that specific issues may arise within specialist clinical areas that require adaptations to the policy. In this instance the department concerned should assess the risks and develop appropriate protocols accordingly. However, any adaptations must be agreed and ratified by the Clinical Governance and Risk Management Committee.

It is the policy of Simply Teeth:

That, so far as is reasonably possible, no examination investigation or treatment will be carried out on an individual without the informed consent * of the patient or person with parental responsibility in the case of a child. Consent may be given in the following ways:

Written consent for any investigation or treatment which carries significant risk and/or _is associated with substantial known side-effects.

Implied consent for example the offering of an arm for blood to be taken after a full explanation of why the sample(s) are needed.

Oral consent the patient clearly and explicitly states that s/he agrees to what is being proposed and has full understanding of it. (Where possible this should be witnessed and it should always be documented in the patient's notes.)

***Informed consent results only when a process has been followed which ensures that the patient received sufficient information, in an accessible manner, such that s/he understands the risks, benefits, likely consequences and alternatives of any proposed treatment and indeed of non-treatment. The patient must be given the opportunity to obtain any further information relating to the treatment s/he believes to be relevant, prior to giving consent.**

That no individual can give consent for another adult, regardless of age or ability.

That the responsibility for obtaining informed consent is that of the health professional responsible for the aspect of treatment that requires consent.

That wherever possible verbal discussion and explanation will be supported by written information, leaflets etc, produced in accessible formats.

That details of all information given must be recorded in the individuals case notes.

Notes for those working with children and young people:

See the Department of Health *Seeking consent – working with children* document.

For children under the age of 16 consent to examination and or treatment will be given by a parent.

***The term ‘parent’ in this context is shorthand for ‘person with parental responsibility’. 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.**

Adoptive parents do have parental responsibility.

Long term foster parents do not, if the child is placed with foster parents and has a care order the responsibility would lie with the Local Authority.

Having said this all children should be as involved as possible in decisions about their healthcare:-

Following the legal decision in the House of Lords case of ‘Gillick’ in 1985, it is clear that a child under 16 years may consent to medical treatment if s/he is judged to be competent to give consent. This may be helpful in cases where a child who is under 16 years does not want his/her parents to be consulted about his/her care. The health professional should ‘seek to persuade’ such a child to tell his/her parents or allow him/her to do so, and can only be justified in proceeding without parental consent if the best interests of the child are being served. The health professional must be certain in such cases that the child has sufficient maturity to understand the nature, purpose and hazards of treatment in order to give valid consent. The health professional may seek assistance from colleagues in reaching this decision.

Young people over the age of 16 are deemed able to give consent for themselves as long as they have “sufficient understanding and intelligence to enable him or her to understand fully what is proposed.”

However, those with parental responsibility retain the right to give permission for that child until he/she reaches the age of 18.

In situations where the patient is under 16, who does not have the ‘appropriate-competence’, and where parental refusal conflicts with the best interest of the child then it is permissible to consider treatment despite parental refusal. Equally someone with parental responsibility can authorise treatment, even when the child (up to the age of 18) actively dissents, so long as the treatment is in the child’s best interests.

In all these circumstances legal advice should always be sought if there are any concerns as to what is in the best interests of the child/young person.

Notes for all health care staff

As mentioned before, “It is rarely a legal requirement to seek written consent” and “It will not usually be necessary to document a patient’s consent to routine and low risk procedures”. Professional judgement and accountability should, however, be applied in cases where there may be reason to believe that consent may be disputed later, or if the procedure is of particular concern to the patient.

It is good practice to involve the patient, person with parental responsibility in the case of children and/or significant others where the person lacks capacity, in the formation of care plans and to document the same.

Evidence that consent has been obtained may take the form of the patient/ carer signing the treatment/ care plan.

Once written consent has been given it is required that the practitioner seeks verbal clarification of continuing consent each time the procedure is repeated. However, providing there is no change either to the patients’ condition or to the treatment, consent is valid indefinitely provided there is no new evidence of risks or other treatment options.

Patients may withdraw consent at any time.

Consent to treatment should be obtained by a health professional capable of carrying out the procedure, or who has received training on obtaining consent as per the policy, and s/he should:

Explain it fully and clearly to the patient in a manner they can understand

Answer any questions raised

Recognise his/her own knowledge limitations and the importance of seeking assistance if in doubt.

