Acacium Group
Consent

Policy Reference | CLIN 06

Version | V3.0

Policy Name	Consent
Purpose of Document	To ensure staff respect an individual's capacity to accept or deny treatment, or intervention.
Target Audience	All Acacium Group support workers, carers and nurses.
Version	V3.0
Author	Karen Matthews-Shard
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Risk and Resource Implications	To ensure staff respect an individual's capacity to accept or deny treatment, or intervention
Associated Strategies and SOPs	CLIN 08 Safeguarding Children and Young Adults CLIN 09 Safeguarding Vulnerable Adults CLIN 19 Resuscitation CLIN 41 Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguarding Policy
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History

Version	Date	Changes made/comments	By whom
V1.1	Dec 2012	Annual review and Equality and Diversity Statement added.	KNF/KMS
V1.1	Dec 2013	Annual review	KNF/KMS
V2	Nov 2014	Annual review.	KNF/KMS
V2	Jan 2018	Annual review and implementation of new document history page.	KMS/SJ
V2	Mar 2018	Updated front sheet to include new review frequency date.	KMS/MS
V 2.1	Nov 2018	Updated in relation to training	KMS/SJ
V2.2	Jan 2020	Updated to new Acacium Group Template	CC
V2.3	Oct 2020	Updated re rebrand	CCR/CC
V2.4	Jan 2021	Updated re Rebrand 2	CC
V2.5	Apr 2021	CHS brand added	CC
V2.6	Jan 2022	Review	CAG
V2.7	Jun 2022	Review	AM
V3.0	Jan 2024	Rebrand	Clinical Advisory Group

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1. Introduction

1.1 Acacium Group Consent Policy is for adults and children. This Policy covers the consent procedures, processes and requirements in place within Acacium Group. The Policy has been developed in accordance with the Department of Health Model Policy for Consent and with consideration for recent new legislation introduced under the Mental Capacity Act 2005.

1.2 It is a general legal and ethical principle that valid consent must be obtained before starting any treatment or providing personal care for a client. This principle reflects the rights of the client to determine what happens to them. A healthcare professional who does not respect this principle may be liable to legal action by the client.

1.3 Acacium Group is responsible for ensuring that all staff meet the requirements within the Policy. In order to do this, appropriate training is put in place to ensure that the training needs of all staff that this applies to are met.

1.4 Acacium Group believes that every client has the right to be fully involved and informed about the care they may expect to receive. The client should be informed about risks and benefits as well as alternatives to planned care. If a client wishes to decline an aspect of care/therapy they are entitled to know what the consequences of that decision may be and that if a decision is made to decline care, this should be respected even if the nurse or carer disagrees with the decision. There are times when the Healthcare professional can continue to provide care against the decision made by the client as long as this is clearly in the best interest of the client as long as it has not been refused in advance in a valid and applicable advance decision.

1.5 In order to give consent the client must be deemed capable of making that decision and any advance decisions must be respected, if they were made when the client had good mental capacity.

1.6 Acacium Group Healthcare professionals who are unsure at any time of what action to take should contact their Acacium Group Line Manager immediately for advice.

2. Purpose of Policy

2.1 The purpose of this Policy is to provide staff with information and guidance on the legal requirements that exist with regard to consent and also to outline the processes within Acacium Group in relation to consent where it has been approved.

3. Scope of Policy

3.1 The Policy covers good practice guidance for consent for all clinical and care procedures, consent in children, consent for clients who lack the capacity to make decisions for themselves, requirements for the provision of information for clients and who should obtain consent.

4. Definitions

Topic	Explanation
Procedure	A formal set of steps to follow in order to achieve specific outcomes, which are specifically agreed for designated staff. Any deviation from the steps is acceptable if this can be justified and the rationale for doing so documented appropriately.
Competence	Should be acquired through general professional training, attending educational workshops, observation and supervised practice in the clinical setting. Competence can be examined by questioning knowledge, observing practice and reflective practice journal.
Consent	A client's (or person with legal authority/parental responsibility) agreement for a Healthcare Professional to provide care.
Capacity	The ability to understand and retain the information relevant to the decision in question, believe that information, and weigh up that information in order to determine choice. Also includes being able to communicate that decision.
Gillick competence	Gillick competency and Fraser guidelines help people who work with children to balance the need to listen to children's wishes with the responsibility to keep them safe. When practitioners are trying to decide whether a child is mature enough to make decisions about things that affect them, they often talk about whether the child is 'Gillick competent' or whether they meet the 'Fraser guidelines' Although the two terms are frequently used together and originate from the same legal case, there are distinct differences between them. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. For more information https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines
Healthcare professionals	All Acacium Group staff that provide clinical care to clients.
LPA (Lasting Power of Attorney	A representative previously appointed by the client to protect the future needs of the client in case of incapacity.
Independent Mental Capacity Advocate (IMCA)	Representative for those who lack capacity and have no family or support network to support decision making.
Enduring Power of Attorney (EPA)	EPAs were replaced by LPAs in October 2007. However, if an EPA was made and signed an EPA before 1 October 2007, it should still be valid. An EPA covers decisions about property and financial affairs, and it comes into

