



Consent to Personal Treatment & Care

1. Background

It is a general ethical and legal principle that valid consent must be obtained from service users in relation to the examination, care, treatment and support they receive. This principle reflects the rights of the service user to determine what happens to them and is a fundamental part of good practice.

This policy has been developed to ensure that Abbeyfield The Dales Ltd. (“ATD”) Care Homes and Domiciliary Care Agencies gain valid consent from residents in relation to the care and treatment provided for them.

2. Objectives

Through the delivery of this policy we aim to:

- Comply with all relevant and current legislation;
- Ensure that service users receive the care and support they agree to.;
- Ensure each Registered Manager obtains, and acts in accordance with, the consent of the service user in relation to their care; and
- Ensure that clear procedures are followed where a service user is unable to give or withhold consent to their care to ensure that their rights are protected and that decisions are made in their best interests in accordance with legislative requirements.

3. Scope

All established staff, agency staff and volunteers working in the care home; regional staff; staff based at head office.

4. Policy

4.1. Consent

Treatment and personal care of residents must only be provided with their consent, or the consent of a person acting lawfully on their behalf. Every resident must be presumed to have the mental capacity to consent to or refuse treatment or personal care.

A resident may lack capacity to consent where they have an impairment of, or disturbance in, the functioning of their mind or brain and are unable to:

- Understand the information relevant to the decision;
- Retain that information;
- Use or weigh that information as part of the process of making the decision; or
- Communicate their decision – by any means, including blinking an eye or squeezing a hand.

4.2. Valid Consent

To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the resident either to accept or refuse the treatment or personal care. Such pressure can come from partners or family members, as well as health or care practitioners.

The resident must be fully informed about the treatment or personal care to which they are consenting. Agreement where the resident does not know what the intervention entails should not be regarded as 'consent'.

Consent may only be given on behalf of a resident by someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy.

4.3. Form of Consent

The validity of consent does not depend on the form in which it is given. Consent may be implied and includes non-verbal communication, such as sign language or by a resident offering their hand when asked if they would like help to move.

Written consent may be appropriate for significant decisions. Whilst written consent serves as evidence of consent, if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not make the consent valid.

4.4. Residents who lack capacity

Where a resident lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Staff who obtain the consent of residents should be familiar with the principles and codes of practice associated with the Mental Capacity Act 2005, and be able to apply those when appropriate, for any of the residents they are caring for.

4.5. Who should seek consent?

The seeking and giving of consent must be treated as a process that continues throughout the duration of treatment and personal care, recognising that it may be withheld and/or withdrawn at any time.

4.6. When consent is refused

If a resident with capacity, or someone acting lawfully on their behalf, makes a voluntary and appropriately informed decision to refuse treatment or personal care (whether at the time or in advance), this decision must be respected.

4.7. Withdrawal of consent

A resident with capacity is entitled to withdraw consent at any time, including during treatment or personal care. If there are any concerns about the resident's capacity to understand the consequences of withdrawing consent, an assessment of capacity should be undertaken.

4.8. End of life care

For some residents who are entering the last days of life, mental capacity to understand and engage in shared decision-making and the ability to consent to treatment/personal care may be limited. This could be temporary or fluctuating, for example it may be caused by delirium associated with an infection or it could be a permanent loss of capacity from dementia or other similar irreversible condition. However, the framework for seeking consent towards the end of a resident's life is essentially the same as for any treatment and personal care.

4.9. Emergencies

In situations where a resident is conscious, where possible, consent still needs to be sought for emergency treatment, if they have capacity to be able to give it. If the emergency is so significant (i.e. lifesaving), that there is no time to seek consent, or the resident is unconscious, the rationale for the treatment must be recorded in the resident's care records. Once recovered, the reasons why treatment was necessary should be fully explained to the resident. However, if staff are aware that there is a valid and applicable Advance Decision to Refuse Treatment (ADRT) in place this should be respected and the treatment should not be given.

4.10. Mental Capacity Act 2005 (MCA)

The Mental Capacity Act 2005 provides legally binding guidance for decision making about the care and treatment of people who lack capacity to make a decision. All situations where a resident's mental capacity to make decisions about their care or treatment is in question should be dealt with in accordance with ATD's Mental Capacity Act Policy and Procedure.

There is provision under the MCA for a Lasting Power of Attorney (LPA) who may be able to make personal welfare and healthcare decisions on behalf of a person who lacks capacity. Where this is the case the LPA should be registered with the Office of the Public Guardian and the person acting for the resident who lacks capacity should consult the resident about their welfare and treatment.

The LPA cannot make decisions about refusing treatment which may lead to a shortened life, even where there is an advance decision to refuse treatment – only medical professionals can do this in consultation with other members of the health care team, relatives and other involved individuals. Advance decisions should be respected (see Advance Decisions to Refuse Treatment Policy).

