Patient Consent
Study Guide

Session Overview

Description

This session is an outline of the general principles of consent and focuses on the types of consent to treatment. It examines what happens before the age of consent and what can be done when consent is refused. It also looks at consent in the case of people with learning difficulties, living wills and organ donation.

Learning Objectives

By the end of this session you will be able to:

- Determine an appropriate level of consent for any given procedure and patient
- Help patients reach informed decisions in the consent process
- Document the consent procedure and fill in consent forms
- Appreciate the ethical considerations of consent
- Utilise the guidelines on consent for organ donation

The Patient's Perspective

Part of ensuring patient safety is making certain that patients understand their proposed care and are happy for it to take place. Patients should be provided with comprehensive information, which allows them to make an informed decision on their healthcare. Agreement on the procedure or treatment to be undertaken is called 'consent'.

Patients have a right to determine what happens to their own bodies and consent to treatment is central to all forms of healthcare. It is also a matter of common courtesy between health professionals and patients.

The patient centred perspective is taken as the **ideal consenting model** (see the diagram). In effect the decision making process is 'shared'.

It is important to remember that a significant proportion of complaints made to all NHS Trusts are precipitated by poor communication before treatment.

What is Consent?

Information for Consent

Which of the following do you believe is the minimum information?

Select one or more options from the answers below.

A. The nature of the procedure
B. The benefits
C. The risks
D. Advice
E. The alternatives

All of these options are necessary to provide a complete picture for decision-making and consent.

Seeking Consent

Invasive procedures, such as an anaesthetic, usually require written consent. However, to what extent do you think that consent in general should be sought?

For which of the following actions would you obtain consent?

A. Open heart surgery
B. Carrying out a physical examination
C. Cutting toe nails
D. Helping the patient walk to the toilet
E. Taking an x-ray

Consent should be sought for everything that involves the patient, whether helping a patient to stand, or performing major surgery.

Establishing the need for formal consent may be complex in some situations, for example, written consent may be required for cutting toe nails if the patient is diabetic and at risk of infection.

Consent

Consent is a patient's agreement for a health professional to provide care. This agreement may be provided in a variety of ways:

- Non-verbally, such as presenting an arm for blood pressure to be measured
- Orally, as for a physical examination
- Written, if the treatment is complex, involves an anaesthetic or sedation, there may be significant consequences for the patient's future life, or healthcare is not the primary reason for the procedure

Seeking consent should always be a process of joint decision-making that reflects a recognition of people's dignity and autonomy.

Both the consent to treatment forms and the NHS consent policy emphasise the importance of making written information available to patients on their treatment options.

Verbal Consent

Consent During Routine Procedure

Consent is not always written, and will be given verbally in most everyday occurrences.

Consider the actions taken in the transcript, which shows a patient having blood taken.

Nurse: Have you had your blood taken before?

Patient: Yeah. I will be surprised if there is any left.

Nurse: Ok, if you can squeeze your hand for me… scratch coming now… ok…relax your hand… can you hold it for me? … Right… shall we put some tape on…that's it you are done!

Nb: This transcript is taken from a video which is available on Moodle (or LEARN from 20 May). You will be able to access this once you have activated your ICT user account, but this may not be before your induction.

Consent Given for Blood?

Do you believe that consent for blood to be taken was given in the transcript (above)?

A. Yes
B. No

A is correct: By extending their arm for the blood to be taken the patient has given consent for the procedure to go ahead for previously agreed tests.

Consent Given for Plaster?

If this patient's arm swells in a severe allergic reaction to the sticking plaster, would you believe that valid consent had been given by the patient for the plaster to be used?

If this patient's arm swells in a severe allergic reaction to the sticking plaster, would you believe that valid consent had been given by the patient for the plaster to be used?

A. Yes
B. No

B is correct.

This was a staged procedure and consent should be sought for each stage. In this video, consent to apply the sticking plaster was not sought prior to sticking it on the patient's arm.

Who Should Seek Consent?

A. Any person taking consent is held legally responsible
B. It is a health professional's own responsibility to ensure that when they ask a colleague to seek consent on their behalf, that person is competent to do so
C. It is a health professional's own responsibility to ensure that they work within their own competence and do not agree to perform tasks outside of that competence

Correct Answer: All of the above

Refusing Consent

Obstacles to Consent

A 48-year-old woman has very heavy troublesome periods. She has four children and does not want any more. Following initial hormone therapy and a series of investigations, a hysterectomy has been determined as the best solution.

The woman is vehemently against the idea and is unable to voice why.

Think about what steps you would take?

For example:

- Explain that sex can continue after a hysterectomy
- Discuss the types of hysterectomy and the organs to be removed, e.g. are ovaries included?
- Offer an opportunity to talk to another professional, perhaps of a different gender
- Explore the psychological aspects of losing her womb
- Accept the refusal
    - While patients are entitled to refuse treatment at any stage, be aware that refusal to consent may indicate a fear of the wider effects of a procedure.
    - Also, be aware that if the clinician is of a different gender to the patient, they may be happy to discuss the situation with another professional, of perhaps the same gender.

Refusal of Consent

You are bound by law to respect such a decision, however serious the likely outcome, when made by an adult with the capacity to understand the implications of refusing the proposed intervention.

The only exceptions are:

- Those related to the treatment of mental disorder under the Mental Health Act (1983) where such interventions may be applied without consent. However, remember that even in these patients the treatment of non-psychiatric disease still requires informed consent
- Those resulting from the refusal of children aged 16-17 or under 16 but Gillick competent. In these cases a person with parental responsibility, or the court, may overturn the decision of the child.

Shared Decision Making

Shared decision making is part of the process of consent when there are 2 or more possible options. This is true for both high and low risk procedures, particularly where the treatment outcomes are uncertain or may impact on emotional, social or religious aspects of the patient's life.

Process

This involves the discussion of more than one option for treatment or investigation, including the uncertainties about outcomes as well as the risks and benefits.

Outcome

The doctor and patient's joint agreement to proceed with a particular course of action whilst rejecting the alternatives.

Exclusions

Exclusions are not appropriate when there is only one medical option for treatment or investigation. They are usually dealt with by simple consent for low risk options (e.g. treatment of a contrast reaction) or by informed consent for high risk (e.g. insertion of a nephrostomy for pyonephrosis in a single kidney) ones.