	effect if someone loses mental capacity, or if and individua wants someone to act on their behalf.
Best Interests	Best Interests is a statutory principle set out in section 4 of the Mental Capacity Act. It states that 'Any act done, or a decision made, under this Act or on behalf of a person who lacks capacity must be done, or made, in his best interests'. Because the Best Interests principle is a statutory principle there is a legal requirement for all Decision Makers to apply it when making decisions on behalf of a person who lacks capacity. (Mental Capacity Act 2005)

5. Roles & Responsibilities

Job Title	Responsibilities
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision
Operations Board	Ensure that the Directors have management and accountability structures that deliver safe and effective services.
Team Leaders and Senior Nurses/managers	• Demonstrate leadership, be informed about, and take responsibility for the actions of their staff • Monitor that Acacium Group nurses and carers are complying with this policy • Maintain confidentiality of clients • Support their staff throughout the process of reporting concerns • Ensure their staff access training, supervision and support relevant to their roles and responsibilities. • Ensure their staff are clear about their professional roles and responsibilities • Ensure their staff make comprehensive and accurate healthcare records • Ensure their staff work effectively with professionals from other relevant organisations • Facilitate and/or undertake regular audit of practices • Ensure the promotion and management of privacy and dignity is in appraisals and Personal Development Plans.
Individual Staff Members	• Be aware of Acacium Group policies procedures and related Standard Operating Procedures (SOPs) • Uphold this policy in the delivery of care at all times • Take part in training, including attending updates so that they maintain their skills and are familiar with procedures

	- All practitioners should ensure they receive supervision and guidance on a regular basis, as agreed with the line manager - All staff should maintain accurate comprehensive and legible records, with records being stored securely in line with local guidance. - Work in line with their regulatory body codes of conduct
Clinical Advisory Group (CAG)	Review polices associated documents and training content for the Group. To support high clinical standards and quality improvement agendas in line with the Groups vision, strategic aims

6. Why Consent is Crucial to Clients

6.1 Consent to treatment means a person must give permission before they receive any type of medical treatment, test or examination.

6.2 Consent from a client is needed regardless of the procedure and the principle of consent is an important part of medical ethics and international human rights law.

6.3 Valid consent to care is therefore absolutely central in all forms of healthcare, from providing personal care to complex interventions. Seeking consent is also a matter of common courtesy between health professionals and clients.

6.4 When gaining consent the healthcare worker will need, good communication skills, honesty and respect for the client. Asking for, and obtaining consent shows respect and allows the client to make an informed decisions regarding their care or treatment, avoiding coercion and misunderstandings. This allow the person to weigh up the benefits and the consequences of their decision.

7. Why Consent is Crucial to Healthcare Professionals

7.1 For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.

The meaning of these terms is:

- Voluntary – the decision whether to provide to treatment must be made by the person, and must not be influenced by pressure from medical staff, friends or family
- Informed – the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead
- Capacity – the person must be capable of giving consent, which means they understand the information given to them and can use it to make an informed decision

7.2 A medical or care intervention without valid informed consent is a criminal offence and the individual (and their employer) can be charged with battery. Examples of such situations include treatment against the patient's will, different treatment than the one consented for and treatment after consenting deliberately with wrong information.

8. What Consent Is and Lack of Consent

8.1 Consent is:

8.1.1 A client's agreement for a Healthcare professional to provide care. Clients 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 client must:

- Have capacity to make the particular decision
- Have received sufficient and relevant information to make the decision which has been communicated in an appropriate way for that client
- Have the ability to retain the information and weigh up the consequences
- Give consent voluntarily and freely, not under duress.

