# Policy for Consent to Examination or Treatment

**CATEGORY:** Policy  
**CLASSIFICATION:** Clinical Governance  
**PURPOSE**  
To set out the agreed policy for obtaining consent from patients prior to examination or treatment.

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<th>Controlled Document Number:</th>
<th>024</th>
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<tr>
<td>Version Number:</td>
<td>6</td>
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<td>Controlled Document Sponsor:</td>
<td>Executive Medical Director</td>
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<td>Controlled Document Lead:</td>
<td>Head of Clinical Risk and Compliance</td>
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<td>Approved By:</td>
<td>Chief Executive</td>
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<tr>
<td>On:</td>
<td>5th September 2013</td>
</tr>
<tr>
<td>Review Date:</td>
<td>August 2016</td>
</tr>
<tr>
<td>Distribution:</td>
<td>All those who carry out examinations or treatment on patients. All those with delegated responsibility to take consent.</td>
</tr>
<tr>
<td></td>
<td>- Essential Reading for:</td>
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<td>- Information for:</td>
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*Procedure for Consent to Examination or Treatment  
Controlled document number: 024  
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1 Policy Statement

1.1 The purpose of this policy is to detail clearly the structures and procedures, both Trust-wide and at specialty level, that apply to consent to treatment.

1.2 The Department of Health has issued a range of guidance documents on consent (see references section), and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards for staff at the Trust taking consent to ensure they comply with the guidance, common law, Human Tissue Act 2004 and the Mental Capacity Act 2005. 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.

2 Scope

2.1 This Policy applies to all clinical services of the Trust and all clinical staff employed by the Trust including contractors, volunteers, students, locum and agency staff and staff employed on honorary contracts.

2.2 The policy does not cover taking consent for the following:

2.2.1 consent for photographic images; this is detailed in the Trust Photographic and Video Recording Consent and Confidentiality Policy;

2.2.3 data protection or use of patient records; and

2.2.4 clinical trials

3 Framework

3.1 This section describes the broad framework for taking of consent for examination or treatment. Detailed operational instructions for the implementation of this policy are contained in the associated Procedure for Consent to Examination or Treatment. The procedure may be amended by authority of the Medical Director, provided that such amendments are compliant with this policy.

3.2 The Trust’s framework for ensuring full participation in consent encompasses the following:

3.2.1 All staff providing care or treatment to a patient will first ensure that the patient has consented to receive treatment.

3.2.2 All staff who obtain consent to treatment will either:

a) be able to carry out the procedure; or
b) be deemed competent to take consent for the procedure and have delegated authority to do so in accordance with the Procedure for Consent to Examination or Treatment

3.3 FY1 doctors will not take written consent under any circumstance.

3.4 If there is any suggestion that a patient lacks the capacity to consent then they will undertake an assessment of their capacity, in line with the Mental Capacity Act.

3.5 All staff making decisions on behalf of a patient who lacks capacity will, wherever possible, consult with the patient’s family and or carers and will ensure, based on all evidence available, that the care provided is in the patient’s best interest.

3.6 All staff will respect patient’s refusal of treatment when the patient is considered to have capacity to consent subject to 3.5.

3.7 When taking consent from a patient, information about the risks, benefits and alternatives must be communicated in a way that the patient can understand. Whenever possible this information can be given using patient information leaflets.

3.8 Where tissue is to be taken during a procedure for storage or use specific consent must be taken and this must be recorded on appropriate section of the consent form.

3.9 Training will be available to relevant staff as set out in the Trust’s Training Needs Analysis.

**Delegated Consent**

3.10 Clinical Service Leads in each specialty must ensure that the protocol for obtaining consent is followed and delegated consent competency is completed for each delegate. This will act as a guide to Junior Doctors and the Risk and Compliance Unit when undertaking any audit of consent.

**4 Duties**

4.1 **Medical Director**

Is responsible for ensuring there is a framework for reviewing compliance with the Trust policy and procedure, ensuring that the policy remains fit for purpose and is reviewed as required and at least every three years. This may be delegated to the Associate Medical Director for Clinical Standards and Governance.

4.2 **Associate Medical Director for Clinical Standards and Governance**

4.2.1 may be nominated by the Medical Director to review compliance with the Trust policy and procedure, ensuring that the policy remains fit for purpose and is reviewed as required and at least every three years.
4.2.2 is responsible for monitoring adherence to this Policy as set out in the monitoring matrix in Appendix A.

4.3 Clinical Service Lead/Senior Nurse

Senior Nurse refers to Matron or Sister/Charge Nurse

Clinical Service Leads or Senior Nurse are responsible for ensuring that:

4.3.1 staff who will be given responsibility for taking delegated consent are identified on arriving within their specialty;

4.3.2 a local procedure specific training programme is in place for staff to whom the consent process is delegated, and who are not capable of performing the procedure;

4.3.3 the Consent Competency Protocol, or a local equivalent, agreed with the Risk and Compliance Unit (RCU), is completed for each individual, and will provide confirmation that staff taking delegated consent have been given appropriate training to take consent for specific procedures;

4.3.4 a list of all individuals identified as taking delegated consent, and all completed competency statements are sent to the RCU.

4.3.5 where the annual consent audit identifies staff who have obtained consent for a procedure without being authorised to do so according to the Competency Statement records held, or because they are at FY1 level, ensure that the staff member is immediately informed that they must not undertake such consent until they have been assessed as competent to do so;

a) the staff member is given the appropriate training and has an assessment of competency undertaken within 28 days;

b) the competency assessment document is sent to RCU.

4.3.6 Ensuring that action plans are produced within their specialty, when necessary, as a result of the annual consent audit.

4.4 Risk and Compliance Unit (RCU)

The RCU will

4.4.1 contact Clinical Service Leads or Clinical Governance Leads to identify where delegated consent is taken by medical staff not capable of performing the procedure, and to identify which grades of staff take such consent.

4.4.2 request lists of registered nursing staff identified as taking delegated consent, and copies of their competency assessments.

4.4.3 maintain a record of which specialties undertake delegated consent, and contact Clinical Service Leads or Clinical
Governance Leads and the Trust Practice Development Team annually to ensure that this record is updated where required;

4.4.4 holding records of the individuals taking delegated consent, as identified by specialties;

4.4.5 holding records of all competency statements supplied by specialties.

4.4.6 monitoring compliance by conducting an annual consent audit, which will include checking that consent is being taken only by the appropriate staff in accordance with records of competency statements.

4.4.7 contacting the Clinical Service Lead where annual consent audit identifies staff who have obtained consent for a procedure without being authorised to do so according to the competency statement records held.

4.5 Medical recruitment

Will send RCU a list of all medical training grade new starters and start dates on a monthly basis.

4.6 Trust Practice Development Team

4.6.1 The Practice Development Team will be responsible for ensuring that any delegated consent protocol or local guideline includes details of how nursing staff are identified for taking delegated consent in the specialty, the arrangements for nurse training and competency assessment, and the monitoring and auditing arrangements to ensure that all staff who obtain consent are authorised to do so.

4.6.2 Ensure the protocol or local guideline is on the Intranet.

4.7 All Staff

All staff providing treatment are responsible for ensuring:

4.7.1 that valid and effective consent has been provided by the patient and where written consent is required all Trust documentation has been completed as appropriate;

4.7.2 that where they are making decisions on behalf of a patient who lacks capacity they will, wherever possible, consult with the patient’s family and or carers and will ensure, based on all evidence available, that the care provided is in the patient’s best interest.

4.7.3 Will respect patient’s refusal of treatment when the patient is considered to have capacity to consent subject to section 3.5 of the Procedure.
4.7.4 will that they complete an incident form in line with the Policy for the Prevention and Management of Incidents including Serious Incidents Requiring Investigation if there is any breach of this policy.

4.8 Consultant Staff

4.3.1 have an overall responsibility for the care of the patient and this will also extend to ensuring consent is taken.

4.3.2 are to ensure that when delegating consent delegates are fully trained and competent to obtain consent for the procedure in accordance with the Procedure for Consent to Examination or Treatment

16.4 FY1 Doctors

Are not to take written consent under any circumstance

5 Implementation and Monitoring

5.1 Implementation

5.1.1 This policy will be communicated to all relevant staff via email.

5.1.2 The policy itself will be made available on the Trust intranet site.

5.2 Monitoring

Appendix A provides full details on how the policy will be monitored by the Trust.

6 References

Department of Health (2009) Reference guide to consent for examination or treatment, 2nd Ed. (online) available from: www.dh.gov.uk


UK Parliament (2005) Mental Capacity Act


NHSLA (2012/13) NHSLA Risk Management Standards

7 Associated Policy and Procedural Documentation

7.1 Procedure for Consent to Examination or Treatment

7.2 Consent Competency Protocol

7.3 Trust Photographic and Video Recording Consent and Confidentiality Policy

7.4 Policy on Research Governance

7.5 Policy for the Prevention and Management of Incidents Including Serious Incidents Requiring Investigation
## APPENDIX A: Monitoring

<table>
<thead>
<tr>
<th>MONITORING OF COMPLIANCE</th>
<th>MONITORING LEAD</th>
<th>REPORTED TO PERSON/GROUP</th>
<th>MONITORING PROCESS</th>
<th>MONITORING FREQUENCY</th>
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<tr>
<td>Adherence to this policy will be monitored by the Risk and Compliance Unit via an annual Trust wide audit of consent.</td>
<td>Head of Governance</td>
<td>Clinical Standards and Audit Group / Associate Medical Director for Clinical Standards and Governance</td>
<td>This will involve auditing a random sample of consent forms from those taking written consent in the Trust to ensure that documentation is being completed and that consent is being taken only by the appropriate staff.</td>
<td>Annually</td>
</tr>
<tr>
<td>The results of the audit will be disseminated to specialty level where an action plan to improve the completion of the consent forms will be generated,</td>
<td>Head of Governance</td>
<td>Clinical Service Leads or a nominated person, exceptions will be reported to the Divisional Clinical Quality Group.</td>
<td>The responsibility of producing and implementing this action plan will be that of the Clinical Service Leads or Senior Nurses depending on the group of staff involved. The implementation of these action plans will be monitored by the Risk and Compliance Unit and exceptions reported to Divisional Clinical Quality Group and the Clinical Quality Monitoring Group.</td>
<td>Annually</td>
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