Simple Consent

Introduction

All medical interventions or decisions not to intervene require the agreement of the patient. Simple consent implies that the patient has had an opportunity to discuss and authorise low risk procedures. It applies in situations where there is only one clear course of action but is also valid where there are multiple reasonable options to choose from.

Where patients are anxious or inquisitive and choose to heighten the level of discussion, the process may be similar to fully informed consent.

Patient information leaflets sent with outpatient appointment letters are often used to improve the level of understanding prior to attendance for low risk procedures.

Process/Interaction

To a variable degree, doctor and patient discuss the proposed treatment or investigation (including any alternative approaches) and the risks and benefits of each option.

Outcome

Simple consent may be implied through the patient directly complying with a course of action e.g. a radiologist explains the intravenous pyelogram procedure and associated risks. Consent is implied when the patient subsequently allows insertion of an IV cannula. No consent form is required but there should be a written record of the contrast injection.

Remember (again) that a signature on a form does not validate the consent procedure, it must be informed.

Informed Consent

Introduction

Informed consent is a legsally required undertaking prior to all high risk procedures, which records the patient's explicit authorisation of a medical intervention and thereby affects the doctor's liability in the event of any untoward complications.

It is applicable whether there are multiple actions to choose from or only one option.

Process

Not confined to the simple application of signatures on a form but includes the preliminary discussion. Ideally this should take place outside of the area in which the procedure is to be performed and well in advance.

Patient information leaflets

In the non-emergency situation, provision of leaflets in the outpatient clinic should improve the level of understanding and help the patient to come to a fully informed decision.

Interaction

The proposed treatment or investigation (including any alternative approaches) and the risks and benefits of each option are discussed.

A written record of such discussion is advisable in an elective setting.

Outcome

The patient's expression of acceptance (and usually a signature) or refusal of the proposed action. The full engagement of patients in a preliminary discussion is more likely to lead to a satisfactory outcome.

Explain the Procedure

Note that the standard consent form in the UK leaves minimal space for explanation of the procedure. If the procedure is complex then document the explanation in the patient notes. Use diagrams to explain complex concepts and offer the patient a copy of any material used in the discussion.

Most patients do not desire in depth technical details of the procedure and prefer an overview which emphasises:

- Availability of sedation/analgesia whenever necessary
- The expected probability of successful performance of the procedure
- The expected probability of a clinical benefit, e.g. symptom relief or cure
- The expected probability of recurrence and management strategies if this occurs

Written Consent

Written consent is a legal principle developed by the courts over many years. It is likely that it derived from the Nuremberg code, which required doctors to obtain voluntary consent before conducting medical experiments.

Written consent is usually required where a treatment or procedure has certain inherent risks. This allows you to document the possible outcomes that you have discussed with the patient. In turn, the patient may also request to document the extent of the risk they are prepared to take.

The consent acknowledges the risks. In the case of a patient undergoing chemotherapy for testicular cancer, the treatment may cure the disease, but cause infertility in the remaining testicle. The patient should be given the option of sperm storage and failure to take this into account could leave you open to litigation in a few years' time.

Good practice in implementing consent has been developed by the government. The documentation around this is available from the DOH web site and was implemented as a standard on 1 April 2002.
Standards are also produced by the General Medical Council (GMC).

Consent for Research

Written consent is also essential in any sort of medical research involving patients. Written consent must be obtained to show that any patient participating in research understands that it is a trial procedure and knows the full extent of the information available about that piece of research.

This applies whether it is physical or psychological research, or to test a new medicine.
A local ethical committee must give approval for the research to be carried out in its region before research can commence. An approval certificate should be available for any research that you are asked to work on.

Competent Consent

What Makes a Patient Competent

Patients can only give their consent if they are competent to do so. But what makes a patient incompetent? What circumstances may indicate a patient is incompetent to give consent?

A. Patients who are drunk
B. Patients with severe mental disorders
C. Patients with a communication disability

Correct Answer: A and B

Patients who are drunk or with severe mental disorders that are actively out of control are unlikely to be able to make an informed decision.

Patients with a communication disability may need to be assessed by a speech and language therapist to help with an informed decision.

How to Handle an Incompetent Patient

Patients may be able to understand some things and not others. Treat every conversation to obtain consent as a distinct event.

Where a patient lacks the ability to decide you should:

- Look for a precedent in previous clinical decisions
- Assess previous preferences – some patients with conditions that deteriorate such as Alzheimer's have an advance statement of their preferences prepared
- Identify the patient's cultural, religious and employment considerations
- Enquire about third party knowledge, close relatives for example
- Choose the option which least restricts the patient's future choices

Mental disorders provide complex problems for gaining informed consent, and the Safety in Mental Health Act Code of Practice 2007 covers this in more detail.

Emergency Consent

A patient may be unable to give consent if they arrive in Accident & Emergency after an accident.
If urgent treatment is required, can you make **ALL** decisions for their care?

A. Yes
B. No

Correct Answer: B No

Where emergency treatment is needed and the patient is unable to give consent, the patient should be treated for the urgent problems immediately.

Other treatment should be carried out when patients can consider their consent.
The emergency treatment should be explained to the patient as soon as possible.

Children

Children 16 years of age and over are considered capable of giving informed consent. A child can give consent, if the individual is capable of understanding the particular circumstances involved.
Where a child is too young, or the considerations are too complex, then the parents must be involved in the consent process. One parent is usually sufficient. However for sensitive issues where opinions may vary, such as circumcision, consent should be sought from both parents.

Rights of the Individual & Role of Parent/Carer in Consent

Age of Consent

At what point does an individual become autonomous? A baby is not autonomous: decisions on its welfare must be made by its parents or another appropriate individual. A young adult is autonomous, however, and makes his or her own decisions.

Between these extremes, an individual gradually develops autonomy. This can create ethical and legal difficulties for the clinician.

The Family Law Reform Act 1969 states that the age of consent to medical treatment is 16. The Children Act 1989 deals with the following issues in children under 16:

- Parental responsibility and parent's rights
- Providing services
- Protecting children
- Looking after children away from home

The presumption is that parents will make decisions in the best interests of the child, so the guiding principle is one of partnership with parents based on agreement.

When agreement is not possible, the welfare of the child is paramount. The following pages illustrate representative problems in this area, together with comments on the relevant ethical and legal issues.

Consent Required?

Rob is a 4-year-old boy. He has been admitted to hospital with cellulitis and antibiotic therapy is indicated. His mother suffered an unpleasant reaction to antibiotics as a teenager and refuses to allow the child to have this treatment. His father thinks that the medical advice to treat with antibiotics should be accepted.
Would you treat this child without his mother's permission?

A. **Yes**

B. **No**

A is correct.

Legally, where parents disagree, the clinician only requires the consent of one parent for treatment to be provided.

Legal Position

If Rob were judged to have the capacity to give permission he could give consent, but at his age this is unlikely. The law says that consent for treatment of an incompetent child is primarily a parental responsibility.

Parents not married

Where a child's mother and father were not married to each other at the time of birth, the mother has parental responsibility and the father does not. However, a father may acquire parental responsibility under the provisions of the Children Act.

Parents disagree

More than one person may have parental responsibility for the same child at the same time, in the same circumstances.

Legally, where parents disagree, the clinician only requires the consent of one parent for treatment to be provided.

Both parents withhold consent

If both Rob's parents were to withhold consent, legal advice should be obtained. The court could authorise the treatment to go ahead.

Refusing Consent

John is 13. He needs a blood transfusion. He and his parents have strong religious convictions, and on this basis he refuses treatment. His parents accept his decision.

Could you apply to a court to have the patient's decision overruled?

A. Yes
B. No

A is correct.

Different understandings of what constitutes the welfare of the child are not easily resolved.

In cases where competent young people (who are legally under the age of consent) refuse treatment, the respect for autonomy, which underlies all medical care, is a powerful factor in any decision about recourse to the courts.

In general, the law recognises the right of a minor who understands the implications of the decision, to **consent to treatment** even if the child's parents object.

On the other hand it places **limitations on the same person's right to refuse treatment**, allowing the parents to override such a refusal.

A clinician could apply to the court to override a refusal by a competent minor.

Patients with Learning Difficulties

Introduction

Particular care should be exercised in obtaining consent from patients with learning difficulties.
Communication may be problematic with such patients even where they are competent.
Carers are often an important part of the process of obtaining consent but cannot consent on behalf of the patient.

Competency and Decision Making Capacity

Competent patients should make their own healthcare decisions, based on the principle of autonomy, whereas patients lacking competency should be protected from making bad decisions, based on the principle of beneficence.

Dynamic nature of competency

Competency may be a dynamic state and may change quickly, as when a stuporous patient is admitted with sepsis and lacks competency but a few hours later has responded to treatment and regains competency.

When is a patient no longer autonomous?

Nor is competency an absolute. In mentally disabled patients, impaired mental capacity may correspond with impaired decision making capacity, but what degree of impairment disqualifies a person as an autonomous agent?

Risk and benefit

There are no widely accepted criteria for competency and so clinicians often assess it on a sliding scale that varies with the degree of risk and benefit to the patient.

For example, a low level of competency is required if a patient elects to receive a life saving treatment with low risk and high probability of benefit. If the patient refuses the same treatment, more information may be needed in the face of greater risk.

Who Gives Consent?

A. Clinician
B. Relative
C. Carer

Answer on next page.

Answer: A is correct

When the patient does not have the mental capacity to consent, the clinician is required to act in the patient's best interest.

The clinician may consult relatives and carers in reaching a view of the patient's best interest, but unless they have been given legal authority to act, a carer or relative cannot give consent on behalf of the patient.

Issues with Consent

Autonomy is a difficult issue in patients with psychiatric illness. Some patients clearly have no ability to comprehend matters relating to their physical illness. In others, impaired thought (e.g. delusions) can co-exist with a rational understanding of physical illness and the need for treatment. Some individuals may alternate between periods of rationality and seriously impaired comprehension.

Problems also abound in gaining consent to treatment of the medical illness itself. For example, schizophrenic patients may refuse treatment because they do not believe themselves to be ill.

The law permits investigation or treatment (including treatment of mental illness) of patients who lack the capacity to decide, provided they comply and the treatment is in the patient's best interests. If patients do not comply they can be treated for any mental disorder only within the safeguards of the Mental Health Act 1983, and any physical disorder arising from that mental disorder. This also applies to patients with impaired mental capacity.

Could you Section this Patient?

Leola is 28 and has been diagnosed with bipolar disorder. She has been living an itinerant life for six months and presents at a city-centre hospital accident and emergency department, where she is admitted due to severe infection in her toes resulting from frostbite.

Due to a life-long fear of anaesthesia, Leola refuses surgery.

However, doctors fear that her foot is now becoming gangrenous. Could Leola be sectioned under the Mental Health Act 1983 on the grounds that she is not competent to refuse consent for surgery?

A. Yes
B. No

B is correct.

Although compulsory treatment might benefit her, the Mental Health Act 1983 states that Leola cannot be sectioned for medical treatment that does not relate to her mental state.

Even sectioned patients, who are capable of understanding, can refuse treatment for a physical condition that does not relate to their mental state.

Living Wills

A living will is a written document containing a person's preferences about life-sustaining treatment and about a proxy-decision maker.

The person completes the advance directive when competent, and it takes effect if the person becomes incompetent.

Properly constituted living wills are legally binding in some US states. In the UK, if patients were competent when the will was written and they accurately predicted the clinical circumstances which have now arisen, their views should be respected.

Pros

Proponents of the living will feel it has strong justification based upon the autonomous right of the individual to self-determination.

Cons

Opponents base their counter arguments on the uncertainty of medical prognosis, invalidation of consent and the concern that euthanasia could be condoned.

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Screening

Introduction

Discovering a disease in its early stages usually confers better long-term treatment outcomes for a patient and routine screening is now offered for a variety of conditions.

However an investigation of cervical screening services in Bristol showed that screening also has potential difficulties.

A distinguished physician recently noted that: 'By offering screening to 250,000, we have helped a few, harmed thousands, disappointed many and kept a few lawyers in work.'

Screening is entirely voluntary. Strong pressure is sometimes exerted on professionals, reflecting the financial inducements for screening.

Concerns associated with screening can be dispelled if patients are aware of correct and comprehensive information.

False positives in screening cause significant distress to the patient that can raise personal stress levels for as long as a year after the event.

Do you think the patient should be informed of the rate of false positives?

Side Effects

The side-effects of screening include:

- Anxiety
- False positives
- False reassurance
- Unnecessary investigations, biopsies etc.
- Over diagnosis and treatment
- Legal issues
- Employment and financial issues
    - It should be noted that legal, employment and financial issues are often overlooked in obtaining consent for screening. These have the potential to have important implications and should be fully explored where appropriate.
    - Consent is about managing patients' expectations as well as facilitating understanding and discussing options openly. Explaining the limitations of screening is an essential part of the process of consent.

Organ Donation

Opt-in Vs Opt Out

Organ donation and tissue transplantation give rise to a number of ethical issues and as the technology improves new dilemmas will probably arise.

In relation to organ donation, some countries have an opt-out system, whereby consent to donation is presumed unless a person carries a 'non-organ donor' card.

In England we have an opt-in system of organ donation, whereby organs cannot be taken without consent from the donor before death or from the relatives after the donor's death.

Relatives may be reluctant to give consent for various reasons.

Possible objections to consent

- Uneasiness at the thought of the body not being kept intact after death or the perception that the body is in some way sentient, that it is still able to perceive or feel things
- The feeling that certain organs are more important and are perceived as having symbolic significance, for example the eyes or heart
- A belief that it is disrespectful to tamper with the body of a dead person, who should be allowed to rest in peace
- Distrust of doctors – the concern that doctors may exceed ethical limits or incorrectly determine death
- The belief that transplantation goes against nature
- Religious and cultural reasons

A new approach to consent for organ removal was developed following the Alder Hey Inquiry to ensure that relatives' wishes are considered respectfully. Click on the link in resources to view the Alder Hey Inquiry.

Reasons for Withholding Consent

To the clinician, some or all of these concerns may seem misplaced but they should nonetheless be respected. Although you may not view them as sufficient for withholding consent, which of the following reasons would you empathise with?

A. The illusion of sentience in a dead body; that it is in someway still alive
B. The need to respect the dead
C. Distrust of the medical establishment
D. The belief that transplantation is contrary to nature
E. Religious and cultural reasons

According to an opinion poll on Health Care Skills three quarters of people empathise with the **need to respect the dead** and three quarters also select **religious and cultural reasons**.

Almost a third identify with the illusion of sentience in a dead body; that it is in someway still alive and a quarter of people distrust the medical establishment. The belief that transplantation is contrary to nature is shared by less than a fifth of people.

Self Assessment Questions (Answers are shown after Question 6)

Question 1

Consent is always necessary. Which of the following forms of consent are recognised by the law?

A. Oral
B. Written
C. Implied

Question 2

Which of the following criteria would you think are strictly necessary to confirm the validity of consent?

A. The doctor taking consent does the procedure
B. The patient must be competent to take the decision
C. The patient must be over the age of 17
D. The patient must not be acting under duress
E. If the patient is unconscious a blood relative must consent
F. The patient must have received sufficient information

Question 3

A seventy year old male with peripheral vascular disease requires an external iliac artery angioplasty.

Can you list below the specific factors that you would mention during the consenting process?

A. Technical approach
B. Alternative options
C. Failure to recanalise
D. Groin haematoma
E. Distal embolization
F. Limb loss

Question 4

An elderly male patient with a single kidney presents acutely with a pyonephrosis due to an impacted distal ureteric stone. Retrograde ureteric catheterisation has failed or is not appropriate and percutaneous nephrostomy is indicated.

A. Alternative options
B. Systemic bacteraemia
C. Failure to place nephrostomy
D. Intra-or peri-renal haematoma
E. Perforation of collecting system

Question 5

In both the preceding scenarios, what other general information would you be expected to give that applies to all consent episodes?

A. Your name and status
B. Level of discomfort or pain
C. Analgesia
D. Reassure
E. Monitoring apparatus
F. Period of observation

Question 6

Which of the list below are critical factors required to ensure that a consenting procedure is appropriate and valid?

A. Shared decision making
B. Voluntary
C. Competence
D. Sufficient information

Self Assessment Questions with Answers

Question 1

Consent is always necessary. Which of the following forms of consent are recognised by the law?

A. Oral
B. Written
C. Implied

Answers:

The law recognises that consent can take many forms, depending on the circumstances, and all of the options are acceptable.

Question 2

Which of the following criteria would you think are strictly necessary to confirm the validity of consent?

A. The doctor taking consent does the procedure
B. The patient must be competent to take the decision
C. The patient must be over the age of 17
D. The patient must not be acting under duress
E. If the patient is unconscious a blood relative must consent
F. The patient must have received sufficient information

Answers:

These statements are true:

- The patient must be competent to take the decision
- The patient must not be acting under duress
- The patient must have received sufficient information

Question 3

A seventy year old male with peripheral vascular disease requires an external iliac artery angioplasty.

Can you list below the specific factors that you would mention during the consenting process?

A. Technical approach
B. Alternative options
C. Failure to recanalise
D. Groin haematoma
E. Distal embolization
F. Limb loss

Answers:

A. Correct Technical approach: how the procedure is done in layman's terms
A. Correct Alternative options: conservative management, surgical bypass
B. Correct Failure to recanalise or target vessel re-occlusion (less than 10%)
C. Correct Groin haematoma: 3-4% (transfusion or surgery in less than 1%)
D. Correct Distal embolisation: requiring active treatment less than 1%
E. Correct Limb loss: less than 1%.

You must also specifically highlight **arterial rupture** (less than 1%) but this more commonly occurs in females.

Question 4

An elderly male patient with a single kidney presents acutely with a pyonephrosis due to an impacted distal ureteric stone. Retrograde ureteric catheterisation has failed or is not appropriate and percutaneous nephrostomy is indicated.

A. Alternative options
B. Systemic bacteraemia
C. Failure to place nephrostomy
D. Intra-or peri-renal haematoma
E. Perforation of collecting system

Correct Answers:

A. Correct. Alternative options: conservative management, retrograde ureteric catherisation.
A. Correct. Systemic bacteraemia requiring active treatment 5-10%.
B. Correct. Failure to place nephrostomy less than 5%.
C. Correct. Intra-or peri-renal haematoma 3-4% (transfusion, angiogram/embolisation in less than 1%).
D. Correct. Perforation of collecting system less than 1%.

Question 5

In both the preceding scenarios, what other general information would you be expected to give that applies to all consent episodes?

A. Your name and status
B. Level of discomfort or pain
C. Analgesia
D. Reassure
E. Monitoring apparatus
F. Period of observation

Correct Answers:

A. Correct. Your name and status: essential for the patient to be at their ease and only courteous!
B. Correct. Level of discomfort or pain to be expected with that procedure.
C. Correct. Analgesia that may be required and potential for sedation also.
D. Correct. Reassure that adequate staff will be present for monitoring purposes.
E. Correct. Describe monitoring apparatus that may be used during the procedure.
F. Correct. Discuss the period of observation or bedrest that may be needed post-procedure.

AND don't forget to ask the patient whether they have any other concerns they wish to highlight.

Question 6

Which of the list below are critical factors required to ensure that a consenting procedure is appropriate and valid?

A. Shared decision making
B. Voluntary
C. Competence
D. Sufficient information

Correct Answers:

The three critical factors required to ensure that a consenting procedure is appropriate and valid are:

- **Competence**: age is not greatly important (within reason) as long as the patient is conscious and capable of understanding your description of procedure and risks
- **Voluntary**: consent must be given freely and without the patient feeling powerless to object
- **Sufficient information**: and always ensure that you answer all direct questions, however difficult

It is best practice to ensure that a written record of your discussion is made, even if the patient is too ill to actually sign anything. A signed consent form may not necessarily protect you if the above factors are not also in place.

Shared decision making is part of the process of consent when there are two or more possible treatment options and would be part of the giving information process.

Session Key Points

- Patients have a right to determine what happens to their own bodies and consent to treatment is central to all forms of healthcare
- Consent is a patient's agreement for a health professional to provide care. This agreement may be implied, oral or written
- Seeking consent should always be a process of joint decision-making that reflects a recognition of people's dignity and autonomy
- Patients can only give their consent if they are competent to do so and the consent is voluntary based on sufficient information
- Any person taking consent is held legally responsible
- Children 16 years of age and over are considered capable of giving informed consent. A child can give consent, if the individual is capable of understanding the particular circumstances involved
- A living will is a written document containing a person's preferences about life-sustaining treatment and about a proxy-decision maker which takes effect if the person becomes incompetent
- In the UK organs cannot be taken without consent from the donor before death or from the relatives after the donor's death and the relatives may be reluctant to give consent

Session Summary

<u>Learning Objectives</u>

Having completed this session you will be able to:

- Determine an appropriate level of consent for any given procedure and patient
- Help patients reach informed decisions in the consent process
- Document the consent procedure and fill in consent forms
- Appreciate the ethical considerations of consent
- Utilise the guidelines on consent for organ donation

Capacity and Difficult Consent

Description

This session describes clinical scenarios involving patients with complex medical and ethical problems relating to consent, which clinicians will find challenging.

Learning Objectives

By the end of this session you will be able to:

- Recognise the need for involving mental health or more experienced personnel
- Identify patients who may need deprivation of liberty safeguards
- Identify how to minimise the risk of deprivation of liberty occurring
- Recognise legal frameworks when faced with challenging decisions about patient management

Introduction

The deprivation of liberty safeguards (DoLS) were introduced in the Mental Capacity Act (MCA) 2005 with the aim of protecting people in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards ensure that a care home or hospital only restricts someone's liberty when there is no other way of safely taking care of that person.

The DoLS legislation is complex; doctors need to be able to identify patients who may need to be deprived of their liberty in a hospital or care home.

Who is affected?

DoLS apply to anyone who:

- Is aged 18 years or older
- Is resident in England or Wales
- Is suffering a disease or disorder of the mind and lacks capacity to give consent to care/treatment
- Is receiving care or treatment that might amount to deprivation of liberty under article 5 of the European Convention of Human Rights

Unfortunately, there is no simple legal definition of deprivation of liberty and the decision as to whether or not a person has been deprived of their liberty is a legal question which ultimately can only be determined in a court of law.

Look at the statements below and decide if you think they may constitute a deprivation of liberty.

A. A patient being restrained in order to admit them to hospital
B. Medication being given against a person's will
C. Staff making all decisions about treatment choices and interventions
D. Staff deciding whether a patient can be discharged into the care of others
E. A patient losing autonomy because they are under continuous supervision and control

In each of these scenarios there could be a deprivation of liberty, and further discussion should take place with a senior clinician to decide whether or not an application needs to be made for DoLS.

The DoLS system provides a proper legal process and suitable protection for vulnerable people in whom deprivation of liberty seems to be unavoidable and in their best interests.

Risk Minimised

How might we minimise the risks associated with deprivation of liberty?

We can reduce the risk of deprivation of liberty occurring by:

- Ensuring that all decisions are taken and reviewed in a structured way, and the reasons for decisions recorded
- Ensuring that a patient's capacity to decide whether or not to accept care or treatment is carefully assessed and recorded
- Considering whether a person's care or treatment needs could be met in a less restrictive way
- Ensuring that restrictions are kept to the minimum necessary and for the shortest possible period
- Ensuring involvement of family, friends or carers, and if necessary involving advocacy services
- Ensuring decisions are shared by the multi-disciplinary team where possible
- Clearly documenting and regularly reviewing the care plan

It is important that you know the procedure in your hospital for DoLS and how to action any concerns.

Case Study 1

A 78-year-old lady (Mrs A) has enjoyed good health for most of her life. Having cared for her demented husband in the last few years of his life, she decided to make an advance decision to refuse treatment (ADRT), telling her friends 'I don't want to be kept alive when life's not worth living'.
In April she was treated by her GP with a short course of amoxicillin for a urinary tract infection. Two weeks later she became very confused with no other symptoms and was referred to the emergency department.

Initial observations and test results

Temperature	37.5
Blood pressure	135/85
Chest examination	Clear
Abdominal examination	Soft, non-tender BS present, PR not done
Cardiovascular examination	No abnormalities
Abbreviated mental test score	6/10
Hb	13.0 g/dl
Neuts	9 x 10
U/Es	Within normal limits
Pulse	88
O2 saturation	97%
Focal neurological signs	No
WCC	12.5 x 10
CRP	48.5 mg/L
Urinary dipstix	Normal
Chest x-ray	Within normal limits
Abdominal x-ray	Within normal limits

Question: What is the likely cause of Mrs A's confusion?

Answer on next page.

Answer:

Sepsis is the most likely cause of her acute confusional state (delirium) especially in view of the raised CRP and neutrophil count.

In the older person, sepsis is not always accompanied by classical signs, and in view of her recent treatment with antibiotics, *Clostridium difficile (C diff)* infection should also be considered.

Mrs A was admitted for further observation. That evening her niece phoned the ward and said that Mrs A had an ADRT and was not to receive any treatment. The following day Mrs A developed loose offensive stools and a presumptive diagnosis of *C diff* was made.

What would you do next?

A. Give Mrs A standard treatment for C diff

B. Withhold treatment until you have seen the ADRT

Correct Answer:

A. Correct. At this point you do not know if the ADRT exists, is valid or applicable, therefore Mrs A should be treated until further information is available.

B. Incorrect. As above, so witholding treatment would be potentially negligent.

<u>Advance Decision to Refuse Treatment</u>

It is important to establish:

1. Does the ADRT actually exist?

   If the ADRT concerns the refusal of life-sustaining treatment it must be written, witnessed and clearly indicate that Mrs A recognises the consequences of refusing life-sustaining treatment.

2. Is it valid?

   Mrs A is >18 years old and the limited biographical details available suggest that she had capacity to make an ADRT prior to the onset of her acute confusional state.

3. Is it applicable in these circumstances?

   The ADRT must be applicable to Mrs A's current circumstances, and the majority of ADRTs only apply when that person has reached a particular state. Mrs A's niece confirms that prior to this hospital admission her aunt enjoyed a good quality of life. She also brings in her ADRT (Fig 1).

I **(name, address)**

Make this declaration (colloquially known as a 'Living Will') this **(day, month, year)** to state my wishes in case I become unable to communicate and cannot take part in decisions about my medical care.

1 I HEREBY DECLARE that in the event I shall become terminally ill (as defined in clause 2 THEN I do not wish to be kept alive by medical treatment and I wish medical treatment to be limited to keeping me comfortable and free from pain

2 By 'terminally ill' I mean one or more of the following:

2.1 I am in a poor physical condition through illness or accident from which there is no likelihood of recovery and which is so serious that my life is nearing its end

2.2 My mental functions have become permanently impaired with no likelihood of improvement and the impairment is so severe that I do not understand what is happening to me AND I am in a poor physical condition through illness or accident

2.3 I become permanently unconscious with no likelihood of regaining consciousness

3 I further DECLARE that I have discussed my wishes herein declared with my doctor Dr **(name, address)** in consultation dated **(day, month, year)**.

IN WITNESS my hand this **(day, month, year)**

SIGNED BY THE ABOVE NAMED **(name, address)** a DECLARATION of her wishes in the presence of:

Witness signature:
Name:
Address:
Occupation:

Having looked at Mrs A's ADRT, do you think the ADRT is applicable?

1. Yes
2. No

B. Correct.

Mrs A was previously in good health and is not 'terminally ill', as defined in her ADRT. Currently she has a potentially curable condition and there is every likelihood that following treatment of the C diff infection she will be restored to her normal level of functioning.

Doctor's responsibilities are to enquire whether or not the patient has previously expressed wishes about how she would like to be treated. This includes ADRT and lasting power of attorney (LPA). If the patient is said to have either an ADRT or LPA, the doctor must determine whether or not these are valid and applicable in the current situation.

The MDU advises doctors that if an ADRT is valid and clearly applicable to the circumstances, it should be respected.

It is worth noting that the 13th British Social Attitudes Report shows that only 2% of the UK population have made advance decisions with 13% stating an intention to do so.

Summary

The MCA enables adults living in England and Wales to make decisions in advance regarding possible future treatment at a time when they might lack capacity to make such decisions.

ADRTs can be written or verbal, but refusal of life-sustaining treatment must be written, signed and witnessed and clearly state that the person understands the consequences of refusing life-sustaining treatment. Life-sustaining treatment is defined in the MCA as treatment that, in the view of the person providing healthcare to the person concerned, is necessary to sustain their life, and includes artificial nutrition and hydration.

Doctors have a responsibility to enquire about previously expressed treatment wishes (verbal, ADRT or LPA) and to ensure that they actually exist, are valid and applicable to the patient's current circumstances.

Case Study 2

A 23-year-old woman (Miss B) with history of personality disorder is brought to emergency department by her boyfriend. She took an impulsive overdose of 40 paracetamol tablets (500 mg each). She had been drinking alcohol prior to taking tablets and had an argument with her mother before she took the tablets.
While you are clerking her, she is tearful and wants to leave stating that she 'feels fine'. She has needle phobia and does not like hospitals. She does not feel that she needs any tests or treatment as she has taken paracetamol overdoses in the past and it has never harmed her. She refuses all investigations and treatments.

Can you stop her from leaving the department?

Question: Can she be restrained in order to admit her to hospital?

Yes. You can restrain her against her will if you feel she lacks capacity.

No. If you feel she has capacity you cannot restrain her even if you feel her decision is unwise. However you also have a duty of care to her and therefore need to take the following steps before you can allow her to go:

- You assess her medical and psychiatric risk. She has a previous history of self harm, personality disorder and lack of insight. Medically she has a high risk of liver damage due to the number of tablets (20 gm in total) she has taken with alcohol. This is the most common cause of acute liver failure, and an excess of 12 gm in total dose can be fatal
- Assess her capacity 'to refuse treatment'. It is important that Miss B makes an informed decision based on facts rather than her fear of hospitals and needles. Facilitate her decision by emphasising she could die from liver failure and why you want to keep her for observations. Ask her boyfriend if he can talk to her and do not rush her. You can say you will do bloods later. As she is refusing N-Acetylcysteine (treatment of choice) give option of oral methionine 2.5 g orally every 4 hours for four doses if within 12 hours of overdose
- Talk to senior medical staff and nursing staff and get advice

Legal Factors: If you feel she lacks capacity and decide to keep her in hospital what legal power can you use to stop her leaving?

- If she does not have capacity you apply principles of MCA (best interest principle). All medical treatment is provided under MCA.
- If she is trying to leave the hospital, you can call security to restrain her.
- If you believe she has a mental illness, you can apply section 5(2) of MHA, which allows you to detain her for 72 hours for observations. You inform psychiatrists you have applied this section and the patient is not allowed to leave the ward.
- All doctors above FY1 grade can authorise section 5(2) for assessment (*see session - Ethical and Legal Issues/11_04 Mental Capacity Assessment*).
- If psychiatry team conclude there is very high risk of suicide and she needs inpatient treatment, they can apply MHA section 2 or 3 for assessment and treatment of mental illness, not physical illness.

Capacity Factors: What factors may influence her capacity?

Factors which may influence her capacity:

- Recent alcohol intake
- Personality disorder
- Fear of hospitals and needles

The median mortality from suicide after deliberate self-harm is:

- 2% within the first year
- 7% in the first 10 years
- 15% thereafter

Summary

Deliberate self-harm is a common reason for emergency admission to hospital and is a risk factor for completed suicide.

All patients who attend hospital following attempting suicide or harming themselves should have a specialist mental health assessment before leaving, in addition to medical treatment (NICE guidance) (See session - Good Clinical Care/Self Harm Assessment).

If a patient lacks capacity in these acute situations, you can treat in the best interest of the patient.

If a patient has full capacity and refuses treatment for physical/medical complications, you must respect their wishes.

Case Study 3

Introduction

Mr D is a 51-year-old Scottish man with a long history of alcohol abuse. He was admitted after having been found unconscious, and neuroimaging showed a suprasellar space-occupying lesion, thought most likely to be a lymphoma. This lesion was treated with steroids which resulted in dramatic shrinkage, but shortly after this Mr D discharged himself.

He was readmitted 2 weeks later with pneumonia and type 2 respiratory failure which required admission to ICU and ventilation. He recovered slowly from this with improvement in his respiratory function, but remained confused and very aggressive towards staff and refused all interventions, claiming that God was the only person who could help him. He was reviewed by the liaison psychiatry team who made a diagnosis of schizophrenia.

Possible reasons could Mr D may have had for refusing further interventions:

- Possible reasons that Mr D may have for refusing further interventions:
- Lack of understanding of the consequences of refusal, because of his underlying mental disorder. Mr D may lack the capacity to understand the information he has been given, or the information may not have been given to him in a format that he can readily understand
- Depression, either long-standing or as a consequence of being told the diagnosis
- Alcohol withdrawal. This should be considered, although it is unlikely to occur at this late stage (typically alcohol withdrawal symptoms last for 5–7 days)
- Nicotine withdrawal
- Anger at diagnosis, or some aspect of his recent treatment
- Chronic delirium or post-traumatic stress following his ICU admission
- Misperceptions about the diagnosis, treatments or prognosis
- Acute confusional state
- Impaired cognition secondary to chronic alcohol abuse, space-occupying lesion or schizophrenia

Improving Decision Making

What actions might you initiate that might help Mr D improve his decision making?

Ways to help Mr D's decision-making ability could include:

- Address any clinical issues such as hypoxia, sepsis or side-effects from drugs such as analgesics
- Ensure drug history is accurate, paying regard to previous intake of alcohol, tobacco and recreational drugs
- Does Mr D have impaired cognition? If so search for a cause
- Does he have poor decision-making ability because of his schizophrenia? If so, will that change with drug treatment?
- Give Mr D information about his condition and check that he has understood it
- Involve others, such as friends, family members and mental health advocates

Further History

The medical team found it difficult to assess his capacity because of his disordered thinking and requested help from psychiatry colleagues. They felt that, because of his schizophrenia, he lacked capacity to make decisions about further investigations and treatment. It was felt that in his best interests he should be investigated and was subsequently shown to have pituitary dysgerminoma (good prognosis with 90% 5-year survival, usually treated by chemo- and radio therapy).

Mr D continued to refuse all interventions. After a further episode of aspiration pneumonia he was found to have an unsafe swallow which was treated with radiographic insertion of gastrostomy tube.

Mr D insisted that all he wanted was to go down to the pub and ‘have a few pints’. He continued to be extremely verbally abusive and racist towards staff, and needed one-to-one nursing because of his aggression (and on one occasion he was seen drinking water from the bathroom).

One Sunday morning the F2 was called to see him. The ward sister said 'he always kicks off at the weekend, and now he wants to discharge himself'.

As the F2, what would you do?

A. Ask security to restrain him
B. Use rapid tranquilisation procedure
C. Detain him under MHA
D. Detain him under DoLS
E. Inform senior clinician

Answers on next page.

Answers:

- **A.** Correct. Ask security to restrain him. This is appropriate only if you feel he is a danger to himself or others.
- **B.** Incorrect. Use of rapid tranquilisation procedure is inappropriate because of his history of type 2 respiratory failure. This should only be considered as a last resort, if full resuscitation facilities are available and under the direction of a senior clinician.
- **C.** Incorrect. This would only be applicable if you thought his behaviour was secondary to his mental health problem and would allow you to deliver treatment for his schizophrenia, not for his medical conditions.
- **D.** Incorrect. This is not appropriate at this stage; if however he needs restraint for a more prolonged period this is something that you may need to consider.
- **E. Correct.**

What to do Next?

Following discussion with your consultant and the weekend duty manager, a decision was made to give him IV haloperidol when his aggression was unmanageable. It was felt that he became more aggressive at weekends because he was then nursed by agency staff. The ward sister arranged for him to have consistent nursing at all times. He was prescribed regular IV haloperidol and security staff were regularly called to the ward to physically restrain him. During one of these incidents the hospital librarian entered his room; she subsequently visited PALS complaining that a patient was being assaulted and that she had noted that he was covered in horrific bruises.

What would you do next?

- Inform senior clinician
- Treat as critical incident
- Check his platelets and clotting
- Up haloperidol frequency so that security staff do not need to restrain him
- Up haloperidol dosage so that security staff do not need to restrain him

Deprivation of Liberty Safeguards?

Should an application for DoLS be made?

A. No, this is restraint not DoLS
B. No, because he has not been sectioned
C. No, because he is Scottish
D. No, this will only be needed if he is transferred to a care home
E. No, this will only be needed if he is transferred to a care home

Answers on next page

Answers:

A. False. DoLS should certainly be considered if restraint is needed for prolonged periods of time.

B. False. Person needs to have a mental health disability but does not need to have been sectioned.

C. False. Applies to residents of England and Wales.

D. False.

Summary

If someone lacks capacity to make a decision it may be possible to postpone the decision until their capacity has improved (except emergency situations). All efforts must be made to improve their capacity and if capacity fluctuates the capacity assessment should take this into account.

If someone lacks capacity to make a decision regarding a medical intervention the doctor needs to make a decision on their behalf, bearing in mind their previously expressed wishes and acting in their best interests.

Restraint can only be used when it is in the person's best interests, when there is reasonable belief that it is necessary to prevent harm. The least amount of force necessary should be used and for the shortest possible time.

The decision to restrain must be regularly reviewed; if restraint is applied for a prolonged period an application for a Deprivation of Liberty order may need to be considered.

Case Study 4

Introduction

Mr E is an 85-year-old with dementia who communicates mainly in Arabic. He presents with fever and a gangrenous foot and is seen by the surgeons who will be involved. They feel below knee amputation is the best treatment.

He refuses to have an operation and says to his family that he does not want any bother and wants to be left alone. You start antibiotics and pain relief.

His family ask you what you are going to do. They are willing to sign a consent form on his behalf as he has dementia.

The surgeons should proceed with amputation

Yes. Incorrect.
No. Correct.

You need to respect autonomy, apply principles of MCA and assess capacity. Just because he has dementia you cannot assume that Mr E does not have capacity. If a patient has capacity you cannot force him to have an operation.

His capacity may be influenced by poor understanding due to language barrier, delirium (due to infection, dementia) and pain.

Use a hospital interpreter (not family member) to ascertain why he does not want an operation and to discuss the benefits and risks of the operation.

Facilitate his decision making by optimising pain relief, improving sensory deficits and providing information in a way he can understand.

Family

Mr E is found to lack the capacity to make a decision about the amputation. You need to discuss with his family his previously expressed wishes and views about operations. The decision will need to be a multidisciplinary decision with surgeons, medical team, family, nurses and possible therapists (who will be involved in rehabilitation) to identify the best treatment for him at present. The decision maker will need to take into account the risks and benefits of conservative, versus operative treatment versus no treatment.

Can family sign the consent form?

A. Yes
B. No

Answer on next page.

Answer:

Yes. Incorrect. Reconsider your decision.

No. Correct.

Next of kin cannot sign the consent form unless they have a LPA that has been registered with the Office of the Public Guardian.

Summary

Knowing a person has dementia is not enough to say they cannot make a decision.

If patients with dementia made a LPA before they had dementia or in the early stages of dementia, then the attorneys can make decisions on the patient's behalf when they lack capacity.

Two types of LPAs replaced enduring power of attorney (EPA) in the MCA. A **property and affairs LPA** gives the attorney(s) the power to make decisions about financial and property matters and a **personal welfare LPA** gives the attorney(s) the power to make decisions about health and personal welfare, such as day-to-day care, medical treatment, consent for operations and do not attempt resuscitation (DNAR) decisions.

If there is no LPA and a patient lacks capacity, then the medical team has to make a best interests decision with regards to medical or surgical treatment.

Case Study 5

Introduction

Mr F is 55-year-old with bronchial carcinoma with liver and bony metastases. He is very optimistic, has a very positive attitude to life and lives with his wife and 15-year-old son. He has had several admissions over the past 3 months with recurrent malignant pleural effusions and chest infections. His oncology team has no further chemotherapy that will be helpful and he has a few weeks to live.

The team decision at the oncology MDT meeting is that cardiopulmonary resuscitation (CPR) would not be appropriate. His consultant has a long discussion with him but Mr F wants everything done, including CPR.

Would you sign the DNAR form?

Neither decision would be wrong.

This is a difficult question. Decisions about CPR raise very sensitive and potentially distressing issues for patients, relatives and some healthcare professionals. This must not prevent discussion, either to inform patients or involve patients in the decision-making process, where appropriate.

CPR is active medical treatment and patients cannot demand medical treatment if it is felt that it would not be beneficial. Mr F is at high risk of cardiorespiratory arrest and his chances of survival post-CPR are very limited. Doctors should not be offering futile interventions to patients, but in practice most consultants would not sign the DNAR if patient insisted he wanted CPR. All DNAR decisions are dynamic and can be reviewed at regular intervals.

The medical team should continue to discuss CPR with Mr F and it is particularly important to reassure him and his relatives that he will still get all symptomatic treatment. Unfortunately, many people misinterpret a DNAR order as ‘we’re no longer going to do anything for you’.

Cardiopulmonary Resuscitation Law

What legal aspects of CPR do you need to adhere to?

A. No specific law covering CPR
B. Constitutes an active medical treatment (so patient cannot demand this)
C. If competent patient demands CPR in event of arrest, then a doctor has to respect this
D. If a patient has a written advance care plan requesting CPR the doctor has to respect this

Answer on the next page

Answer

Decisions about CPR must be made on the basis of an individual assessment of each patient's case. Legally you do not have to discuss DNAR decisions with all patients. If it will cause more distress or if patients are too unwell, then the clinical team can make a best interests decision.

If a competent patient insists on CPR even when it is thought to be clinically futile, then this should be respected, but a series of discussions with the patient and family will usually be necessary to ensure that the overall situation is fully appreciated.

All relevant discussions about CPR and DNAR decisions should be clearly documented in patient's health records. It is important to document the patient's reasoning and understanding about DNAR forms. DNAR decisions apply only to CPR and not to any other aspects of treatment.

In terminal phases of cancer and chronic progressive diseases (e.g. motor neurone disease (MND), chronic obstructive pulmonary disease (COPD), congestive cardiac failure (CCF) and end-stage dementia) advance care planning, including making decisions about CPR, is an important part of good clinical care for those at risk of cardiorespiratory arrest.

<u>Summary</u>

Decisions about CPR must be made on the basis of an individual assessment of each patient's case, involving multidisciplinary teams as much as possible.

A DNAR decision does not override clinical judgement if there is a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged (e.g. respiratory arrest due to mucus plugging in a patient with metastatic cancer).
Advance care planning should include decisions around CPR for those at risk of cardiorespiratory arrest (i.e. end stage CCF, COPD, dementia, MND, extensive stroke).

It is not necessary to initiate discussion about CPR with a patient if there is no reason to believe that the patient is likely to suffer a cardiorespiratory arrest.

A patient cannot demand CPR through an advance care plan but if a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable ADRT refusing CPR, this should be respected.

Session Key Points

- Every one has capacity until proven otherwise
- Capacity can be temporarily influenced by drugs, alcohol, illness, fear, depression and delirium. Individuals must be supported and given as much help as possible to enable them to make their own decisions
- If a patient lacks capacity, apply the five principles of the MCA. When acting in the person's best interests the least restrictive intervention should be carried out
- Emergency treatment can be applied under the best interests principle of the MCA
- Legal obligation may be different from moral and ethical obligation
- It is important to clearly document all decisions, provide clear handover and involve multidisciplinary team members for challenging and complex patients

Session Summary

<u>Learning Objectives</u>

Having completed this session you will be able to:

- Recognise the need for involving mental health or more experienced personnel
- Identify patients who may need deprivation of liberty safeguards
- Identify how to minimise the risk of deprivation of liberty occurring
- Recognise legal frameworks when faced with challenging decisions about patient management