8.1.2 For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. Consent can be given by:

- The client who has capacity
- Someone with parental responsibility for a client under the age of 18
- Someone authorised to do so under a lasting power of attorney (LPA)
- Someone who has the authority to make treatment decisions as a court appointed deputy.

8.1.3 The context of consent can take many different forms, ranging from the active request by a client of a particular aspect of care (which may or may not be appropriate or available) to the passive acceptance of a nurse's or carer's advice. In some cases, the nurse or carer will suggest a particular form of care and after discussion the client may agree to accept it. In others, there may be a number of ways of providing care, and the nurse or carer will help the client to decide between them. Some clients, especially those with chronic conditions, become very well informed about their illness and may actively request particular aspects of care.

8.2 Lack of consent

8.2.1 Where an adult client lacks the capacity (either temporarily or permanently) to give or withhold consent for themselves, no-one else can give consent on their behalf (the only exception to this is clients who have appointed in advance a personal welfare lasting power of attorney (LPA). See 'Section 12.1.4' of this Policy for more information about LPAs.

8.2.2 Care, however, may be given if it is in the client's best interests, as long as it has not been refused in advance in a valid and applicable advance decision. See 'Section 12' for more information regarding consent processes for clients who lack capacity. Reference should also be made to the Acacium Group policies for complying with safeguarding vulnerable adults and children which includes legislation from the Mental Capacity Act 2005 and the Liberty Protection Safeguards (as of April 2022)

8.2.3 Further details on advance decisions can be found in the department of Health guidance, 'Reference guide to consent for examination or treatment', updated July 2009 (chapter 1, paragraphs 47 – 52 inclusive).

8.2.4 Further details on advance decisions can be found in 'chapter 9' of the Mental Capacity Act Code Of Practice 2005 and the Acacium Group Resuscitation Policy.

9. Consent Process

9.1 Capacity

9.1.1 We must always assume a person has capacity, unless determined otherwise. When considering if a person lacks capacity to make a decision, it must be remembered that it is a ‘time and specific’ test. A person may be able to make some decisions and not others, or a person may be able to make a decision on one day and not on the next. To make an informed decision the client must have all the information required, be able to retain and relay the information and communicate their decision. If the client requires communication adjustments, such as: interpreter, larger font documentation, this can be facilitated. Please refer to 11.8 and 11.9.

9.1.2 The final arbiter in any disputes would be the Court of Protection.

9.1.3 The Mental Capacity Act 2005 defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. A person lacks capacity if:

- They have an impairment or disturbance (for example, a disability, condition or trauma, or the effect of medication, drugs or alcohol) that affects the way their mind or brain works
- That impairment or disturbance means they are unable to make a specific decision at the time it needs to be made.

9.2 Assessment of capacity (in accordance with the Mental Capacity Act)

9.2.1 An assessment of a client’s capacity must be based on their ability to make a specific decision at the time it needs to be made, and not the ability to make decisions in general. A client is unable to make a decision if they cannot do one or more of the following things:

- Understand the information given to them that is relevant to the decision required
- Retain that information long enough to be able to make the decision
- Be able to use or weigh up the information as part of the decision making process
- Communicate their decision – this could be by talking, using a form of sign language, or non-verbal communication techniques (as documented in the client’s care plan).

9.2.2 Under the Mental Capacity Act a person is assumed to have capacity until it is established that they lack it.

9.2.3 A client’s capacity to consent may be temporarily affected by factors, such as unconsciousness, confusion, panic, shock, fatigue, pain or medication. These factors must be considered. However, the existence of such factors should not lead to an automatic assumption that the client does not have the capacity to consent.

9.2.4 When obtaining consent the Mental Capacity Act requires that all practical and appropriate steps are taken to enable a client to make the decisions themselves. This includes the following:

- Providing relevant information
- Communicating in an appropriate way
- Making the client feel at ease
- Supporting the client.

9.2.5 If there is any doubt, the healthcare professional should assess the capacity of the client to make the decision in question and seek support by the wider/relevant MDT if still unclear.

9.3 Documentation of assessment of capacity

9.3.1 Where an adult client does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in the client's care record at the time in accordance with the principles outlined in the Mental Capacity Act 2005 (HMSO 2005).

9.3.2 If a descsion is made that a client does not have capacity the Decision Maker must be able to describe why they had a reasonable belief of a lack of capacity. This should always be recorded within a patient's case notes or care plan.