4.11. Deprivation of Liberty Safeguards (MCA DOLS)

The Mental Capacity Act 2005 contains procedures for authorising the deprivation of liberty in establishments (and hospitals) of some people who lack capacity to decide to be there. Guidance on the operation of the procedures is contained in ATD's Deprivation of Liberty Safeguards (MCA DOLS) Policy. The MCA DOLS Policy should be used for all residents who lack capacity to make their own decisions and where personal freedoms need to be restricted in the resident's best interests, to the extent that it amounts to a deprivation of liberty.

Depriving a resident of their liberty should be a relatively rare occurrence. Residents are entitled to be cared for in the least restrictive way possible and care planning should **always** consider if there are other less restrictive options available to avoid unnecessary deprivation of liberty.

5. Finance, Value for Money & Social Value

N/A

6. Supported Appendices

APPENDIX 1: Consent form

7. Linked Policies

Autonomy & Choice (R003P)

Medication Administration - Domiciliary/Extra Care (C035P)

Advocacy and the Duty to Consult (R001P)

Advance Decisions to Refuse Treatment (C003P)

Mental Capacity Act (C015P)

Deprivation of Liberty Safeguards (MCA DOLS) (C010P)

8. Legislation/Regulation

The Mental Health Act 1983

The Mental Capacity Act 2005

Section 20 regulations of the Health & Social Care Act 2008

Essential Standards of Quality and Safety

Outcome 2: Consent to care and treatment

Please note that the standards are changing in late 2014. Draft guidelines below are likely to replace the above standards. Guidance for providers on meeting the fundamental standards and on CQC's enforcement powers.

Regulation 10: Dignity & Respect

Regulation 11 Need for Consent

9. Review

Every 3 years, subject to any regulatory or legislative updates.

10. Guidance (New Section)

[DoH Reference guide to consent for examination or treatment](#)

[NICE Guideline NG108 Decision making and mental capacity](#)

11. Procedure (Moved from section 4)

11.1. Assessment of capacity

The assessment of a resident's mental capacity to consent to or refuse medical treatment is ultimately a matter for the doctors treating the resident but all staff have a responsibility to participate in discussions about the assessment and their observations regarding the residents' ability to consent. Senior staff are best placed to know about the emotions, concerns, and views of the resident and if there are concerns about the resident's understanding then other involved members of that resident's health team must be informed. (See Mental Capacity Act Policy)

11.2. Informed consent

All staff must obtain informed consent before carrying out any treatment or care. Consent should be obtained by the person who will give the treatment or care. Before seeking consent staff must understand the risks and benefits of any procedure they propose to undertake and must ensure they give this information to the resident clearly and concisely. They should ensure that the resident understands, within their assessed limitations, and they must support whatever decision the resident makes. The assumption that consent does not always need to be obtained if the resident receives a treatment regularly is wrong, so each and every procedure, treatment or care provided must have valid consent at the time of doing.

Consent must be voluntary and not obtained under duress, or undue influence from family, friends or health care professionals.

The proposed treatment or care must be explained to the resident so that they understand the implications of treatment and options available, allowing them to give informed consent or refusal, including discharge against medical advice. It is essential that adequate information is given to enable the resident to make a meaningful decision. If the information is deemed insufficient, a complaint could be made to the regulatory bodies.

11.3. Types of consent

Consent can be demonstrated in a number of ways. Agreement can be indicated verbally, in writing, or by cooperation. Refusal can be demonstrated in the same way. Written consent should be given before receiving treatment that involves significant risks or side effects or is complex; the written consent stands as a record that discussions have taken place and records the resident's choice. Where treatment is refused, a summary of the discussions and decisions should be placed in the medical records and care documentation. A signature on a consent form does not itself prove the consent is valid, the point of the form is to record the decision and discussions taken place.

Residents should give verbal consent to physical examinations and be offered a chaperone if undergoing such an examination. Unless informed otherwise, female residents should have a female chaperone when undergoing a physical examination by a male professional.

11.4. Refused consent

A competent resident can refuse consent to treatment, even if that refusal will shorten their life. A resident who has capacity may make an irrational decision, but as long as the resident understands the implications of the proposed treatment or care, then refusal to consent must be accepted. If irrational decisions are based on misperception of reality, it may be that their capacity is lacking and further assessment of the resident's ability to understand should be undertaken. (See Mental Capacity Act Policy) The refusal should be in writing, and recorded in the care plan or medical notes, stating that it represents an informed decision.

11.5. Lack of capacity

The principles governing consent must be applied in the same way to the care of those who are mentally incapacitated. This may be temporary, due to sedation, or it could be longer term such as cognitive impairment in a progressive illness such as dementia. Where a resident is considered incapable of providing consent, all involved health professionals along with Senior staff from the Home should provide an objective assessment of the resident's needs, proposed care and treatment. Relevant people close to the resident should be consulted and any previous instruction the resident has given should be respected. In some cases of incapacity, decisions concerning treatment will need Court of Protection authority, unless there is a health & welfare LPA or Court Appointed Deputy.

