# Consent Policy

## Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for consent:

We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

## Scope

EFH ensures that good quality arrangements are in place for obtaining and acting in accordance with the consent of residents (and others with lawful decision-making powers) in relation to the care and support they receive.

## Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

## Policy Statement

Definitions

Consent is the process of agreeing to care, treatment or support based on access to all relevant and easily digestible information regarding their care, treatment, or support needs.

Valid Consent is consent given voluntarily by an appropriately informed person who has the capacity to consent to the care or intervention in question (this will be the person or someone who is authorised to do so under a Lasting Power of Attorney (LPA) or someone who has authority to make treatment decisions as a court appointed deputy. Acquiescence where the person does not know what the intervention entails is not ‘consent.’

Express Consent is consent that is specifically sought and documented in either the resident’s record or on a consent form or both.

Implied Consent is where consent to a procedure is implied by the person’s actions e.g. within a care pathway when an individual is asked to transfer from chair to bed, implied consent is assumed by their participation in the manoeuvre.

Lack of Capacity is where a person is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. It does not matter if this is permanent or temporary (Mental Capacity Act, 2005). A person lacks capacity if they have an impairment or disturbance (for example a disability, condition or trauma or the effect of drugs or alcohol) that affects the way their mind or brain works, and that impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

Independent Mental Capacity Advocate (IMCA) is a person who is instructed to support and represent the interests of a person who lacks capacity and does not have anyone to speak on their behalf when serious decisions need to be made. This can include changes of accommodation, serious medical treatment or safeguarding concerns.

IMCAs are not decision makers for the person who lacks capacity; they ensure that decision making is done appropriately and in accordance with the Mental Capacity Act.

The duties of an IMCA are to:

Support the person who lacks capacity and represent their views and interests to the decision maker.
Obtain and evaluate information, both through interviewing the person and through examining relevant records and documents.
Obtain the views of professionals providing treatment for the person who lacks capacity.
Identify alternative courses of action.
Obtain a further medical opinion, if required, and prepare a report (that the decision maker must consider).

Court of Protection - Where a person lacks capacity to make a decision relating to their welfare, then the Court of Protection can make an order making a decision on their behalf. Alternatively, the Court of Protection can appoint a deputy to make decisions on behalf of the person who lacks capacity.

Court Appointed Deputy is a person, judged by the Court of Protection to have the necessary skills and abilities and who is prepared to take on the duty and responsibility of the role, who can make decisions on behalf of the person who lacks capacity. The principles of the Mental Capacity Act must be followed, and decisions must be made in the person’s best interests. Where a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity then it is the deputy rather than the health professional who makes the treatment decision. A deputy cannot go against a decision of an attorney under an LPA made before the person lacks capacity.

Lasting Power of Attorney (LPA) - The Mental Capacity Act enables a person aged 18 or over to appoint an attorney to look after their health and welfare, or property and affairs decisions if they should lack capacity in the future. An LPA is a legal document that allows a chosen person (the attorney) to make decisions that are as valid as one made by the person (the donor). An LPA must be registered with the Office of the Public Guardian before it can be used.

It is very important that staff check LPA documentation to ensure it has been registered with the OPG (Office of the Public Guardian) and to understand the specific decision-making responsibilities the LPA provides the attorney with.

Best Interests - The legal requirements of the Mental Capacity Act are underpinned by five statutory principles. One of the key principles is that any act done for, or any decision made on behalf of, a person who lacks capacity must be done or made in that person’s best interests. This principle applies to health and social care professionals and to anyone working with or caring for a person who lacks capacity. By virtue of this, the Act also creates a new offence of ill treatment or wilful neglect of someone who lacks capacity by someone with responsibility for their care or with decision making powers.

The Mental Capacity Act allows carers, health care and social care workers to carry out certain tasks without fear of liability. These tasks include the personal care, health care or treatment of people who lack capacity to consent to them. The aim is to give legal backing for acts that need to be carried out in the best interests of the person who lacks capacity to consent. When determining what is in a person’s best interests, carers, health care and social care workers MUST NOT make assumptions about someone’s best interests merely on the person’s age or appearance, condition, or any aspect of their behaviour.

All staff are required to read and follow this policy, including the organisation key principles of consent:

Seeking a resident’s informed consent is a process, not a signature.

Consent must be informed, voluntary and given by a resident with capacity to do so.

Special rules apply for residents who lack capacity.

Assessment of ‘capacity’ is decision and time specific.

Consent can be withdrawn at any time by the resident.

Residents must be informed about risks, benefits and consequences of proposed care and treatment.

Consent is the voluntary and continuing permission of a person to receive a specific care intervention, treatment or to undergo a particular procedure and staff need to ensure that the Consent Policy is being implemented as intended.

All staff must also read the organisation’s policy on the Mental Capacity Act 2005 including Deprivation of Liberty Safeguards.

## The Policy

Consent will be sought from residents in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA) Regulation 11. In so doing the organisation will support the residents’ human rights, dignity and respect.

EFH will provide staff with training in consent and the Mental Capacity Act 2005 at induction and as part of annual updates to ensure staff are up to date with best and evidence-based practice.