9.3.3 In relation to more complex decisions involving perhaps a life changing decision it is essential that there is evidence of a formal, clear, and recorded process. In order to achieve this Record of Capacity Test and Best Interests Assessment form (MCA 1) must be completed – this should be obtained via the relevant NHS/Social Services team for the client's location and completed in collaboration with other professional involved in the individual's care.

9.3.4 Local policy should be followed and Acacium Group Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguarding Policy should be referenced.

9.4 Reasonableness

9.4.1 A person cannot be assessed as not having capacity because the health professional feels the decision made by the client is unreasonable. A person is entitled to make a decision which may be perceived to be unwise or irrational if they have the capacity to do so.

9.4.2 However, if the decision appears irrational based on a misperception of reality, as opposed to a different value system, then the client may not be able to weigh up or make use of the relevant information and hence may lack the capacity to make the decision in question.

9.5 Lasting Power of Attorney (LPA)

9.5.1 In the unlikely event that a Acacium Group worker is involved with the need to make a decision about a serious medical treatment the Acacium Group worker should be aware of the fact that a client has previously appointed a personal welfare lasting power of attorney (LPA), which has been registered with the Office of the Public Guardian. This person has authority to provide consent on behalf of the person who lacks capacity. If a registered welfare LPA exists they must always be contacted regarding the decision about a serious intervention that is in a client's best interests and their input should be clearly documented in the client's care records.

9.5.2 In most situations, people who lack capacity will have a network of support from family members or friends who take an interest in their welfare, or from a court appointed deputy or an attorney appointed under a lasting power of attorney. However, some people who lack capacity may have no one to support them with major, potentially life-changing decisions and because of this the MCA has created an Independent Mental Capacity Advisor role (IMCA). An IMCA will not be the decision-maker, but the decision-maker has a duty to seek advice from the IMCA and to take into account the information given by the IMCA. If you are the decision-maker, it will be your duty to instruct the IMCA before making the decision (apart from in emergency situations).

9.5.3 However, the support of an Independent Mental Capacity Advisor should not ever be required by a Acacium worker as the Acacium Group worker should not be involved in potentially life-changing decisions.

9.5.4 Care or treatment, however, may be given if it is in the client's best interests, provided that it has not been refused in advance in a valid and applicable advance decision to refuse.

NB:

- An apparent lack of capacity to give or withhold consent may also be the result of communication difficulties rather than a genuine lack of capacity. You should involve appropriate colleagues in making such assessments of lack of capacity, such as speech and language therapists, unless the urgency of the client's situation prevents this.
- Relatives or carers **cannot** provide consent on behalf of a client who lacks the capacity to make a decision for themselves unless they are an officially appointed representative or parent or guardian (refer to 12.9).

9.6 Advance decisions to refuse treatment

9.6.1 Before undertaking any procedures check that there is no information in the client's records in relation to previous advance decisions to refuse treatment.

9.6.2 Further details on advance decision to refuse treatments can also be found in the Acacium Group Resuscitation Policy, the Department of Health's 'Reference guide to consent for examination or treatment' (updated July 2009 [chapter 2, paragraphs 1 - 33), and in 'chapter 9' of the Mental Capacity Act Code Of Practice.

9.7 Information required in order to gain valid consent

9.7.1 It is advisable to inform the client of any significant risks, those that are unavoidable (even if small), frequently occurring risks, the alternatives and the risks incurred by doing nothing. A record of the information given must be made.

9.7.2 If information is offered but declined, it is **important** to record this in the client's care records. However, a client who has declined may change his / her mind and require information later. Therefore, they must be given the opportunity to receive information again at a later point.

9.7.3 It is also good practice when seeking consent to discuss possible additional procedures when seeking consent for the original intervention if it is felt there may be a need for this.

9.8 Provision for clients whose first language is not English

9.8.1 It is unlikely that Acacium Group worker will be faced with this situation. However, if they do, they should know that it is not appropriate to use children or any family member /significant other, to interpret for the individual who does not speak English. Line management support will be required to access and arrange a suitable interpreter to ensure that information is given and understood in order to ensure the principles of informed consent are followed https://www.nhs.uk/conditions/consent-to-treatment/

9.9 Available information leaflets

9.9.1 Where available, information leaflets in the required language should be provided to support the information giving and understanding process. The client should be given the opportunity to read this and ask questions, via an interpretation service, prior to giving consent unless there is an urgent need to provide care. It is always helpful to document when an information leaflet has been given and the involvement of an interpreter.

