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Content

Intent

Through the implementation this policy, NHS Borders aims to promote a balanced partnership between patients and healthcare staff delivering care and treatment and promote supported decision making. The policy acknowledges the rights of the person under Common Law and in keeping with the Equality Act 2010 that to give or withhold consent prior to the provision of clinical treatment is a basic principle of health care.

Introduction

This document offers guidance to NHS Borders' employees who are involved in seeking consent from a person or from a person's proxy/welfare attorney/welfare guardian where legal posers to provide consent on the patient's behalf in respect of assessment and treatment have been granted.

People have a legal, fundamental, ethical and moral right to decide what happens to their bodies. Healthcare staff have a responsibility to ensure they obtain valid consent from a patient before undertaking any type of care or treatment intervention, failure to do so may leave healthcare staff open to criminal charges, civil action and allegations of misconduct.

Healthcare professionals must work in partnership with their patients, respecting their right to make decisions about their care. The partnership must be based on openness, trust and good communication. Key to establishing this is respect for patient autonomy and the patient's right to make a decision whether or not to accept any medical or clinical intervention even if refusal of such may be to their detriment. The responsibility is on the healthcare professional for ensuring that their patient is fully involved, has all the information they wish and need, understands the details and implications of the intervention including any risks that may be pertinent to them and is informed of alternative treatment options. Alternative options include the option of having no treatment. The concept of material risk introduced. Only then can the patient, and not the healthcare professional, make a decision about what they believe to be in their best interest.

There is no definitive definition of 'supported decision making'. The Mental Welfare Commission refers to it as 'any process in which the individual is provided with as much support and information as they need in order for them to be able to':

1) make a decision for themselves; and/or
2) express their will and preferences within the context of substitute decision-making.

Any discussion about a person's condition or treatment options should be carried out with them in a way the person can understand and, whenever possible in a place and at a time when the person is best able to understand and retain what is discussed. The discussion may be supported by the use of accurate and up to date written material, including visual or other aids.

Consent:

- may be implied or explicit and may be obtained verbally or in writing
- is only valid if it is voluntary and informed and if the person consenting is deemed to have the capacity to make the decision
- is not usually a single event but is part of an ongoing process
- requires a number of steps in the process including ensuring the patient is fully informed of the risks and benefits of any proposed treatment and alternative options and the risks and benefits of no intervention
- may be withheld or withdrawn in respect of all or any aspect of the care or treatment being provided at any point during an episode of care or treatment even if given initially

NHS Borders Completion of Health Records Policy states:

> *It is the responsibility of **all** NHS Borders staff providing direct care, whether a registered practitioner or someone in a support role, to make a note of all encounters and interventions relating to the patient in the appropriate section of the patient's health record.*

This includes the recording of having obtained the person's consent, whether verbal or written, prior to a procedure or treatment being carried out and in particular where the intended procedure or treatment is of an intimate nature.

This policy relates to all patients receiving care provided by NHS Borders. The policy is applicable to all staff working in clinical environments within NHS Borders premises where care and treatment is provided to individuals. It is applicable to all NHS Borders staff who delivers care and treatment in an individual's home and/or other community setting. Healthcare professionals must also be aware of any standards, guidance or policies pertaining to consent that have been issued by their respective professional and/or regulatory bodies.

Standards

1 Obtaining Consent

The prime responsibility for obtaining consent for any clinical intervention lies with the healthcare professional undertaking the intervention. *See Appendix 1*

If it is not possible for the healthcare professional undertaking the intervention to seek consent this duty can be delegated to someone else, provided that the person it is delegated to:

(a) is suitably trained and qualified.
(b) has suitable knowledge of the proposed intervention and understands the risks involved
(c) understands and agrees to act in accordance with this policy

The healthcare professional who delegates the consent process remains responsible for ensuring that the patient has been given sufficient time, information and support to make an informed decision, and has given their consent before the intervention is started.

Where there is any doubt about consent having been given the intervention should not proceed, and the person who is undertaking the intervention or the person in charge of the case should be informed. In the course of obtaining a person's consent, healthcare professionals must not exert pressure or undue influence, nor employ deceit.

Health care professionals must ensure that where a person has communication difficulties every method, including human and mechanical, is employed in the attempt to support the person's decision making regarding consent. Consent does not always have to be given in writing. It can be given verbally or implied by a person's actions.

When consent is not given in writing a summary of salient points in relation to verbal and/or written information provided to the person or their proxy/ welfare attorney /welfare guardian, and the outcome of any discussion, must be documented in the patient's health record.

Senior healthcare staff should ensure that monitoring arrangements are in place to ensure consent is obtained appropriately.

2 Provision of Information

Information must be provided to the person in respect of the proposed examination, procedure, treatment or anaesthesia prior to consent being sought.