Staff are required to read and understand CQC guidance on Regulation 11: Consent, and to understand and comply with their ongoing responsibility to seek valid consent for all care delivered (see references).

The management team will provide supervision and spot checks which will be used to assess competency and ensure staff deliver this element of their job role compliant with the regulations and fundamental standards.

### Gaining Consent

A competent staff member who carries out the care is ultimately responsible for ensuring the person has genuinely consented. They may be held responsible in law if this is challenged at a later date.

Before residents can come to a decision about consenting to their care, they need information in a format they can understand about their care including the risk and benefits.

Where the resident indicates that they do not want information this MUST be documented in their care record and the consent form. They should be informed of risks or benefits, no matter how small or remote, unless they have expressly indicated they do not want the information.

The presumption must be that the resident wishes to be well informed and has the capacity to receive, understand and make a decision on the information.

Care assessments and care plans should be signed by the resident, or their personal welfare power of attorney where they lack capacity, as an agreed representation of their care and support needs. Any consent documentation within the assessment or care plan should also be signed and dated.

### Valid Consent

Consent is valid if given voluntarily and by an appropriately informed person who has the capacity to consent to the care in question. A resident who does not understand what the care procedure involves, cannot give consent.

Consent can take many different forms, ranging from the active request by a resident for a shower or other personal care, to the passive acceptance of a staff member asking for the resident’s arm to take a blood pressure reading.

In some cases, the staff member will suggest a particular activity, and after discussion the resident may agree to accept it. In others, there may be a number of options for activities and the staff member will help the resident to decide between them, e.g. walk to the park or trip to the shops.

Who can give consent?

A person has the potential capacity to consent if:

They are the resident, or
They are someone authorised to act on the resident's behalf for specific decisions such as an attorney (appointed under a lasting power of attorney or a court appointed deputy) where the person lacks capacity to consent.
Ongoing Consent as a Process

Informed consent is an ongoing process and consequently providers must ensure that residents:

Continue to understand what they are consenting to.
Can withdraw consent at any time for an individual episode of care or for the provision of care.
Are provided with relevant new information which could influence their decision to consent.
Rights to make capacitated unwise decisions are respected.
Continue to consent to care, treatment and support in an informed environment.

No adult can consent on behalf of another adult without legal authority.

Reviewing Informed Consent

Resident care and support plans will be reviewed as needs change or on a quarterly basis, whichever is the sooner. As part of the review process consent will be considered and where significant changes are made, e.g. commencement of medication administration, consent will be obtained.

Advance Decision to Refuse an Investigation/Treatment

This is defined as a decision made by a resident to refuse a specific medical investigation or treatment in the circumstances set out (previously known as a living will or advance directive) NHS - Advance Decision.

These are important documents and should be kept in the resident's care and support file. It is important that these Advanced Decisions are respected, especially where there may be a deterioration over time in the resident's capacity to consent due to degenerative processes e.g. dementia. Paramedics and healthcare professionals should be made aware of Advance Decisions when transferring residents to hospital or treating them in the home.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 11 requires providers of regulated activities to seek consent for the health and care activities they undertake for residents.

Residents have a fundamental legal and ethical right to determine what happens to their own bodies, and to consent to activities of personal care delivered by the organisation in support of their care needs.

The assumption is that all residents have the capacity make decisions and consent to care, unless they have been assessed as lacking the mental capacity to do so under the Mental Capacity Act 2005.

"The aim of the Mental Capacity Act 2005 is to balance the importance of care, treatment and support of people who lack capacity with a need to protect their interests and respect their current and previously expressed wishes and feelings".

The ethical principle relating to informed consent is the belief that everyone should be treated with dignity and respect, and that their needs when gaining informed consent must be person centred and support their:

- Ethnicity
- Gender

- Disability
- Religious beliefs
- Culture
- Language
- Level of understanding

Sensitivity and care will be taken when gaining informed consent. When the individual has made the decision relating to their care, treatment or support this organisation will respect that decision and record it within their care and support plan.

It is important to remember that adults at risk are potentially susceptible to coercion by nature of their relationship with this organisation and staff. The organisation and staff recognise autonomous and informed decision making as paramount to the service delivery, and commits to never coerce consent decisions from residents.

UK case law on consent has established 3 requirements that need to be satisfied before an individual can give informed consent:

1. Consent should be given by someone with the mental capacity to do so

2. Sufficient information should be given to the individual

3. Consent must be freely given

If any of these requirements are lacking, then the consent is invalid.

Implied informed consent

This may arise when express written and/or verbal consent is not given, e.g., when an individual is asked to transfer from chair to bed, implied consent is assumed by their participation in the manoeuvre.

The process of gaining informed consent

Below are the factors to be considered when going through the process of obtaining informed consent.

It is important to make individuals, their family or representative as comfortable as possible at the assessment of needs stage in order that they are able to concentrate and feel confident enough to ask questions and gain as much information as possible for them to make an informed decision.

Ensure the location is private and as free from interruptions as possible. Supportive repetition may be necessary to ensure information is retained and understood so: repeat, explain and re-enforce the information given.

Follow up and ask questions to check understanding and comprehension of the information.

Consider the nature of the resident’s current frame of mind, e.g. recent news of a life-threatening illness may impact on their ability to be able to make informed decisions regarding care or support.

Prepare information to support the discussion and to leave behind with the resident and family, in a format appropriate to the resident’s needs e.g. prepare information material in different formats and languages, where appropriate.

The signing of a consent form is standard practice in confirming that the individual has freely given their informed consent to care or support they receive.

Residents must not be asked to sign the consent form until they have been given adequate information and time to consider their decision. It is important to explain verbally all aspects of their care or support, ask questions and check their understanding.

During the assessment of needs process, it is important to engage with the resident, their family, or representative in a meaningful and professional manner in order to make the process as effective and responsive to the resident's needs as possible.

Empowerment

Adult safeguarding requires that the principle of empowerment, based on a presumption of person-led decision making and informed consent. This must also be seen as the individual being able to take person led decisions, and that their views and wishes are to be listened to and respected.

Where there is a lack of capacity for a specific issue the Mental Capacity Act 2005 Code of Practice must be observed.

Assessing an individual's capacity to give informed consent for a specific area must be undertaken in an autonomous manner. It is important to involve multi-agency partners, legal representatives, advocates person representatives and others who know the person in making such decisions.

The provision of accurate and meaningful information is at the very heart of acquiring informed consent.

Below are factors to consider when working with individuals or groups who may be considered at risk.

Resident Needs

A resident may have a range of support needs which should be taken into account, some of which are not always obvious such as:

Difficulty with reading or writing may conceal their limitations due to embarrassment (e.g., "I've forgotten my glasses, I will read it later") while others may have visual or hearing impairment.

It is vital therefore to sensitively explore the person's abilities. The ability to process information can slow with age, or some health conditions, people should be given plenty of time and opportunity to ask questions, and to think about whether they desire the care, treatment and support. It is important that the person is encouraged to participate fully in the consent process.

Capacity to decide

A person can only give consent if they are capable of choosing between alternative courses of action. This means they must be able to understand the information given to them.

A person who is deemed to have a lack of capacity to make a particular decision if they are unable to do one or more of the following:

Understand the information relevant to the decision (including the consequences of deciding one way or the other, and of not making the decision).

Retain that information.

Use or weigh the information as part of the process of making their decision.

Communicate their decision once reached (including nonverbal methods of communication).

Where a person lacks mental capacity, a best-interests decision meeting involving those who know the individual should be instigated using the Mental Capacity Act 2005 Code of Practice guidance for best interests decisions.

Residents with a learning disability

Residents with learning disabilities or difficulties must be accorded the same respect and right to self-determination as anyone else.

To support decision making use plain language in a format that the person uses, supported if necessary, by using other materials such as pictures or easy read. Dependent upon the needs of the individual, it may be necessary to present the information in different formats over a longer duration.

Every effort will be made to seek informed consent and it may be necessary to involve a range of multi-agency partners who are knowledgeable about the individual's situation.

EFH may need to involve appropriate colleagues such as specialist learning disability teams and speech and language therapists in supported decision making and assessments of capacity where communication difficulties are suspected. This is to ensure the person is supported and empowered to make their own decision wherever possible.

## Refusal of Consent

Adults are entitled to refuse any care or treatment, even when it would clearly benefit their life, well-being, health or when refusal of the treatment may result in their death, as long as they have the mental capacity to make such a decision.

The only exception to this rule is where treatment is for a mental disorder and the person is detained under the Mental Health Act 1983.

A person may withdraw their consent after having signed a consent form. A person's decision should always be respected (as long as they have capacity) even in life threatening situations or where the reasons seem irrational or where they do not give a reason at all.

Where a person has refused a particular care, treatment/ intervention, the staff MUST ensure that they continue to provide any other appropriate care to which the person gives consent. The Registered Manager and GP or other health or social care professional (where required) must be informed of any changes to consent.

EFH will ensure that staff have the requisite training and support to participate effectively in obtaining informed consent. All staff should have the knowledge, expertise, and competencies to give sufficient information in an appropriate format and answer any questions raised by the individual, their family or representative. Where staff do not feel competent or comfortable in this role, they are required to raise this with their line manager or the Registered Manager.

It is vital that staff can assess a resident's capacity to give informed consent. If staff are open, honest and ensure the individual's understanding, then truly informed consent will be obtained.

## Training

Care staff are provided with training regarding consent at all suitable stages of their employment from induction onwards.

## Seeking Feedback about

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of information sharing and confidentiality. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

## References

CQC - Regulation 11: Need for Consent

Gov.UK - The Mental Capacity Act 2005

Mental Capacity Act 2005 Code of Practice

SCIE - Mental Capacity at a glance

NICE guideline 108 Decision-making and mental capacity

NHS - Advance Decision

DoH - Reference guide to consent for examination or treatment.

| Review date | Next Review Date |
|---|---|
| May 2024 | May 2027 |