9.10 Obtaining consent

9.10.1 It is rarely a legal requirement to seek written consent and for Acacium Group worker there will not be a need to obtain any consent in writing.

9.10.2 It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking consent'. If a client has consented to care or an intervention one time it does not mean that consent has been given for the same care or intervention when it needs to be repeated. Consent must be seen as a continuous process.

9.11 Forms of consent

9.11.1 There are different types of consent in health care and social care settings. The Department of Health (DH) and professional bodies have produced comprehensive guidance about consent. The DH guidance includes information about what consent is, the different types of consent, when consent should be obtained, by whom and in what circumstances. This note reflects some of the key points from the DH guidance. The validity of consent does not depend on the form in which it is given.

9.11.2 Written consent

Written consent merely serves as evidence of consent. It is valid if it is given voluntarily and appropriate information and capacity have been satisfied. A signature on a form will not make the consent valid. It is good practice to use forms for written consent where an intervention such as surgery is to be undertaken. Most providers' consent policies will require written consent to be obtained in these circumstances. Most professional bodies and the guidance from DH also advise this as good practice. Details of the assessment of capacity, and the conclusion reached, should be recorded in the case notes.

9.11.3 Verbal (explicit) and non-verbal (implied or implicit) consent

Sometimes verbal consent might be referred to as 'explicit' consent, and non-verbal may be referred to as 'implied' or 'implicit' consent. An example of non-verbal or implied consent would be where a person, after receiving appropriate information, holds out an arm for their blood pressure to be taken or opens their mouth for their teeth or throat to be examined. However, the person must have understood what examination or treatment is intended, and why, for such consent to be valid. This could also apply for patient transport services. For example, when a person is called to get into an ambulance in order to be transported for treatment.

An example of verbal or explicit consent would be where a doctor carries out a rectal examination of a patient and tells the patient what they want to do and asks them if they agree to such an examination. If the patient agrees then this is explicit consent (verbal consent). In all cases, staff should be aware of the different types of consent and the importance of ensuring that the person understands what is going to happen to them.

https://www.cqc.org.uk/sites/default/files/documents/rp_poc1b_100476_20110331_v1_00_sn_consent_updated_for_publication.pdf

9.12 Responsibility for seeking consent

9.12.1 The health professional carrying out the procedure is ultimately responsible for ensuring that the client is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

9.13 Emergency procedures

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

9.13.2 There are some situations where the nature of the client's medical condition or urgency of the situation will mean the best interests' principle should be applied.

9.13.3 Any best interests' decisions should be made by appropriately informed and qualified Acacium Group worker and should be fully documented in the client's care records. The client should be fully informed of all of the events retrospectively.

9.14 Refusal of consent to treatment or care

9.14.1 An adult client with capacity to make decisions is entitled to refuse any treatment, except in circumstances governed by the Mental Health Act 1983. The situation for children is more complex: see the Department of Health's 'Seeking consent: working with children' for more detail. The following paragraphs apply primarily to adults.

9.14.2 If, after discussion of possible treatment or care options, a client refuses all treatment or care, this fact should be clearly documented in their records. If the client has already consented but then changes their mind, the healthcare professionals should note this in the care records.

9.14.3 Where a client has refused a particular intervention, the healthcare professionals must ensure that they continue to provide any other appropriate care to which the client has consented. Healthcare professionals should also ensure that the client realises they are free to change their mind and accept treatment or care if they wish to do so at a later date. Where delay may affect a client's choices or prognosis, they should be advised accordingly.

9.14.4 If a client consents to a particular procedure but refuses certain aspects of the intervention, the healthcare professional must explain to the client the possible consequences of their partial refusal. If a healthcare professional genuinely believes that the procedure cannot be safely carried out under the client's stipulated conditions, they are not obliged to perform it. They must, however, continue to provide any other appropriate care. Guidance should be sought from their Line Manager if this poses difficulties.

9.15 Withdrawal of consent

9.15.1 Clients may, if they wish, withdraw consent at any time including during the procedure. Where possible, the procedure should be stopped to establish the client's concerns and explain the consequences of not completing the procedure. A withdrawal of consent may be a cry of pain or anxiety rather than a withdrawal of consent and appropriate reassurance may enable the worker to continue with the client's consent. If stopping the procedure puts the client at risk, the healthcare professional may be entitled to continue until that risk no longer applies.