Information must be provided to the person in respect of the proposed examination, procedure, treatment or anaesthesia prior to consent being sought. Information should be specific to the circumstances of the person to whom it is being given. The healthcare professional has a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative treatments including the option of no treatment. A material risk is one which a reasonable person in the patient's position would be likely to attach significance to.

Alternatively it is one which the healthcare professional should be reasonably aware that their patient would attach significance to. This is a major change from previous legislation about consent which described and quantified risk in terms of what a reasonable body of medical opinion would consider significant. The significance of the risk is now likely to reflect a variety of factors besides its magnitude:

- the nature of the risk, the effect which its occurrence would have on the life of the patient
- the importance to the patient of the benefits sought to be achieved by the treatment
- the alternatives available and the risks involved in those alternatives

The assessment of risk is therefore fact-sensitive and also sensitive to the characteristics of the patient. In circumstances when the healthcare professional believes that disclosure of certain information would cause severe harm to the person, withholding information would not be unlawful. However healthcare professionals should recognize that such circumstances when this "therapeutic exception" applies are expected to be rare. Information given should be supplied in a manner and format that can be understood by the person receiving it, e.g. in easy read material, in a language they understand (using an interpreter if required), using diagrams, pictures, or symbols, etc.

Information regarding accessing Interpretation and Translation Services can be found on NHS Borders intranet – Equality and Diversity **http://intranet/microsites/index.asp?siteid=92&uid=1**

When an interpreter is used they must be independent and impartial. The Learning Disability Liaison Nurse can provide support and advice and obtain information in easy read format for patients with a Learning Disability. Technical information and language should, as far as possible, be used to explain any proposed treatment. When giving information healthcare staff should be aware that the person may require extra support, e.g. a relative, carer or advocacy support, to enable him/her to make an informed decision.

With the agreement of the person and where circumstances allow, a relative, carer, friend or patient advocate, may be present during any discussion where consent is being sought. Where there is a relative, carer, or other present, the healthcare professional must be alert to the potential for the person to be pressured into a particular decision. Enough time requires to be given to allow the person to consider the information provided and permit him/her to discuss it with his/her family and friends if desired. All questions must be answered honestly Should the person not wish to know all the facts this should be respected but in case he/she has a change of mind, further opportunities to receive information should be offered before commencement and during the course of the treatment The person's wishes should be documented accordingly

3 Written Consent

A 'Consent for treatment form' where required, must be completed prior to an examination or treatment being commenced.

- Staff responsible for the care of the person will check that the form is completed
- written consent will be obtained in relation to all routine blood tests carried out in connection with screening in pregnancy
- it is considered good practice to seek written consent where:
    - a treatment or procedure is complex or involves significant risk
    - the procedure involves general anaesthesia or sedation
    - provision of clinical care is not the primary purpose of the procedure
    - there may be significant consequences for the person's employment, social or personal life
- where the 'consent for treatment' form has been signed prior to the day of the intervention staff must confirm on the day of the procedure that the person still wishes the intervention to go ahead. This should be documented in the person's health records
- a signature on a form can be taken as evidence that the person has given consent. However if a person does not understand the proposed procedure, if English is not their first language or they are a British Sign Language user, the consent, even when a signature is obtained, may not be valid
- only the recipient of the proposed procedure can sign the 'consent for treatment' form. The exception to this is where the person has been deemed to be incapable of giving consent. In such circumstances the welfare guardian with stated medical views can sign on behalf of the person – please refer to Adults with Incapacity (Scotland) Act 2000). In the case of children see standard 7 of this policy
- completed 'Consent for treatment' forms should be secured and retained within patients' healthcare records

4 Withdrawal of Consent

A person has the right to withdraw his/her consent at any time.

- a person has the right to withdraw his/her consent after he/she has signed a 'Consent to Treatment' form; the signature is evidence of the process of consent giving, not a binding contract
- consent to any intervention should be treated as an ongoing process
- the person may choose to consent to only part not all of a proposed treatment/ intervention
- the person may change his/her mind and withdraw consent at any point during the course of treatment/intervention
- the person's right to refuse treatment at any time during his/her care extends to the pregnant woman, even when failure to treat may harm the foetus

5 Presence of Students

The person's consent will be sought regarding students being present during a treatment/intervention.