Under **no** circumstances may any trainee/student take an active part in obtaining written consent; although they should be allowed to observe and learn about obtaining written consent as part of their training.

Consent to initial treatment does not imply consent to further treatment, and it must be checked at each intervention. Where consent has been given in advance of a procedure, e.g. for immunisation, this should be checked and if necessary sought again at the time of intervention.

When patients are attending for an investigation or treatment requiring full written consent, which is to be carried out on the first visit, information about the procedure should be sent at least 7 days in advance. The information must include details of someone who could answer any questions they may have and how to contact them. The fact that the information has been sent should be clearly identifiable in the notes. It is acknowledged that, in some circumstances, this may not be achievable. In those situations it is essential to clearly document what information has been provided, both written and verbal.

Procedures requiring Written Consent

This list was initially produced by looking at a wide variety of resources within professional groups to indicate those procedures where written consent was recommended as well as give examples of those where verbal consent was felt to be more appropriate. **Any such list is not exhaustive and will be subject to amendments.**

All areas are required to obtain written consent for any treatment as part of a project or programme of research. Other areas deemed appropriate by the health professionals in dentistry can be deemed as all invasive treatments that carry potentially life threatening risks.

Notes for those working with those unable to give consent

See Simply Teeth policy document- *mental capacity act document* or Department of Health *Seeking consent- working with people with learning disabilities*.

Where an individual lacks the capacity to give consent, no other person may do so for them.

In order to establish whether a patient has the capacity to give consent, the healthcare professional must ask themselves the following questions:

Does the patient understand and retain relevant information about both the positive and negative aspects of treatment?

Can the patient then make a decision about which treatment or indeed no treatment?

Can the patient communicate their decision?

If the answer to any of the above is no, in the opinion of the health professional who is assessing capacity, then a second opinion from a consultant and indeed a legal opinion may be needed. It is worthy of noting that the courts have encouraged the obtaining of a psychiatric opinion in such cases. Additionally, it may be useful to obtain the opinion of a psychologist and/or a speech and language therapist.

It is still lawful to provide treatment without consent where the patient is unable to give consent if it is agreed to be in the patient's best interests*.

***Best interests go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being, 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 been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences. It is good practice to seek the opinions of these people.**

It should be remembered that some individuals who lack the capacity to give consent on whole packages of care might have the ability to give consent to certain aspects of it. Every effort must be made to enable them to do so.

Notes for Dentists

See BDA Advice Booklet B1 “Ethics in Dentistry”

Informed consent requires that the dentist gives a full explanation of the nature, purpose and material risks of the proposed procedures in language that the patient can understand (using an interpreter and visual aids where necessary). The patient should have the opportunity to consider the information and ask questions in order to arrive at a balanced judgement of whether to proceed with the proposed treatment.

For consent to be valid it must be informed and specific. The patient should be competent and normally aged over 16 years. The consent must be freely given.

Informed Consent: Patient must receive a full explanation of the nature, purpose and risks of the proposed procedure and of any options, including doing nothing.

Specific Consent: Consenting to each part of the proposed care i.e. consenting to sedation, and consenting to extractions.

Who should obtain consent?

Normally the dentist providing the care should obtain consent. In no circumstances can surgery staff obtain consent. The dentist must obtain consent for any work referred to a hygienist or therapist.

Implied Consent is acceptable only for an examination i.e. where a patient arranges an appointment and lies on your chair to allow you to look at their teeth.

Oral Consent is acceptable for routine care once the treatment plan and options have been discussed. But the patient can withdraw their consent at any time as the treatment progresses.

Written Consent should be given for:

Extensive treatment plans

Treatment under sedation

The provision of sedation

Procedures which could have long lasting consequences e.g. lingual nerve damage

When providing private items of care to an otherwise NHS patient

Consent under duress is not valid even if it is in writing.

It is wise to get consent for other eventualities if the patient is being sedated e.g. for a surgical extraction, even if you expect it to be forceps.

Refusal to give consent

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 2005 see Simply Teeth policy document- *mental capacity act document*. This covers people with mental illness, who are deemed either to be a danger to themselves or to others.

The courts have ruled that a mentally competent person over the age of 18 has an absolute right to refuse intervention for any reason at all, whether it is rational or irrational, even though the consequences of this decision may be fatal for the patient (and/or for an unborn child).

In potentially life-threatening circumstances such refusal to consent should immediately be brought to the attention of the Senior Staff so that a decision can be made regarding whether a court declaration should be sought.