9.16 Advance decisions to refuse treatment

9.16.1 A client may have made an advance decision to refuse particular treatment in anticipation of future incapacity. A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment. (Established in common law and the Mental Capacity Act 2005).

9.16.2 Acacium Group workers must follow an advance decision if it is valid and applicable, even if it may result in the person's death. If they do not they could face criminal prosecution or civil liability.

9.17 Documentation

9.17.1 Consent should be entered in the client's care records.

9.18 Photography

9.18.1 In some instances, there may be a clinical requirement to obtain photographs for the purpose of clinical observations and record keeping.

9.18.2 Consent should be obtained prior to taking any photograph of the client or their property. Photographs should only be taken on Acacium Group devices that password protected and storage should be in line with Acacium Group Data Protection Policies.

10. Consent for Children and Young People

10.1 The legal position concerning consent and refusal of treatment by those under the age of 18 is different from the position of adults. Relevant legislation includes the Family Law Reform Act 1969 and the Children Act 1989. If children are competent to give consent for themselves, you should seek consent directly from them. The legal position regarding 'competence' is different for children aged over 16 than it is for children under the age of 16.

10.2 When young children are being cared for by Acacium Group it will not usually seem practicable to seek their parents' consent on every occasion, for every routine intervention. However, it should be remembered that, in law, such consent is required. There should, therefore, be discussion with the children's parent(s) in regard to what routine procedures will be necessary, and to ensure that consent for these interventions is obtained in advance. If parents specify that they wish to be asked before particular procedures are initiated, healthcare professionals must do so, unless the delay in involving them would put the child's health at risk.

10.3 Only people with 'parental responsibility' are entitled to give consent on behalf of their children. 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 healthcare professionals are in any doubt about whether the person with the child parental responsibility for that child has, they should consult their Line Manager. Additional detailed guidance is available in the Department of Health's guidance, 'Reference guide to consent for examination or treatment'.

10.4 Consent by 16 - 17 year olds

10.4.1 Young people aged 16 – 17 are presumed in law to be capable of consenting to their own medical treatment or care. Parental consent is not required though it is good practice to involve the young person's family in the decision making process. However, there are certain situations where the refusal of treatment in a 16 – 17 year old can be overridden by a person with parental responsibility or by a court.

10.4.2 Capacity to give consent must be assessed the same as for adults using the same criteria. For those that lack capacity, the Mental Capacity Act applies in the same way that it does for adults except where the young person may be overwhelmed by the implications of the decision they have to make. If capacity is not clear, then a declaration from the court should be sought.

10.4.3 We should never automatically assume that a child with learning disabilities is not competent to take his or her own decisions. If the child with learning disabilities is not competent to take a particular decision, then a person with parental responsibility can take that decision for the child, although the child should still be involved. However, once the child reaches 18 – **no-one** else can take decisions on their behalf.

10.5 Young person aged 16 - 17 with capacity refusing consent

10.5.1 It is possible for a decision made by a young person to refuse treatment to be overruled if there is a risk of death, or severe or permanent injury. It would be best to seek a court declaration. In an emergency situation it would be acceptable to undertake treatment to preserve life or prevent serious damage to health.

10.6 Consent in children under the age of 16

10.6.1 Children under the age of 16 are not automatically presumed to be legally competent to make decisions about their care. However, courts have stated that children under 16 will be competent to give valid consent to a particular intervention if they have sufficient understanding and intelligence to enable them to fully understand what is proposed. There is no specific age when a child becomes competent to consent to treatment. It depends on the individual child, and the seriousness and complexity of the decision required.

10.7 Consent by a "Gillick competent or Fraser guidelines" individual

10.7.1 If a child is "Gillick competent or Fraser guidelines" and is able to give **voluntary** consent after receiving appropriate information, that consent is valid and additional consent by a person with parental responsibility is not required. The young person's family should still be involved in the decision making process. There may be ability to consent to some interventions but not others.

10.8 Young person under aged 16 lacking capacity

10.8.1 Where a person under the age of 16 lacks capacity to consent, this can be given on their behalf by any one person with parental responsibility as long as they have capacity or have been granted capacity by the court. Where a person with parental responsibility refuses to consent on behalf of the young person a court ruling should be sought. Parental refusal can be overridden in an emergency.