- the person has the right to refuse to have students present
- healthcare staff must respect the patient's wishes regarding the presence of students

6 Capacity and Consent

If in the course of obtaining a person's consent to an intervention, the healthcare professional is led to doubt the person's capacity to give consent, the intervention cannot proceed except in an emergency situation as outlined in Standard 10 of this policy. Where there are doubts regarding capacity, the Adults with Incapacity (Scotland) Act 2000 must be referred to. *See Appendix 2*

- when a person's capacity to give consent is in doubt, he/she must be referred to the medical practitioner primarily responsible for the episode of medical treatment. The medical practitioner must take action to ascertain if there are any current formal arrangements, e.g. Welfare Attorney or Welfare Guardian, in place under the Adults with Incapacity (Scotland) 2000 act. The Office of the Public Welfare Guardian may be consulted to confirm the existence of a proxy and whether the proxy has been granted the power of consent to medical treatment. Reasonable effort must be made to identify and consult with the person's welfare guardian. A copy of the certificate of appointment of welfare guardianship must be obtained from the person's welfare guardian and retained within the health records
- common law authority to treat remains in place for persons unable to consent. This allows emergency medical treatment to be delivered for the preservation of life or the prevention of serious deterioration in health
- the medical practitioner primarily responsible for the episode of medical treatment can formally assess the person's capacity to give consent to medical treatment and issue a certificate of incapacity, in keeping with the principles of the Adults with Incapacity (Scotland) Act 2000. Issuing a medical certificate of incapacity grants the medical practitioner primarily responsible a general authority to treat someone who lacks capacity, providing the principles of the Adults With Incapacity(Scotland)Act 2000 (The Act) are followed
- dental practitioners, ophthalmic opticians, nurses and others who have completed training in the assessment of capacity are authorised to sign a certificate for the purposes of Section 47(A1) of the Adults with Incapacity (Scotland) Act 2000 in respect of treatment that they are responsible for (Adults with Incapacity (Scotland) Act Part 5 Amendment)
- people in Scotland aged 16 years and over are presumed to have capacity, i.e. to understand and remember what is being proposed, to weigh up relevant information taking account of the benefits, risks and options, and to use this to make a decision. A person may lack capacity due to impairment or disturbance of mental functioning that impairs his/her ability to make a decision to consent to or refuse treatment
- where there is a dispute between the proxy and the primarily responsible medical practitioner about the medical treatment, a second opinion is required from a 'nominated medical practitioner', appointed by the Mental Welfare Commission (MWC). This opinion can be appealed against to the Court of Session by either party
- having a mental disorder does not necessarily make a person incapable of giving or refusing consent. A mental disorder is defined by the Mental Health (Care and Treatment) (Scotland) Act 2003 as any mental illness, personality disorder or learning disability 'however caused or manifested'
- a person who would otherwise be competent may temporarily be incapable of giving or refusing consent due to factors such as fatigue, drunkenness, sedation, shock, fear or pain
- there are a number of exclusions to the general authority to treat under the Adults with Incapacity (Scotland) Act 2000, including:
    - treatments falling under the Mental Health (Care and Treatment)(Scotland) Act 2003
    - the use of force or detention (beyond the minimum immediately necessary)
    - covert medication (unless following principles outlined by the Mental Welfare

- commission and other professional bodies)
- treatments regulated under section 48(2) of the Act, including: sterilisation, medical or surgical treatments to reduce sexual drive, electroconvulsive therapy, or abortion

- where a Section 47 Adults with Incapacity certificate is in place a treatment plan should be used

7 Children & Young People

In Scots law, a child/young person under 16 years can have legal capacity to consent to any surgical, medical or dental treatment where in the opinion of a qualified medical practitioner attending, the child/young person is capable of understanding the nature and possible consequences of the procedure or treatment.

The healthcare professional should take into account and fully document their assessment of the child in relation to:

- can the child/young person understand the nature and potential complications and risks of the intervention
- can the child/young person make a valued judgement and balance the risks and benefits in respect of the intervention

- when a child/young person does not consent to treatment, this must be fully documented in his/her healthcare record as this can in some circumstances lead to a decision-making problem
- giving information in stages should be considered to allow the child/young person (& parents) time to fully assimilate the information prior to making a decision regarding consent
- consent may be given on behalf of a child/young person by:
  - their Mother
  - their natural Father if married to the mother or divorced from her
  - their natural Father if the child/young person's birth is registered after 4th May 2006 and he is registered as the father on the birth certificate
  - their natural Father if not/never married to the mother where Parental Rights and Parental Responsibilities have been obtained via the court
  - their legal guardian
  - A person with Residence Order
  - A person with delegated parental responsibilities – **does not include babysitters, child minders or teachers**
- where there is any doubt regarding the person's legal entitlement to give consent the NH organisation will seek legal advice
- when a child/young person is in hospital it is not always practicable to seek parental consent prior to every routine intervention such as blood tests, urine tests or x-rays. All anticipated routine procedures that will be necessary to carry out should be discussed with the parent(s) when the child/young person is admitted
- should parents specify they wish to be consulted before particular procedures are carried out this must be respected unless a delay in carrying out a procedure would put the child/young person's health at risk
- where parental consent is refused and withholding of treatment is deemed to put the child/young person's health at risk and if time permits an application can be made to a Court of Session Judge. If time is not available to pursue this, a second Consultant opinion should be sought and written support in respect of the necessity of treatment and that withholding treatment will put the patient's life in danger is obtained. In an emergency situation where a child's life is in imminent danger treatment could proceed without a second opinion, a detailed record will be made in the child/young person's healthcare record

