**VALID CONSENT – CLINIC POLICY**

*This document is a suggested format for a clinic policy on obtaining valid consent in a standard osteopathic/chiropractic practice. It is not exhaustive, but it is simple enough, and short enough, to stand a chance of being read.*

*In particular, it does not go into the requirements for interpreters or formal chaperones, which might differ between the professions. Neither does it deal with the legal minutiae of Enduring Power of Attorney, which might dictate a third party’s authority to give valid consent on behalf of the patient.*

 *It is modelled on a much longer document (45 pages!) in use in one of the UK hospitals, but incorporates elements arising from APM’s online discussion with Sandra Harding and Sarah Tribe (*[*www.hcpg.co.uk*](http://www.hcpg.co.uk)*).*

*For more detailed information on this, and many other compliance matters, please contact them direct.*

# Introduction

Patients have a legal and ethical right to determine what happens to their own bodies. This right is enshrined in the Mental Capacity Act 2005, the Human Rights Act 1998 and in common law. Valid consent to treatment is therefore absolutely central in all forms of healthcare.

Gaining valid consent protects staff from charges of assault and is also a matter of common courtesy between health professionals and patients.

This policy addresses the procedures and responsibilities for obtaining consent to examination or treatment.

1. Purpose

The aim of this document is to ensure that all staff are aware of the need to obtain valid consent for treatment, and that they obtain that valid consent in an appropriate way.

# Definitions

**Valid Consent**: The patient’s agreement for a health professional to provide care or treatment. For consent to be valid, the patient must:

* Have capacity to make the particular decision;
* Have received sufficient information to make it; and
* Not be acting under duress.

The *giving* of consent by a patient is not the same as the consent *process*. The consent process encompasses the whole process of information provision, discussion and decision-making.

**Capacity**: The patient’s ability make decisions. To do so they must:

* understand the information about the decision to be made
* be able to retain that information in their mind;
* evaluate the information

**Gillick Capacity**: A child under the age of 16 is considered to be “Gillick” competent if they have sufficient understanding and intelligence to understand fully what is involved in the proposed intervention. In these circumstances, consent is valid and it is not necessary to obtain additional consent from a person with parental responsibility.

**Intimate Treatment**: treatment in close proximity to the genitals, anus or breasts.

**Invasive Treatment**: any treatment involving puncture of the skin (eg acupuncture or dry-needling), or any per rectum or per vaginal treatment.

**Notes**: the official record of treatment (otherwise known as the Case History)

1. Documentation
	1. In general, oral consent to examination and/or treatment is sufficient, but must be given at the time of each intervention and must be documented in the patient’s case history. It is acceptable to use the abbreviation “VCO” (valid consent obtained) for this purpose. This abbreviation need only be applied once, in which case it will be deemed that consent has been obtained for each aspect of treatment

## Written consent

4.1.1 It is not sufficient to obtain written consent at the commencement of an appointment. Consent must be given contemporaneously with the procedures concerned.

4.1.2. Written consent is required for invasive procedures unless a patient is physically unable to sign. For PR and PV procedures, patients should be given 24 hours to consider the treatment before proceeding.

4.1.3. 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.

## Waiver of Consent

## 4.3.1. A patient may opt not to be warned of the risks and benefits, or to receive other information about their treatment. If so, this must be clearly and explicitly documented in their notes at the appointment when the decision is first made.

## 4.3.2. It must be confirmed at the outset of each subsequent appointment that this continues to be their choice, and the abbreviation “WOC” (Waiver of Consent) must be used to record this.

## 4.3.3. A waiver of consent can be withdrawn at any time, including within an appointment.

##

1. Capacity
	1. There is a presumption that patients who are 16 or over have the mental capacity to make decisions for themselves unless this is assessed to be otherwise at the time.
	2. Children under the age of 13 might have capacity to give valid consent (“Gillick Capacity”), but this will be the exception, not the rule. Practitioners should exercise great care in making this decision; normally parental consent will be required.
	3. Staff must never assume that a patient lacks capacity simply because they are suffering from a mental disorder.
	4. Capacity might vary according to the patient's mental condition, their medication or other factors, and must be assessed in every case in relation to the particular decision being made.
	5. Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, only an attorney appointed under a Lasting Power of Attorney by the patient or a court appointed Deputy may give consent or refuse treatment on their behalf if authorised to do so. However, treatment may be provided by clinicians in the patient’s best interests provided the patient has not made a valid and applicable Advance Decision refusing the specified treatment.
2. Consent