10.8.2 The welfare of the person and their best interests are paramount.

10.9 Parental responsibility

10.9.1 If a child is not competent to give consent for themselves, consent should be obtained from a person with 'parental responsibility'. The Children Act 1989 sets out who has parental responsibility, and this includes:

- The child's parents when they are documented on the birth certificate
- The child's legally appointed guardian – appointed either by court or by a parent with parental responsibility in the event of their own death
- A person in whose favour a court has made a residence order concerning the child
- A local authority designated in a care order in respect of the child.
- A local authority or other authorised person who holds an emergency protection order in respect of the child.
- **NOTE:** Foster parents, step-parents and grandparents do not automatically have parental responsibility
- The mother herself under 16 will be able to give valid consent for her child's treatment if she herself is 'Gillick' competent

10.9.2 Consent given by one person with parental responsibility is valid, even if another person with parental responsibility withholds consent. If there is disagreement between persons with parental responsibility a decision from the court should be sought.

10.9.3 If a health professional believes that the person with parental responsibility is not acting in the best interests of the child or young person, we should not be accepting their consent without first checking with safeguarding protocols.

10.10 If a child is a ward of court

10.10.1 No important decision may be made without the prior consent of the court.

10.11 In an emergency

10.11.1 In an emergency it is justifiable to treat a child who lacks capacity without the consent of a person with parental responsibility, if it is impossible to obtain consent in time, and if the treatment is vital to the survival or health of the child.

10.12 Involving children in decision making

10.12.1 Even when children are not able to give valid consent for themselves it is important to involve them as much as possible in decisions about their own health. Children are entitled to have opinions about their healthcare and we should use methods appropriate to their age and understanding to enable these views to be taken into account.

10.13 **Providing information to children and their parents**

10.13.1 Children and their parents need enough information to enable them to decide whether to consent or not. In particular, they require information about:

- The benefits and the risks of the proposed treatment/intervention
- What the treatment / intervention will involve
- What are the implications of not having the treatment/intervention?
- What alternatives may be available
- What are the practical effects on their lives of having, or not having, the treatment / intervention will be?

10.13.2 If the child's/parent's first language is not English it may also require involving interpreters. If an interpreter is required, it is best practice to avoid asking the child or any family member to interpret for their parents.

11. Record Keeping

11.1 All records must be kept in accordance with national requirements such as the Data Protection Act 1998 and with Acacium Group information governance and records management policies.

11.2 Recording in the client care records must be done according to the best practice developed by Acacium Group.

11.3 All records remain the property of the commissioned provider for the care provision and are subject to audit.

12. Reporting Breaches in Policy

12.1 Acacium Group supports the use of a thorough, open and multi-disciplinary approach to investigating adverse events, where improvements to local practice can be discussed, identified, and disseminated.

12.2 It is important that an open culture exists in order to encourage the immediate reporting of errors or incidents.

12.3 All errors and incidents require a thorough and careful investigation at a local level, taking full account of the context, circumstances and the position of the practitioner involved. Such incidents require sensitive management and a comprehensive assessment of all the circumstances before a professional, and managerial, decision is reached on the appropriate way to proceed.

12.4 If any Acacium Group staff member makes or identifies an error or incident, they should inform their Line Manager and the Clinical Director as soon as possible after the event.

12.5 All errors (client safety incidents) and near misses should be reported through the Acacium Group incident reporting system.

12.6 The Clinical Director would then make the decision to report the incident to the Care Quality Commission.

12.7 When considering allegations of misconduct, the Clinical Director will identify if the error was the result of reckless or incompetent practice, and/or was concealed. If it is identified that this was the case, it may result in disciplinary action and external reporting to the professional bodies.

12.8 For incidents that resulted from other causes, such as the serious pressure of work Acacium Group may still suspend the worker or take local disciplinary action where it is considered to be necessary, even where there was immediate, honest disclosure.

12.9 All lessons learnt from errors and incidents will be reviewed by the Governance Committee and disseminated across the organisation.

13. Training

13.1 Acacium Group will ensure that all staff have an appropriate understanding in obtaining valid consent and, where appropriate, this will be included in client specific training in the home. The level of understanding will be proportionate and relevant, to the roles and responsibilities of each staff member

13.2 Staff will be required to evidence their basic understanding or can voluntarily complete Acacium Group training to ensure that they are competent and have reached an agreed standard of proficiency in the management of obtaining valid consent.

13.3 The delivery of training is the responsibility of the operational teams.

13.4 It is the responsibility of the central training team to organise and publicise educational sessions, and to keep records of attendance.

13.5 All training provided will be mapped to the requirements of individual care packages, the appraisal process, and noted in the personal development plan.

14. Audit / Monitoring

14.1 Processes for monitoring the effectiveness of the Policy include:

- Assessment of satisfaction through questionnaires developed for client use
- Case records review and audit by Acacium Group nurses on an agreed basis. The audit should be completed and returned to the Line Manager with an action plan, if appropriate.
- Incident reporting procedure.
- Appraisal and Personal Development Plan (PDP)

15. Associated Policies / SOPs

Policies

CLIN 08 Safeguarding Children and Young Adults
CLIN 09 Safeguarding Vulnerable Adults
CLIN 19 Resuscitation
CLIN 41 Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguarding Policy
CLIN 36 Nurse Supervision, Appraisal and Revalidation
CLIN 36-1 Nurse Clinical Supervision

16. References

- HSC 2001/023 Good Practice in Consent – Achieving the NHS Plan Commitment to Client-Centred Consent Practice ; www.dh.gov.uk
- Consent: What You Have a Right to Expect: A Guide for Adults 2001; www.dh.gov.uk
- Consent: What You Have a Right to Expect; A Guide for Children and Young People 2001: www.dh.gov.uk
- Consent: What You Have a Right to Expect; A Guide for Parents 2001: www.dh.gov.uk
- Consent: What You Have a Right to Expect; A Guide for Relatives & Carers 2001: www.dh.gov.uk
- Good Practice in Consent Implementation Guide: Consent to Examination or Treatment 2001: www.dh.gov.uk
- Seeking Consent: Working with Children (2001); www.dh.gov.uk
- Seeking Consent: Working with Older People (2001); www.dh.gov.uk
- Mental Capacity Act http://www.legislation.gov.uk/ukpga/2005/9/contents
- Mental Capacity Act Code of Practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Deprivation of Liberty Safeguards Code of Practice http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
- https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla health & wellbeing Part of Acacium Group	xyla health & social services Part of Acacium Group	xyla elective care Part of Acacium Group
xyla digital therapies Part of Acacium Group	CHS Healthcare Part of Acacium Group	DUNN REGULATORY ASSOCIATES Part of Acacium Group

Appendix B: Legislation

1. There are a number of pieces of legislation that relate to providing effective health care and protecting the needs of vulnerable people. The first of these was the need to obtain consent, which became law in 2001. This set the principles for obtaining consent in children, young people and adults.

Legislation	Guidance
Mental Capacity Act 2005 (MCA) (England and Wales)	The Mental Capacity Act was a law passed to offer protection to vulnerable people aged sixteen and above who require medical treatment or care but who, for one reason or another, may not have the ability to retain and use the information given in order to make a decision about the choices they are offered. It places a duty on health professionals to assess capacity, where this in doubt, and ensure provisions are made to support those with making the right decisions where this is needed. The MCA also ensures that advance decisions are fully complied with.
Children Act 1989	This sets out the details for who has parental responsibility for a child.
Children Act 2004	The Children Act 2004 requires providers to protect from harm, safeguard and promote the welfare of children. A breach in this Consent Policy would be against those principles. The Act builds on the 1989 Children Act.
CQC 'Essential Standards of quality and safety' (March 2010)	Outcome 2: Consent to care and treatment. The service user, where they are able, gives valid consent to the examination, care, treatment and support they receive
'Reference guide to consent for examination or treatment' (DH 2009)	Provides a guide to English law concerning consent to physical examination or treatment.
'Seeking consent: working with children' (DH)	Provides a guide to seeking consent from a child and parental responsibility.
Health & Safety at Work Act 1974	The Health & Safety at Work Act 1974 requires that all organisations with more than three staff have in place processes to promote the health and safety of their staff.
Control of Substances Hazardous to Health (COSHH) Regulations 2002	Latex is classed as a hazardous substance which is covered by the Health and Safety Executive's Control of Substances Hazardous to Health (COSHH) Regulations 2002. Under the regulations, organisations have a duty to assess the risk, eliminate, substitute, and limit and control exposure to latex, unless there is a need to use it.
RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995	There is a requirement to report diagnosed cases of Occupational dermatitis (schedule 3) to RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995.

2. Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995.

3. **Equality and diversity**

Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.