- when parental consent is withheld any discussion with the parents should be carried out in front of a witness. The discussion must be documented in the child/young person's healthcare record and countersigned by the witness. Where consent is given this should also be documented
- where examination or treatment is ordered under the Children (Scotland) Act 1995 by a Children's Hearing and the child is deemed to have the necessary capacity, his/her consent should be obtained
- were examination or treatment is ordered under the Children (Scotland) Act 1995 by a Children's Hearing and the child/young person lacks capacity, parental consent should be obtained
- Parents cannot authorise treatment which has been refused by a competent child/young person; the GMC provides further advice at https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years/making-decisions

It is good practice to encourage children/young people to involve their parents in decisions about their health. In situations where the child/young person and parent's views differ, where the child/young person has capacity to make healthcare decisions, then the child/young person's decision should be respected.

8 Advanced Directive

An Advance Directive is drawn up by a person at a time when they are considered to have full capacity. The Advanced Directive gives instructions about medical treatment and interventions the person would and would not be prepared to accept. Should the person subsequently lose the capacity to indicate their wishes directly, the Advance Directive may be enacted, depending on circumstances effective in law, especially where it concerns refusal of a particular treatment. Advance Directives are not legally enforceable under the Adults with Incapacity (Scotland) Act 2000 however, one of the principles of the Act states that the wishes of the adult should be taken into consideration when acting or making a decision on their behalf. A person's Advanced Directive should where possible be adhered to in keeping with the principles of the Act.

- an Advance Directive cannot authorise actions that would be deemed illegal, inappropriate or end a person's life although it may expressly refuse interventions which prolong life
- in situations where something is done which conflicts with the person's wishes the action taken and the reason for it must be recorded
- in respect of Advance Directives relating to cardiopulmonary resuscitation (CPR) the NHS Scotland Do Not Attempt Cardiopulmonary Resuscitation Integrated Adult Policy must be referred to and followed
- in the case of a person who is a Jehovah's Witness, where there is written and immediately available evidence of an Advance Directive regarding the refusal of transfusion of blood and/or blood components, this must be adhered to
- under the provision of the Mental Health (Care and Treatment) (Scotland) Act 2003, a person may choose to draw up an **Advance Statement** which is different to an Advance Directive. An Advance Statement only applies to the treatment the person does or does not wish in relation to a mental disorder and only comes into force when the person's ability to make decisions is significantly impaired by the mental disorder

9 The Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment)(Scotland) Act 2003, section 243, allows for a patient detained in hospital under an Emergency Detention Certificate or a Short Term Detention who does not give consent or is incapable of giving consent, to received

medical treatment for a mental disorder. This would also apply when Section 299 which refers to nurses' power to detain pending medical examination applies. Only Registered Mental Health Nurses and Registered Learning Disability Nurses have the authority to use nurses' power to detain a patient. *See Appendix 3*

- if a person's refusal to consent to treatment is considered to be because they may be mentally ill or a potential risk to him/her self or others then it may be that consideration should be given to whether it may be appropriate to use the Mental Health (Care and Treatment)(Scotland) Act 2003
- where the person does not consent or is incapable of giving consent, urgent medical treatment for mental disorder can be given where it is to:
  - save the person's life
  - prevent serious deterioration in the person's condition
  - alleviate serious suffering on the part of the person
  - prevent the person from behaving violently or from being a danger to him/herself or others
- under section 243, treatment will only be authorised for purposes other than saving the person's life if this is not likely to entail unfavourable and irreversible, physical or psychological consequences
- under section 243, the proposed treatment to be given to alleviate serious suffering or prevent the patient from behaving violently or from being a danger to him/her self or others, must not entail significant physical hazard to the person

10 Emergency Situations

In an emergency situation where the patient is unable to give or refuse consent, it is usually acceptable to provide medical treatment without obtaining consent where immediate treatment is necessary to save life or prevent significant deterioration in the patient's health.

- treatment given in an emergency situation where it is not possible to obtain consent from the person must be no more than is required to save life or prevent significant deterioration in the patient's health
- refer to Standard 8, Advanced Directives in respect of CPR and persons who are Jehovah's Witnesses in respect of blood/blood product transfusion support

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14. NHS Scotland, Do no Attempt Cardiopulmonary Resuscitation Integrated Adult Policy http://www.scotland.gov.uk/Resource/Doc/312784/0098903.pdf

15. Mental Welfare Commission for Scotland Good Practice Guide Covert Medication https://www.mwcscot.org.uk/sites/default/files/2019-06/covert_medication.pdf

16. NHS Borders Completion of Health Records Policy (2017) http://intranet/resource.asp?uid=6143

Roles and Responsibilities

Role	Responsibilities
Medical Director and Director of Nursing, Midwifery and AHPs	Will secure agreement on obtaining consent to treatment and procedures required to ensure this.
General Managers and Heads of Corporate Services supported by Associate Directors of Nursing/ Associate Medical Directors/Associate Director of AHPs	Will disseminate the intranet link to the policy and support implementation.
Clinical Governance & Quality	Will provide audit/improvement in relation to implementation and compliance with the policy
Ward/Departmental Managers	Will ensure that all staff are familiar with the policy and must supervise compliance and monitoring of implementation of the policy.
Individual Clinical Staff	All staff must: • undertake all steps required to ensure that prior to any investigation, examination or treatment the patient is provided with information they understand and is fully informed of the proposed intervention, along with any risks associated with it, before consent to proceed with the intervention is sought • comply with the Consent to Treatment Policy

Implementation Plan

Professional responsibilities

Professional Leads/Partnership Forum/Public Representatives

- disseminate the policy

Clinical Governance & Quality

- lead on review of the policy and support audit of compliance with the policy

Clinical Executive

- agree and sign off the policy

Clinical Managers

- implement the Policy into their area
- supervise compliance with the Policy, organise audits as per standard
- respond to audit results and take corrective action when required

Clinicians

- ensure that their practice complies with this Policy
- participate in regular audit and engage in training and development as necessary

Review

- a multi-disciplinary group will review the Policy three years after issue or following any change in National Standards
- the results of Clinical Audits in relation to the policy will be used to inform this review

Development & Review Groups

Development Group (2008)

Mandy Brotherstone	Manager Children and Young People's Services
Elaine Cockburn	Head of Midwifery
Tom Cripps	Associate Medical Director Clinical Governance/Consultant Anaesthetist
Gordon Elliott	Prevention and Management of Aggression and Violence Co-ordinator
Derrek Hedderly	Charge Nurse, ITU Eleanor Kerr Child Protection Officer
Janice Laing	Operational Lead Training and Professional Development
Liz Lothian	Senior Sister, Day Procedure Unit
Frances Mason	Patient Safety programme Manager
Anne Palmer	Clinical Governance Facilitator 0 Clinical Effectiveness
Marion Paterson	Manager, Assessment and Treatment Learning Disability Service
Alasdair Pattinson	Lead Clinician Podiatry/Lead AHP
Laura Ryan	Clinical Lead Unscheduled Care
Cliff Sharp	Clinical Chair, Mental Health/Consultant Psychiatrist
Margaret Simpson	Public Representative
Isabel Swan	Lead Nurse, Mental Health
Rachel Watt	Adult Protection Training and Development Officer (seconded)

Review Group 2015

Rachel Gowans	Adult Protection Training and Development Officer
David Love	Associate Medical Director Clinical Governance/ Consultant Anaesthetist
Dawn Moss	Nurse Consultant Vulnerable Children & Young People
Anne Palmer	Clinical Governance Facilitator Clinical Effectiveness
Marion Paterson	Team Manager, Learning Disability Service
Cliff Sharp	Associate Medical Director Mental Health/Consultant Psychiatrist
Craig Wheelans	Associate Medical Director Clinical Governance/Clinical Lead Borders Emergency Care Service

Review Group 2018

Janet Bennison	Associate Medical Director Acute Services
Nicky Berry	Associate Director of Nursing Acute Services/Head of Midwifery
Amanda Cotton	Associate Medical Director Mental Health
Annabel Howell	Associate Medical Director Acute Services
Peter Lerpiniere	Associate Director of Nursing Mental Health, Learning Disabilities & Older People
David Love	Associate Medical Director Clinical Governance/ Consultant Anaesthetist
Dawn Moss	Nurse Consultant Vulnerable Children & Young People
Anne Palmer	Clinical Governance & Quality Facilitator - Clinical Effectiveness
Marion Paterson	Team Manager, Learning Disability Service

Review Group 2021/22

Laura Jones	Director of Quality & Improvement
Justin Wilson	Quality Improvement Facilitator - Effective
Janet Bennison	Associate Medical Director – Acute Services
David Love	Consultant Anaesthetist
Priya Kalsi	Senior Dental Officer, Special Care
Christine Proudfoot	Alzheimer Scotland Dementia Nurse Consultant
Marion Kimber	Learning Disabilities Team Manager

Appendix 1 Consent Table

NHS Borders recognises that a person should give consent to any treatment/intervention to be carried out. There are „generic" proposed procedures that will require consent; however the manner in which consent is given may vary. The table below should be referred to for guidance only as the list provided is neither prescriptive nor all-inclusive. The manner in which consent is obtained should be considered in line with each person's individual circumstances and needs.

Implied consent (non-verbal) This is by virtue of the patient's actions, e.g. holding an arm out to have blood taken or blood pressure measured. This consent is only applied where there is no or negligible risk involved in the intervention being undertaken**.**	**Oral or Verbal consent** Where the patient verbally agrees to an intervention proceeding following being provided with appropriate information about the procedure and discussion having taken place**.**	**Express or Written consent** Where the proposed intervention involves significant risk it is appropriate to seek written consent. Prior to obtaining written consent clinical staff must ensure that the patient has had the opportunity to absorb all the information provided and is given adequate opportunity to discuss anything connected with the procedure.
□ measuring of vital signs □ abdominal palpation □ auscultation of foetal heart **Note**: consent is not valid if insufficient information has been given unless the person has stated he/she does not wish to be given information.	□ routine physical examination □ simple venepuncture □ testing of blood/ urine/ sputum samples (except for HIV) □ episiotomy and repair where not previously discussed epidural anaesthesia □ catheterisation of bladder insertion of venous cannulae administration of IV fluids, including blood and blood products □ insertion of naso-gastric tube □ minor wound repair under local anaesthesia □ rigid sigmoidoscopy/ □ colonoscopy/biopsy without sedation □ most diagnostic radiology □ including IVU, Barium and CT □ studies with contrast □ haemodialysis, haemofiltration, peritoneal dialysis □ superficial biopsies without general anaesthesia □ diagnostic „taps", e.g. □ paracentesis or lumbar puncture or joint aspiration □ joint injections under local □ anaesthesia in out-patient department □ joint injections as day case □ or in-patient in theatre insertion of central venous line	□ all major surgical interventions /operations □ all angiography □ all therapeutic radiology procedures □ all body cavity biopsies □ all routine blood tests carried out in pregnancy □ flexible sigmoidoscopy/ colonoscopy and upper GI endoscopy

Appendix 2 Capacity and Consent

Adults with Incapacity and Consent and Patient Information

All NHS Borders staff involved in providing examinations, treatments, operations or investigation should be aware of:

- issues of informed consent, with particular attention to the implications of the Adults with Incapacity (Scotland) Act 2000 and where relevant, the Mental Health (Care and Treatment) (Scotland) Act 2003
- communication techniques, including awareness of the importance of the setting, timing, level of understanding and the state of mind of the individual receiving the information
- their responsibilities regarding consent. The expectation is that practitioners will maintain clinical expertise appropriate to their level of responsibility. It is the duty of NHS Borders to support, facilitate and monitor these skills.

Adults (patients 16 years and over)

Consent for medical treatment can only be provided by the patient, or a validly appointed proxy with powers in relation to medical treatment. A proxy may be a welfare guardian, a welfare attorney or a person authorised under an intervention order.

Incapacity to give consent

The Adults with Incapacity (Scotland) Act 2000 confers authority to treat patients incapable of giving consent. Intrinsic to this authority is the requirement to adhere to the principles of the act. These include:

- the present and past wishes and feelings of the patient
- the views of the patient's named person, carer, welfare guardian or welfare attorney
- the importance of the patient participating as fully as possible
- the importance of providing the maximum benefit to the patient
- the importance of providing appropriate services to the patient
- the needs and circumstances of the patient's carer

The Act also sets out principles in relation to the way in which the function must be discharged.

The Smoking Health & Social Care (Scotland) Act 2005 amends Section 47 of the Adults with Incapacity (Scotland) Act 2000 so as to extend the authority to grant a certificate under Section 47(1) to health professionals other than "registered medical practitioners" provided they have successfully completed the relevant training in the assessment of incapacity.
An Incapacity Certificate may be issues by:

- a medical practitioner
- a dental practitioner, ophthalmic optician or registered nurse who has satisfied prescribed requirements through completion of training
- any other member of a healthcare profession, which the Minister may prescribe in regulations, who has satisfied prescribed requirements.

A certificate of incapacity issued by healthcare professionals other than 'medical practitioners' will only be valid within their own area of practice. The incapacity certificate can remain valid for up to three years. This is however dependent on the nature of the illness from which the patient is suffering.

Further information is available at: http://www.sehd.scot.nhs.uk/mels/CEL2008_11.pdf

Assessment of capacity

If in the professional opinion of any member of staff seeking consent to treat a patient there is any doubt regarding the patient's capacity to give permission, the intervention/treatment cannot proceed. The only exception to this is an emergency or where significant harm to the patient would occur as a result of waiting for formal assessment when common law allows treatment to proceed:

- the patient should in this circumstance be referred to the medical practitioner with primary responsibility for their episode of treatment
- the doctor identified as having primary responsibility will depend on the facts and circumstances but is likely in the community to be the GP. In other areas of practice it will likely be the consultant in charge of the case. **N.B. where the**
- **patient has a mental illness but the proposed treatment is of a physical nature, e.g. a surgical operation, then capacity must be assessed in relation to the physical treatment.**
- patients referred to their primary medical practitioner will be assessed for their capacity to give consent to the treatment in question. Every effort must be made to assist the adult to understand his or her own medical condition. The assessment is individual to the patient and his/her condition at the time of the assessment.

For the purposes of this Act, and unless the context requires otherwise, "adult" means a person who has attained the age of 16 years; "incapable" means incapable of:

(a) acting; or
(b) making decisions; or
(c) communicating decisions; or
(d) understanding decisions; or
(e) retaining the memory of decisions,

as mentioned in any provision of this Act, by reason of mental disorder or of the inability to communicate because of physical disability; but a person shall not fall within this definition by reason only of lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise); and "incapacity" shall be construed accordingly.

The Adults with Incapacity Act (2000), Part V Medical Treatment Code of Practice
http://www.scotland.gov.uk/Publications/2008/06/13114117/3

1.22 Normally an assessment under Part 5 of the Act should seek to determine whether the adult:

- is capable of making and communicating their choice
- understands the nature of what is being asked and why
- has memory abilities that allow the retention of information
- is aware of any alternatives
- has knowledge of the risks and benefits involved
- is aware that such information is of personal relevance to them
- is aware of their right to, and how to, refuse, as well as the consequences of refusal
- has ever expressed their wishes relevant to the issue when greater capacity existed
- is expressing views consistent with their previously preferred moral, cultural, family, and experiential background
- is not under undue influence from a relative, carer or other third party declaring an interest in the care and treatment of the adult

Certification

A Certificate of Incapacity should be issued following formal assessment of capacity.

- if there is a proxy then formal agreement with the proposed treatment must be obtained prior to this going ahead.
- the Certificate of Incapacity permits other staff authorised by or acting on behalf of the primary medical practitioner, e.g. nursing staff, AHP staff, dentists, opticians, etc., to treat the patient as detailed in the accompanying treatment plan.

Legal Proxies

- where the patient has been assessed incapable of giving consent the primary medical practitioner should check if the patient has a validly appointed proxy with powers in relation to medical treatment.
- where there is a validly appointed proxy with powers in relation to medical treatment, the primary medical practitioner should seek their consent prior to any intervention or treatment going ahead. A Certificate of Incapacity is required in this circumstance
- the proxy has the legal responsibility to involve the patient and promote the patient's rights and wishes, if known, throughout the process.

Further information is available at: www.publicwelfareguardian-scotland.gov.uk

Dispute

- if the proxy does not agree with the treatment proposed by the primary medical practitioner, a second opinion can be sought from any of the practitioners listed on the Mental Welfare Commission's list of nominated medical practitioners.
- proxy decision makers have the right to be consulted regarding the dispute and to choose their own nominee from the Mental Welfare Commission list of nominated medical practitioners.

Further information may be obtained via the e-learning package and NES resources:

- Adults with Incapacity for Frontline Practitioners e-Learning Module, AWI can be accessed on Learn Pro https://nhs.learnprouk.com/;
- NES learning resource to support the application of the Adults with Incapacity (Scotland) Act (2000) (AWI) in Acute General Hospitals is available as an interactive PDF and available at: http://www.nes.scot.nhs.uk/media/1557644/capacity_and_consent-interactive.pdf

Appendix 3 The principles of the Mental Health (Care and Treatment) (Scotland) Act 2003

The Act sets out some principles which the majority of people performing functions under the Act have to consider. These include:

- the present and past wishes and feelings of the patient
- the views of the patient's named person, carer, welfare guardian or welfare attorney
- the importance of the patient participating as fully as possible
- the importance of providing the maximum benefit to the patient
- the needs and circumstances of the patient's carer

The Act also sets out principles relating to the way in which the function must be discharged. These require the person discharging the function to do so in a way which, for example:

- involves the minimum restriction on the freedom of the patient that appears to be necessary in the circumstances
- encourages equal opportunities
- if the patient is a child, best secures their welfare**.**

Other sections within the Act place further duties on those discharging functions under the Act:

- a duty to have regard to the Code of Practice on the Act, published by the Scottish Ministers. (This duty does not apply to the Commission, the Tribunal or any court)
- a duty to lessen any harm to child-parent relations, where relevant
- a duty to provide the Scottish Ministers with relevant information, such as research, subject to a number of safeguards.

Further information is available at:
www.scotland.gov.uk/Publications/2003/11/18547/29204

N.B. In relation to the Mental Health (Care and Treatment) (Scotland) Act 2003, a child is someone who has not attained the age of 18 years.

Appendix 4 Formatting Patient Information–Good Practice Guidelines

Do:

- keep front covers
  - simple
  - uncluttered
  - write

- write
  - title in sentence case, the first letter only should be in capital
  - headings in font two size bigger than the main body
  - in manageable sections, with logical link
  - with text aligned to left (justified text is difficult to read for the visually impaired)
  - including 'white space' between sections, for easier reading
  - stating the date of production, review date, department and contact number (individual should be identified as contacts)

- Use
  - Century Gothic 14 font (Comic Sans 14 for persons with Learning Disability and children)
  - everyday words where possible (simplest for e.g. use not utilise and start not commence)
  - active rather than passive verbs
  - lists and bullets as they breakdown the information

Say what you want the reader to do rather than what you do not want

Do not:

- Use
  - jargon
  - long sentences
  - italics or underline **(important information should be highlighted in lower case bold)**
  - abbreviations
  - shiny paper

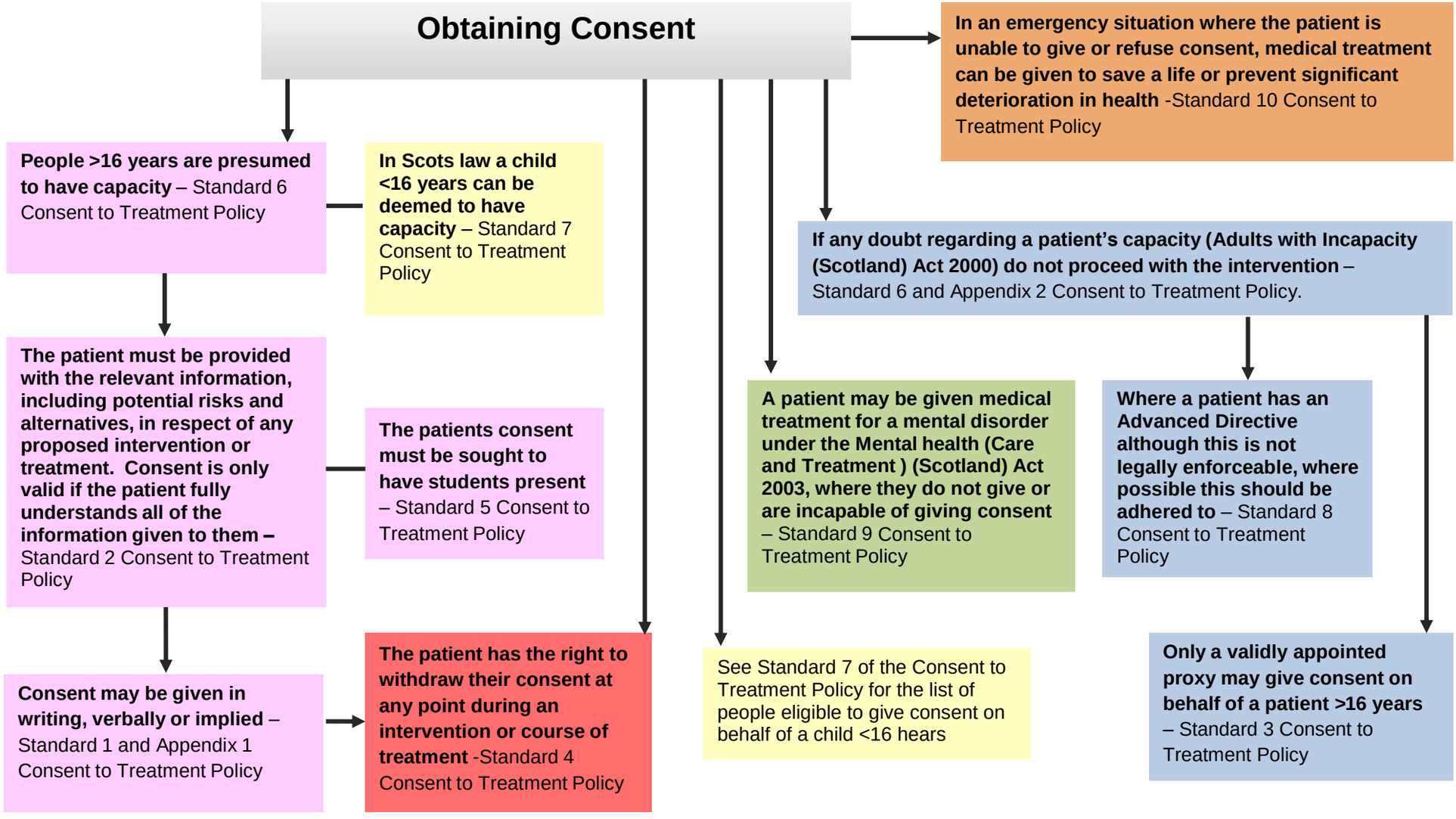
Remember the average reading age in Scotland is approximately 11 years of age

Appendix 5 The seven principles of decision making and consent

Principle one	All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.
Principle two	Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient
Principle three	. All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.
Principle four	Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.
Principle five	Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements.
Principle six	The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.
Principle seven	Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible.

(Extracted from GMC Decision making and consent (2020))

Appendix 6 Consent to Treatment Policy Quick Reference Guide



NHS Border's staff must comply with the NHS Borders Consent to Treatment Policy. The above chart is an abbreviated guide to obtaining patient consent and is not intended to replace the need for all staff carrying out any type of intervention or activity in connection with a patient or their care to be aware of the content of the full policy.