	1. Valid consent applies only to the treatments discussed with the patient, and only at the time of that discussion.
	2. While patients between the ages of 16 and 18 are likely to be able to give consent to treatment, if they refuse then a person with parental responsibility may override that decision. However, if the young person agrees to treatment, the parent may not refuse it.
	3. Consent can be withdrawn at any time.
	4. A patient with capacity may refuse treatment even if the practitioner deems it would be in their best interest to proceed.
	5. Refusal to consent should be documented in the patient’s notes.
	6. Patients are not required to justify their refusal to accept examination or treatment.
3. Confidentiality

7.1. Practitioners have a duty of confidentiality to patients who have “Gillick capacity” and to patients between the ages of 16 and 18.

7.2. It is good practice to involve the child's family in the decision making process provided the Gillick competent child consents to their involvement. Where a child is seen alone, efforts should be made to persuade the child that his or her parents should be informed except in circumstances where it is clearly not in the child’s best interest to do so.

7.3. Healthcare professionals must however respect the views of the Gillick competent child in the event that they do not wish for their parents to be involved.

7.4. When a patient under 18 attends treatment alone, their case may not be discussed with anyone, including parents, without the patient’s consent. This consent can be oral or written, but must be documented in the notes.

# Responsibilities

All practitioners carrying out examination or treatment are responsible for ensuring that valid consent is obtained; it is they who will be held responsible in law if this is challenged later.

# Consent Process

## In most cases the practitioner may initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a practitioner might suggest a 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 most such cases, consent will be given orally.

## If a proposed procedure is invasive written consent will be required, and the patient must be given sufficient time to absorb the necessary information.

## Provision of Sufficient Information

Before patients can come to a decision about treatment, they need sufficient information about their condition and about possible treatments, including risks and benefits (including the risks/benefits of doing nothing). Practitioners must ensure that they provide patients with sufficient information to enable them to make an informed judgment on whether to give or withhold consent. They must inform the patient of any significant, unavoidable or frequently occurring risks. Risks and benefits can be expressed in whichever way is felt best to facilitate patient understanding, but should not be expressed in a way designed to unreasonably influence their decision.

# Emergencies

11.1. In emergency situations patients may not be able to consent to treatment. At such times clinicians can act in the patient’s best interests.

11.2. Some patients might have completed a Do Not Attempt Resuscitation (DNAR) form. Provided the practitioner has seen a copy of this form, **with an original signature** (not a photocopy or image) it is acceptable not to attempt CPR.

11.3. Any treatment (emergency or otherwise) made without consent but in the patient’s best interests must be clearly documented in their notes.

# Parental Reponsibility

## Only the biological parents of a child under 18, adoptive parents, foster parents or a guardian appointed by the court are deemed to have parental responsibility and can give consent to treatment. This responsibility may NOT be delegated to other family members, and is NOT assumed by step-parents.

## Parental responsibility gives the right to give or refuse consent for a child under 16, and to override a decision to refuse treatment by a child between the ages of 16 and 18.

## Only one person with parental responsibility is required to give or refuse consent for the consent to be valid.

## Checklist

## Capacity

|  |  |
| --- | --- |
| Can the patient understand the information necessary to make this decision at this time?  | Yes/No |
|  |  |
| Can the patient retain the information for long enough to make this decision?  | Yes/No |
|  |  |
| Can the patient weigh up the information in order to make this decision?  | Yes/No |
|  |  |
| Can the patient communicate their decision?  | Yes/No |

## Consent

|  |  |
| --- | --- |
| Has the patient been given sufficient information for them to make an informed decision?  | Yes/No |
|  |  |
| Has the patient had sufficient time to process that information (especially if the recommended treatment is invasive)?  | Yes/No |
|  |  |
| Is consent voluntary?  | Yes/No |
|  |  |
| Have the risks and benefits been explained adequately (including the option of doing nothing)?  | Yes/No |
|  |  |
| Is written consent required (invasive procedures)?  | Yes/No |
|  |  |
| Is it necessary to renew consent (eg a long time has passed since risks and benefits were last explained)?  | Yes/No |
|  |  |
| Has the patient been told that they may withdraw consent at any time? | Yes/No |
|  |  |
| Is a chaperone necessary, and if so, has one been offered, and an appropriate person found?  | Yes/No |
|  |  |
| Is valid consent documented in the notes?  | Yes/No |