If the resident lacks capacity to give consent, treatment or care can still be given under the Mental Capacity Act 2005. The person providing the treatment must reasonably believe that the resident does lack capacity at that time to consent, and that the treatment/care will be in the resident's best interests. In addition, the care/treatment must be reasonably necessary and a proportionate response to:

- the likelihood of the resident suffering harm; and
- the seriousness of that harm.

Steps must not be taken that are expressly against decisions made by a person with an LPA for Health & Welfare or a Court Appointed Deputy unless the care/treatment is:

- life-sustaining; or
- necessary to take steps to prevent a serious deterioration in the resident's condition.

Care/treatment should not be given if it is expressly against the wishes of the resident expressed in an advance decision, made when they had capacity.

There are certain sections within the Mental Health Act 1983 that allow for treatment to be given, but the provisions are very specific with clear safeguards (such as second opinions, time limits, particular treatments which are directly linked to the resident's mental disorder). The person receiving the treatment must already be what is termed 'liable to be detained' (those who are detained or have been granted leave of absence – section 17) which is covered in Part IV of the Mental Health Act. ATD, regardless of the care they are registered to provide, do not have the capability to care for any resident who comes under the Mental Health Act 1983, other than those who come under Section 117 (duty to provide after-care) or Guardianship (requires a Care Plan within the remit of Care Programme Approach – CPA) and act as an advocate for the resident. These two exceptions are rare within ATD and agreement for admission under these circumstances must first be reached by the Registered Manager and the Head of Operations.

11.6. Medication

Medication should never be given to a resident without their consent. For consent to be effective, the resident must have been given adequate information about the nature, purpose, associated risks and alternatives to the proposed medication.

Disguising medication is sometimes necessary and justified, for example to save life, prevent deterioration in health, or ensure an improvement in the resident's physical or mental health. However, medication should never be given in a disguised format to a resident without their knowledge or consent if they are capable of deciding about their medical treatment. Giving medication by deception is potentially an assault.

However, there may be exceptional circumstances where it may be appropriate for medication to be administered in another form to a resident who would otherwise not receive essential treatment. This should only ever be done where it is in the best interests of the resident and all other options have been considered. Such a decision, which may be to make medication more palatable or immediately acceptable, must be taken within the context of legal and best practice frameworks. (See Mental Capacity Act) and must involve consultation with the resident's GP, the dispensing pharmacist (who needs to agree to the method of administration due to licence), the Registered Manager, care team, and the resident's relatives/representatives (who should be able to clarify the resident's wishes or best interests). The decision, the action taken, and the names of the parties consulted and involved should be documented within a risk assessment and all relevant sections of the care plan. Regular attempts to encourage the resident to take their medication conventionally should continue and this should be continuously reviewed and documented. The Registered Manager should ensure that the Head of Operations is consulted for advice before any such decisions are taken.

The Medication Policy also provides guidance on this issue.

11.7. Searches

A resident, or if they lack capacity the relevant person to consult, must give consent to having their room or possessions searched. Only in exceptional circumstances should a search take place without the resident's consent, i.e. for the purpose of preventing serious harm to individual residents, staff or visitors. If consent is not given or the resident is unable to consent, the search must be carried out with the approval of the most senior member of staff available. Full consideration of the resident's best interests, including their dignity, self-respect and privacy, must be given. All actions, and reasons for them, must be fully documented in the resident's care plan.



Consent to Treatment and Personal Care

Name: Apt/Suite No:

Consent Form

At Abbeyfield The Dales we aim to provide the right level of care and support to meet your needs. We have developed your care plan with you to make sure that we do everything we should to help you to keep safe and well. We are required to keep records about your care and you can access these records at any time. Your needs will be reviewed regularly with you so that we can make sure we are providing you with the right level of care and support. We may need to share the records we keep about you with other professional people who are involved in your care, for example, doctors, district nurses, and social workers, and we may need them to share with us relevant information which they hold about you.

Please indicate your understanding of these arrangements and your agreement to the treatment and personal care which is recorded in your care plan by **ticking** all boxes which apply.

- I have been involved with the development of my care plan. Yes No
- I understand that I can access my records at any time. Yes No
- I understand that my records may be shared with other health and social care professionals who are involved in my care. Yes No
- I authorise health and social care professionals involved in my care to discuss my needs with the care home staff. Yes No
- I agree to my photograph being used in my personal records. Yes No
- I consent to the treatment and personal care detailed in my care plan. Yes No

Relative/Advocate

If you would like a relative or advocate to be involved in your care, please give their details below:

Name: Relationship to resident: Address: Telephone: Resident signature: Date:

Relative/Advocate Confirmation

I confirm that I have been involved in identifying the above-named resident's needs and I am satisfied that their care plan has been developed in their best interests.

Print name: Signed: Date: