



Registered Charity 1092333

Hart First Response

Communication, Consent and Being Open Policy

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Author: Hester Wain
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1. Summary

- 1.1. This policy states the legal and ethical basis for communication with patients, ensuring consent to treatment, the provision of patient information, being open when harm occurs and treating patients appropriately and with due consideration to their wishes and best interest. This policy is in accordance with the requirements laid down by the Department of Health with respect to seeking consent for examination and treatment of a patient.
- 1.2. Patients have fundamental legal and ethical rights in determining what happens to their own bodies. Valid consent to treatment is therefore absolutely central to all forms of healthcare, from providing personal care to more invasive interventions.
- 1.3. Seeking consent is also a matter of common courtesy between health professionals and patients. All discussion regarding proposed assessment or treatment should be documented, this must include the patient's decision around which treatment is accepted and declined. A good level of communication will facilitate informed consent through to the management of non consent.
- 1.4. It is not uncommon in pre-hospital situations for patients to refuse care or treatment. Although patients may refuse, there is still, in certain circumstances, an ongoing moral duty and legal responsibility for healthcare providers to provide further intervention. This procedure provides guidance on how these situations should be managed.
- 1.5. The Department of Health has issued guidance documents on consent, which may be consulted for good practice and legal guidance.
- 1.6. This policy applies to all Hart First Response volunteers and covers:
 - Communication
 - Being open
 - Consent
 - Restraint

2. Related Policies, Procedures and Acts

- HFR Information Governance Confidentiality and Data Protection Policy
- HFR Safeguarding policy
- HFR Health and Safety Policy
- HFR Risk Management and Incident Reporting policy

- Being open: communicating patient safety incidents with patients, their families and carers NPSA/2009/PSA003
- Confidentiality: NHS code of practice (DH, 2003)
- Department of Health Reference Guide to Consent for Examination or Treatment. The Stationary Office: London.
<http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Consent/index.htm>
- East Midlands Ambulance Service NHS Trust Consent Policy 2010
- Essential Standards of Quality and Safety Care Quality Commission 2010
- General Social Care Council and the Health Professions Council
- GMC Good Medical Practice: Good communication http://www.gmc-uk.org/guidance/good_medical_practice.asp



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- Good practice in consent: achieving the NHS plan commitment to patient centred consent practice (Health Service Circular HSC 2001/023)
- Guide to the public sector equalities duties (Equality and Human Rights Commission, 2009)
- Human Rights in Health Care – A Framework for Local Action (DH)
- Independence, Choice and Risk: A Framework for Supported Decision Making (DH, 2007)
- JRCALC (2006). Clinical Practice Guidelines.
- Mental Capacity Act Code of Practice (2008)
- Mental Capacity Act, 2005 (www.legislation.gov.uk/ukpga/2005/9/contents)
- Real involvement: working with people to improve services (DH, 2008)
- Research governance framework for health and social care: Second edition (DH, 2005)
- Seeking Consent: working with children (DH, 2001)
- Self Harm CG16 NICE
- The NHS Constitution (DH, 2009)
- Valuing People Now: a new three-year strategy for people with learning disabilities – Making it happen for everyone (HM Government, 2009)
- West Midlands Ambulance Service NHS Trust Consent Policy 2010

3. Responsibilities

- 3.1. The Executive Committee is responsible for the effectiveness of this policy. They will therefore monitor performance of HFR in respect of its response to all issues of communication, consent, being open and use of restraint and review trends identified from these as identified within this policy.
- 3.2. The Honorary Secretary (Hon. Sec.) is the Executive lead responsible for the implementation and monitoring of this policy. The Hon. Sec. will ensure:
 - Issues are dealt with in a timely and appropriate way.
 - Undertake any detailed investigation required.
 - That an accurate record of the investigation is kept.
 - That any changes in national guidance are disseminated appropriately.
 - Provide guidance, support and where necessary direct assistance to other volunteers in respect of these matters.
- 3.3. All volunteers have a responsibility to read, understand and implement this policy.
- 3.4. Anyone who does not respect the principles set out in this document may be liable to legal action from the patient and where appropriate their registering body.

4. Definitions

- 4.1. Valid Consent: The voluntary and continuing permission of the patient to be given a particular examination, treatment, operation or examination. Consent is only valid where it is given by an appropriately informed person who has the capacity to consent to the intervention in question
- 4.2. Informed Consent: A patient's consent to a clinical procedure (or to participation in a research study) after being advised of all relevant facts and all risk involved.
- 4.3. Capacity to Consent: The ability to receive, understand and retain information long enough to be able to make a decision. An individual must be assumed to have capacity unless it has been determined that they lack capacity.
- 4.4. Duration of Consent: The length of approval gained by valid consent being given. This generally remains valid unless it is withdrawn by the patient, however, new information should be given to the patient as it arises, and consent regained.
- 4.5. Duty of Care: The absolute responsibility of a healthcare provider to treat and care for a patient with a reasonable degree of skill and care.
- 4.6. Best Interests: An act done or decision made under the Mental Capacity Act for or on behalf of a person who lacks capacity.



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5. Communication

Communication is a key part to any healthcare provider's interaction with a patient. Healthcare providers have a duty to:

- 5.1. Introduce themselves by name to the patient.
- 5.2. Explain and discuss the care, treatment and support options with patients.
- 5.3. Respect the patient's right to take informed risks, while balancing the need for preference and choice with safety and effectiveness.
- 5.4. Promote and respect their privacy, dignity, independence and human rights by:
 - 5.4.1.1. placing the needs, wishes, preferences and decisions of people who use services at the centre of assessment, planning and delivery of care, treatment and support
 - 5.4.1.2. ensuring that the environment allows privacy in which the intimate care, treatment and support needs of the person who uses services are met
 - 5.4.1.3. having clear procedures followed in practice, monitored and reviewed that ensure volunteers understand the concepts of privacy, dignity, independence and human rights and how they should be applied to the people who use the service
 - 5.4.1.4. ensuring that the need to maintain confidentiality or disclose information is taken account of in the assessment of the individual circumstances
 - 5.4.1.5. actively listening to and involving people who use services, or others acting on their behalf, in decision making.
- 5.5. Provide information to help people who use services, or others acting on their behalf, to understand their care, treatment and support, including the risks and benefits, and their rights to make decisions.
- 5.6. Respect and accommodate the choices of people who use services unless:
 - 5.6.1.1. the choice places other people at risk of harm or injury
 - 5.6.1.2. it would not be reasonable to expect the service to have the resources needed to achieve the choice
 - 5.6.1.3. it is not within the provider's stated aims, objectives and purpose to meet the choice
 - 5.6.1.4. the person who uses the service does not have capacity to make that decision
 - 5.6.1.5. the person who uses the service is subject to a legal restriction that prohibits them making a choice.
- 5.7. Ensure that volunteers recognise and respect the diversity and human rights of people who use services and that they are aware of, understand and recognise the person's social and cultural diversity, values and beliefs that may influence patient's decisions and how patients want to receive care, treatment and support.
- 5.8. Ensure that any equipment is used in a way that has regard to the patients dignity, comfort and safety and promotes their independence
- 5.9. Ensure that people who use services can be confident that the outcome of diagnostic tests and assessments will be explained and discussed with them in a way which they are able to understand and which enables them to make informed choices about their care, treatment and support.
- 5.10. Make people who use services aware of independent advocacy services wherever they are available.
- 5.11. Cooperate with independent advocacy services wherever a person who uses services uses one.
- 5.12. Ensure continuity in the patients care, treatment and support as a result of effective communication between all of those who provide it, including other providers such as NHS Ambulance Services. This means that the patient needs to be informed that their



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information will be given to the NHS Ambulance staff and where possible the patient needs to be included in the verbal handover to NHS Ambulance staff. Verbal handover will be based on the SBAR communication tool see appendix 4.

5.13. To communicate effectively volunteers need to:

- 5.13.1. Listen to patients, ask for and respect their views about their health, and respond to their concerns and preferences
- 5.13.2. Share with patients, in a way they can understand, the information they want or need to know about their condition, its likely progression, and the treatment options available to them, including associated risks and uncertainties
- 5.13.3. Respond to patients' questions and keep them informed about the progress of their care
- 5.13.4. Make sure that patients are informed about how information is shared within teams and among those who will be providing their care.
- 5.13.5. Make sure, wherever practical, that arrangements are made to meet patients' language and communication needs.

5.14. **Communicating with relatives**

- 5.14.1. Appropriate communication with the patient's family, friends and other carers is also important. The patient's nearest and dearest often provide invaluable reassurance and support to their loved one and they will want to be kept informed so that they can understand how best to help.
- 5.14.2. However, any information provided to a family member must be within the context of the duty of confidentiality owed to the patient. Often patients will appreciate you speaking to their relatives and updating them of events, but don't assume this is always the case.
- 5.14.3. It is important to establish early on what information the patient would want to be shared, in what circumstances and with whom.
- 5.14.4. The basic principle is that you should only disclose confidential information about a competent adult patient if they consent for you to do so. This means you should seek permission from the patient to speak to their relatives. The patient will need to know what you intend to discuss with their family before they can give informed consent. Make sure they are aware that this may include aspects of their medical history that are relevant to the current illness but which may be sensitive, for example, certain infectious diseases or termination of pregnancy.
- 5.14.5. It can be helpful to have discussions with family members in the presence of the patient to avoid any confusion about what you have said.
- 5.14.6. Young people should be asked if they agree for their parents or guardians to be involved in decisions they need to make.

5.15. **Difficult Situations**

- 5.15.1. Responding to behaviour that presents a risk to healthcare providers or others requires good verbal and non-verbal communication skills.
- 5.15.2. HFR volunteers need to:
 - 5.15.2.1. Understand the value of a stimulating environment, meaningful activity and effective communication in preventing behaviour that presents a risk, taking into account that over-stimulation can sometimes adversely impact the behaviour of people who use services.
 - 5.15.2.2. Understand what can potentially trigger behaviour that presents a risk for each person or to others.
 - 5.15.2.3. Have the skills and knowledge to respond at an early stage and do so to reduce the likelihood of this behaviour happening or recurring.
 - 5.15.2.4. Respond in a person-centred way.



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5.15.2.5. Have the opportunities to talk about how they prevent and manage behaviour with others so that learning is shared and the risk of further incidents is reduced.

6. Being Open

- 6.1. Communicating effectively with patients, their families and carers is a vital part of the process of dealing with patient safety incidents in healthcare. Research has shown that patients are more likely to forgive medical errors when they are discussed in a timely and thoughtful manner, and that being open can decrease the trauma felt by patients following a patient safety incident.
- 6.2. The ten principles of being open adapted from national patient safety agency are detailed in appendix 3.
- 6.3. Openness also has benefits for healthcare providers as it can: help to reduce stress through the use of a formalised, honest, communication method; alleviate the fear of 'being found out'; and improve job satisfaction by:
 - 6.3.1. ensuring that communication with patients, their families and carers has been handled in the most appropriate way;
 - 6.3.2. helping the healthcare professional to develop a good professional reputation for handling a difficult situation properly; and
 - 6.3.3. improving the healthcare professional's understanding of incidents from the perspective of the patient, their family and carers.

6.4. The Being Open Process

- 6.5. The Being Open process begins with the recognition that a patient has suffered harm as a result of a patient safety incident.
- 6.6. As soon as a patient safety incident is identified, the top priorities are prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the patient and with appropriate consent.
- 6.7. This will be followed by:
 - 6.7.1.1. Verbal acknowledgement and apology to the patient
 - 6.7.1.2. Completion of an Incident form and following incident reporting and investigation policy
 - 6.7.1.3. Root Cause Analysis investigation by the HFR Exec
 - 6.7.1.4. Feedback to the patient and volunteers involved by the HFR Exec
 - 6.7.1.5. Learning lessons from the incident and disseminating these to all volunteers
- 6.8. The initial discussion with the patient and/or their carers should proceed in the following manner:
 - 6.8.1.1. The patient and/or their carers should be advised of the identity and role of all people attending the *Being Open* discussion before it takes place. This allows them the opportunity to state their own preferences about which staff should be present
 - 6.8.1.2. There should be an expression of genuine sympathy, regret and an apology for the harm that has occurred
 - 6.8.1.3. The known facts are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed. The patient and/or their carers should be informed that an incident investigation is being carried out and more information will become available as it progresses
 - 6.8.1.4. It should be made clear to the patient and/or their carers that new facts may emerge as the incident investigation proceeds



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- 6.8.1.5. The patient's and/or carer's understanding of what happened should be taken into consideration, as well as any questions they may have
 - 6.8.1.6. There should be consideration and formal noting of the patient's and/or carer's views and concerns, and demonstration that these are being heard and taken seriously
 - 6.8.1.7. Appropriate language and terminology should be used when speaking to patients and/or their carers. For example, using the terms 'patient safety incident' or 'adverse event' may be at best meaningless and at worst insulting to a patient and/or their carers. If a patient's and/or their carer's first language is not English, or they have other communication difficulties, their language needs should be addressed as well as providing information in both verbal and written formats
 - 6.8.1.8. An explanation should be given about what will happen next in terms of the long term treatment plan and incident analysis findings, in which the patient will have the opportunity to be involved
 - 6.8.1.9. Information on likely short and long term effects of the incident (if known) should be shared. The latter may have to be delayed to a subsequent meeting when the situation becomes clearer. Some patients may not wish to know every detail of an incident. They should be reassured that if they change their minds, this information will be made available to them
 - 6.8.1.10. An offer of practical and emotional support should be made to the patient and/or their carers. This may involve giving information on third parties such as charities and voluntary organisations to the patient/carer, as well as offering more direct assistance. Information about the patient and the incident should not normally be disclosed to third parties without the patient's consent. The patient may not wish third parties to know every detail of the incident.
 - 6.8.1.11. The patient/carer should be given the contact details of one member of HFR Exec who will act as a contact point for them. Their role will be to provide both practical and emotional support in a timely manner
 - 6.8.1.12. It should be explained to the patients that they are entitled to continue to receive all usual treatment and continue to be treated with respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere
 - 6.8.1.13. Patients/Carers should be given information on the complaints procedure and offered assistance if they wish to make a complaint
- 6.9. After completion of the incident investigation, feedback should take the form most acceptable to the patient. Whatever method is used, the communication should include:
- 6.9.1.1. the chronology of clinical and other relevant facts
 - 6.9.1.2. details of the patient's and/or their carer's concerns and complaints
 - 6.9.1.3. a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety incident
 - 6.9.1.4. a summary of the factors that contributed to the incident
 - 6.9.1.5. information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored

7. Consent

- 7.1. Before you examine, treat or care for your patient you should obtain their consent. Valid consent can only be given by the patient (or, where relevant, someone with parental responsibility for a child or young person) Or an appropriate representative if patient does not have the capacity to consent, this includes where there is an Advanced Directive in place.



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- 7.2. Patients can change their mind and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them. Consent should be continuous – if previously unexplained treatment is carried out, further consent should be gained.
- 7.3. Information on consent is available in all the PRF booklets (see appendix 2)
- 7.4. Three basic tests are used to ensure that consent is valid:
- 7.4.1. **Does the patient have capacity?** Is the patient able to comprehend/understand and retain information material to the decision, and use that information material to the decision, believe it and use that information, bearing the full consequences in mind?
 - 7.4.2. **Is the consent given voluntarily?** Consent is only valid if given freely, with no pressure or undue influence to accept or refuse treatment.
 - 7.4.3. **Has the patient received sufficient information?** The patient should understand, in broad terms, the nature and purpose of the procedure. Failure to provide all relevant information may render the healthcare provider liable to an action for negligence.
- 7.5. Key Points – Consent**
- 7.5.1. Gaining valid consent is central to all forms of healthcare.
 - 7.5.2. Consent is only valid if it is given freely by a person who has all the relevant facts, is able to assimilate them, and can fully understand the implications of their decision. (i.e. has capacity)
 - 7.5.3. Patients can change their minds and withdraw consent at any time.
 - 7.5.4. Young persons who have the intelligence to fully understand the proposed treatment also have the capacity to consent to such treatment.
 - 7.5.5. The rules of consent do not absolve healthcare providers of their duty of care, nor do they affect the human rights of patients.
- 7.6. Patient Information**
- 7.6.1. The type of information that needs to be given by the healthcare provider will vary depending on circumstance and urgency, but the following is a useful guide to the type of information the patient should receive prior to treatment:
 - 7.6.1.1. Description and method of treatment, removal and ongoing care.
 - 7.6.1.2. Purpose and reason for treatment, removal and ongoing care.
 - 7.6.1.3. Possible complications and side effects of treatment.
 - 7.6.1.4. Treatment options; including the option not to treat and the likely consequences.
 - 7.6.1.5. Explanation of likely benefits of treatment.
 - 7.6.1.6. A reminder that the patients can change their mind about consent at any time.
 - 7.6.2. In practice patients also need to be able to communicate their decision.
 - 7.6.3. Care should be taken not to under-estimate the ability of a patient to communicate, whatever their condition. Many people with learning disabilities have the capacity to consent if time is spent explaining to the individual the issues in simple language, using visual aids. Healthcare providers should take all steps that are reasonable in the circumstances to facilitate communication with the patient, using interpreters or communication aids as appropriate, whilst allowing for the urgency of the situation.
 - 7.6.4. Adults are presumed to have capacity, but where any doubt exists, the healthcare provider should assess the capacity of the patient to make the decision in question. This assessment and the conclusions drawn from it should be recorded in the healthcare record (PRF).
 - 7.6.5. In an emergency/time critical situation where consent cannot be obtained, emergency healthcare providers should provide treatment that is in the patient's best interests and is immediately necessary to save life or avoid significant deterioration in the patient's health.



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7.7. Adults without Capacity - Temporary; Fluctuating and Long Standing Incapacity Assessing Capacity

7.7.1. A person must be assumed to have capacity unless it has been established that they lack capacity. The Mental Capacity Act 2005 defines how to assess the capacity of anyone aged over 18 years of age. Adults who usually have capacity may, especially in emergency situations, become temporarily incapable. Adults without capacity are defined as failing one the three tests below:

- 7.7.1.1. **understand** the information given to them that is relevant to the decision;
- 7.7.1.2. **retain** that information long enough to be able to make the decision;
- 7.7.1.3. use or **weigh up** the information as part of the decision making process;
- 7.7.1.4. **communicate** their decision – this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

7.7.2. In such circumstances it is permitted to apply treatments that are necessary and no more than is reasonably required in the patient's **best interest** pending the recovery of capacity. This includes any action taken to preserve the life, health or well-being of the patient, and can include wider welfare considerations. Where possible, a GP or professional carer should be fully involved if there is doubt concerning the patient's capacity.

7.8. Best Interest

- 7.8.1. To treat the patient in his/her own best interests consider:
- 7.8.2. Involving the person that lacks capacity
- 7.8.3. Have regard for past and present wishes and feelings especially written statements
- 7.8.4. Consult with others who are involved in their care
- 7.8.5. Ensure there is no discrimination
- 7.8.6. The PRF should detail advice and guidance given to the patient, or any referral to specialist staff, ideally signed by the patient (although this simply confirms their presence) and witnessed by a third party.

7.9. Refusal and Withdrawal of Consent

7.9.1. If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment, or decides to withdraw their consent at any time, their decision should be respected. Refusal of consent could include refusing to:

- allow use of the suggested equipment
- accept a copy of the PRF
- accept an advice card

7.9.2. When a patient refuses to consent to any part of the treatment process this should be clearly documented on the PRF.

7.9.3. Exceptions exist for children and some patients under the various Mental Health Acts. If a child makes a decision to refuse or withdraw consent, this can be overridden provided the consequences of refusal are so grave that the child could not possibly fully understand the implications of their decision.

7.9.4. A patient with capacity is entitled to withdraw consent at any time. The healthcare provider should stop the procedure, establish the patient's concerns, and explain the consequences of withdrawal. If, however, stopping a procedure at that point may reasonably be seen to put the patient's life at risk, then the healthcare provider may continue until such risk no longer applies. If this is not possible document the facts on the PRF.

7.9.5. Withholding or withdrawing treatment is not an option for healthcare providers unless consent is withdrawn, as duty of care and the patient's human rights would be jeopardised.



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7.9.6. Patients often refuse treatment and remain at the location, as is their right. There is, however, a responsibility to provide treatment against a patient's wishes in specific circumstances.

7.10. Documentation of Non Transportation

7.10.1. If a patient declines transportation to a treatment centre a PRF must be completed, detailing advice and guidance given to the patient, or any referral to specialist staff, ideally signed by the patient (although this simply confirms their presence) and witnessed by a third party.

7.11. Children and Young People

- The legal position concerning consent and refusal of treatment by those under the age of 18 is different from the position for adults, in particular where treatment is being refused. Where a person under the age of 18 refuses treatment, but consent to treatment is given by a parent, then the parental consent is **valid**. In these circumstances the child should be treated/transported to hospital as appropriate.

7.11.1. Aged 16 - 17 years

7.11.2. Young people aged 16 and 17 years are presumed to have sufficient understanding and intelligence to be able to consent to their own medical treatment. As with adults, healthcare providers should ensure that consent is valid, i.e. given voluntarily by an appropriately informed patient, capable of consenting to the particular intervention. It is, however, good practice to involve the young person's family in the decision-making process, unless the young person specifically wishes to exclude them from the decision making process this needs to be documented on the PRF.

7.11.3. Critical situations involving children and young persons involving a life-threatening emergency may arise during a consultation with a person with parental responsibility who refuses consent, despite such emergency treatment appearing to be in the best interests of the child to prevent grave and irreversible mental or physical harm. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable for all healthcare providers to undertake treatment to preserve life or prevent serious damage to health.

7.11.4. Aged 16 years and under

7.11.5. With patients under the age of 16, those who have sufficient understanding and intelligence to fully understand what is proposed also have the capacity to consent to the intervention. This means that the level of capacity of children varies with the complexity of the treatment/refusal and its consequences. There is no particular age when a child gains capacity to consent. In emergency care, consequences of non-treatment are usually evident – but should be fully explained to ensure that a refusal to give consent is fully informed.

7.11.6. Where possible, the child or young person should be given the opportunity to express their wishes. If this is not possible or feasible, healthcare providers should seek to obtain consent from a person with parental responsibility.

7.11.7. The healthcare providers should ensure as much as reasonably practicable that they have correctly identified who has parental responsibility in circumstances where a child is unable to give consent.

7.11.8. As is the case where patients are giving consent for themselves, those giving consent on behalf of young patients should have the capacity to consent to the intervention in question, be acting voluntarily, and be appropriately informed and be acting in the best interests of the child. In the absence of a person with parental responsibility and a child without capacity, healthcare providers should act in the child's best interest.

7.12. Forms of Consent

7.12.1. Written

7.12.2. Verbal



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7.12.3. Non verbal - Implied (for example presenting an arm for a pulse check)

7.12.4. The majority of pre-hospital care is consented either verbally or non-verbally and this is documented on the PRFs by ticking a box. However, for use of media/photograph written consent (by patient signature) is required.

7.13. Consent and Research

7.13.1. Involvement in a research project requires that valid consent is obtained in writing before any research commences.

7.14. Consent to datasharing

7.14.1. Consent to datasharing should be asked for every PRF completed. The options are yes / no/ not asked.

7.14.2. The question to the patient should be phrased as follows: "If the organisers ask us for your name, address and date of birth as well as why and how we have treated you today, do you give permission for us to pass on your personal information".

7.14.3. If the injury is RIDDOR reportable, or during a Motorsport Association race, the patient must be clearly informed that their personal information will be shared and the yes option can then be completed.

7.14.4. For children under 16 years old without parents or guardians present the "Not asked" box should be circled.

7.15. Consent and Audit

7.15.1. Audit and monitoring are a standard part of quality healthcare practice and as such patients are not personally identified and consent is not needed.

7.16. Duty of Care, Consent and Human Rights

7.16.1. There is a professional, legal and moral consensus about the clinical duty to obtain informed consent. Patients may, however, have cognitive and emotional limitations in understanding clinical information. Social and economic variations are also important variables in understanding the practical difficulties in obtaining informed consent. It is the duty of healthcare providers to act in a patient's best interest by overcoming such difficulties so that the patient has a clear, unbiased and informed view of the care that is being proposed.

7.16.2. Negligence arises when the duty of care is breached and 'reasonably foreseeable harm' arises as a result. A lack of valid consent does not automatically absolve the carer of their duty of care, or risk of negligence.

7.16.3. The European Court of Human Rights has ruled that – 'Treatment without consent, invasive treatment contrary to a patient's best interest, and withholding medical care' can all be deemed 'inhumane or degrading treatment' in extreme cases.

7.16.4. Any healthcare provider who does not treat a needy patient because valid consent was not gained, could be deemed to be negligent if a genuine effort was not made to gain such consent.

7.17. Advance Refusals of Treatment

7.17.1. Patients may have a "living will" or "advance directive" specifying how they would like to be treated in the case of future incapacity. Case law is now clear that refusal of treatment under a living will or advance directive that is made voluntarily by an appropriately informed person with capacity and applicable to subsequent circumstances in which the patient lacks capacity, is legally binding. Healthcare providers should respect the wishes stated in such a document, when they are aware of its existence.

7.17.2. In a pre-hospital emergency environment, there may be situations where there is doubt about the validity of a living will or advance directive. If healthcare providers are not satisfied that the patient had made a prior and specific request to refuse treatment, they should continue to provide all clinical care in the normal way until the validity of the documentation is confirmed e.g. initially where a copy of the document does not appear to be valid but then the original document is handed to you.



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7.18. Self-Harm

- 7.18.1. Cases of self-harm present particular difficulties for healthcare providers. Where the patient is able to communicate, an assessment of their mental capacity should be made as a matter of urgency. If the patient is judged not to have capacity, they may be treated under the basis of temporary incapacity, as outlined above. Similarly, patients who have attempted suicide and are unconscious should be given emergency treatment in all circumstances.
- 7.18.2. In a pre-hospital setting, an instance of self-harm may require urgent intervention, such as in the case of a toxic drug overdose. If the patient refuses treatment, and the delay caused to clinical intervention is tolerable, the patient's GP should be urgently requested to attend the patient and fully assess their level of capacity. If the incident is more critical and there is insufficient time to arrange additional health care professionals, crews currently overcome most situations with commendable determination to act in the best interests of the patient. These practices should continue, but strict determination of the patient's capacity should be made.
- 7.18.3. Healthcare providers usually act intuitively to assess whether they perceive a patient is at risk of suicide. Where possible a formal risk assessment must be completed using the SAD PERSONS deliberate self-harm assessment tool. This should be clearly documented on the PRF.

7.19. Mental Health

- 7.19.1. Treatment involving mentally ill patients is covered by the Mental Health Act 1983, provided that the patient is formally detained under that act. Exceptions under the act only relate to treatment for the mental disorder itself, and not for other illnesses or conditions. This means that any patient detained under the Mental Health Act has every right to impart and deny consent for treatment for physical disorders not directly related to his/her mental illness. The capacity of a person with mental disorder may fluctuate. It is very likely that specialist nursing advice will be available in such circumstances.
- 7.19.2. Patients who have a learning disability may need extra care and explanation when consenting to treatment.

7.20. Consent for Patients whose First Language is not English

- 7.20.1. HFR is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare providers.
- 7.20.2. It is not best practice to use family members to interpret for the patient who does not speak English, however it is recognised that this may be the only option available, volunteers should use the NHS Confed/Ambulance Service Association's Multilingual Emergency Phrasebook that is available on all emergency vehicles. If volunteers are working with the local NHS Ambulance Service and language still is a barrier to effective communication, then they should contact the Emergency Operations Control Centres requesting assistance.

7.21. Clinical Photography and Conventional or Digital Photography

- 7.21.1. Photography intended to benefit the patient's treatment is seen as 'treatment' in itself, and requires valid consent. Photographs should be retained in the patient's healthcare record and no other copies are permissible.
- 7.21.2. Only HFR photographic equipment can be used by authorised persons for this purpose. No photographs are to be taken using personal media devices.
- 7.21.3. All other photography and motion pictures for purposes such as media promotion require patient and volunteer consent, which must be clearly documented in writing.

7.22. Exceptions to the Principle of Consent

- 7.22.1. An unborn foetus has no rights under consent law. A pregnant mother has every right to refuse treatment for herself or her foetus, irrespective of the potential harm that



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may arise to the foetus however the requirements of Safeguarding the unborn child under the Children's Act come into play and a safeguarding referral must be instigated without delay and a request made for support from the Safeguarding Officer.

7.22.2. The Public Health (Control of Disease) Act 1984 provides that, on an order made by the magistrate or sheriff, persons suffering from certain notifiable infectious diseases can be medically examined, removed to, and detained in hospital without their consent. Similarly, Section 47 of the National Assistance Act 1948 provides for the removal to suitable premises of persons in need of care and attention without their consent. Such persons should either be suffering from grave chronic disease or be aged, infirm or physically incapacitated and living in unsanitary conditions. These situations are extremely rare and healthcare providers should dial 999.

7.22.3. If a patient refuses decontamination treatment, for example following a chemical, biological, radiological or nuclear (CBRN) incident, healthcare providers should liaise with the Police, Health Protection Agency and Public Health laboratories to decide on an appropriate course of action. Powers lie within these groups to take action for the public good.

7.22.4. Treatment involving mentally ill patients is covered by the Mental Health Act 1983, provided that the patient is formally detained under that act. Exceptions under the act only relate to treatment for the mental disorder itself, and not for other illnesses or conditions. This means that any patient detained under the Mental Health Act has every right to impart and deny consent for treatment for physical disorders not directly related to his/her mental illness. It is very likely that specialist nursing advice will be available in such circumstances.

8. Restraint

8.1. In some cases, a patient who lacks capacity may resist treatment and the health professional may need to restrain that patient to administer the treatment. The Mental Capacity Act 2005 provides that a person may lawfully restrain a person who lacks capacity, providing that person believes it is reasonably necessary to prevent harm to the patient, and it is a proportionate response to the likelihood of the patient suffering harm and the seriousness of that harm.

8.2. Restraint means:

8.2.1. using, or threatening to use, force to secure the doing of an act which the patient resists; or

8.2.2. restricting the patient's liberty of movement, whether or not the patient resists.

8.3. Healthcare providers should only use restraint where absolutely necessary and should consider the least restrictive means of administering care or treatment. Intended restraint needs to be risk assessed to ensure the appropriate techniques are used. Any act by the healthcare provider that goes beyond restraint could amount to a deprivation of liberty within the meaning of Article 5(1) of the European Convention on Human Rights, which is unlawful.

8.4. The Mental Capacity Act (MCA) identifies two conditions which must be satisfied in Order for protection from liability for restraint to be available:

8.4.1. You must reasonably believe that it is necessary to restrain the person who lacks capacity in order to prevent them from coming to harm.

8.4.2. Any restraint must be reasonable and in proportion to the potential harm.

8.5. Types of restraint:

8.5.1. Overt (wrapping in blanket/ straps on carry chairs and stretchers)

8.5.2. Physical/Mechanical (held by persons, withdrawing of aids eg: zimmer)

8.5.3. Chemical (medication/sedation)

8.5.4. Psychological (stating a patient is not allowed to do something)

8.6. If any HFR volunteer feels that restraint is necessary, the NHS Ambulance Service (and Police if needed) should be contacted.



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- 8.7. If any restraint is used the type of restraint must be recorded on the PRF and logged as an incident.
- 8.8. Any use of restraint will be reviewed by the HFR Exec, who will undertake an assessment of all those involved for signs of injury and any emotional or psychological impact.

9. Staff training and support

- On induction HFR volunteers will receive training on Communication, consent, being open and restraint
- All HFR volunteers will receive annual mandatory training on Communication, consent, being open and restraint
- HFR volunteers will be made aware of this updated policy by members of the HFR Executive as appropriate.
- All HFR volunteers are assigned mentors (members of the HFR Exec) to whom they are encouraged to approach as a first point of contact in the event of a concern.

10. Policy Consultation

- This policy has been circulated to the HFR Executive and Medical Advisor for consultation.
- The policy will be approved by the HFR Executive with future reviews and updates tabled for approval at Exec meetings.

11. Dissemination

Once the policy has been approved a summary of relevant changes (and a link) will be disseminated via email to the HFR volunteers, and a pdf copy of the policy placed by a member of the Exec on the member's section of the website: www.hartresponse.org.uk

12. Monitoring of Compliance and Effectiveness

- Monitoring of the policy will be the responsibility of the HFR Executive. This will be through incidents reported on the HFR database, and annual audits. Actions and lessons learned from incident investigations will be monitored through the HFR Executive. Where any omissions or deficits have been noted results and action plans will be monitored through the HFR Executive.
- Lessons learned will be disseminated to the HFR volunteers through email briefings or via weekly training sessions.
- HFR will provide all required reports to the Care Quality Commission

13. Implementation

- The HFR Executive are responsible for communicating this information to HFR volunteers and ensuring that the procedures are followed.
- All HFR policies are available on the Hart First Response website www.hartfirstresponse.org.uk.

14. Archive Statement

The Honorary Secretary is responsible for archiving all previous versions and supporting evidence of approval for this policy.

15. References

- Being open: communicating patient safety incidents with patients, their families and carers NPSA/2009/PSA003
- Confidentiality: NHS code of practice (DH, 2003)
- Department of Health Reference Guide to Consent for Examination or Treatment. The Stationary Office: London.
<http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Consent/index.htm>



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- East Midlands Ambulance Service NHS Trust Consent Policy 2010
- Essential Standards of Quality and Safety Care Quality Commission 2010
- General Social Care Council and the Health Professions Council
- GMC Good Medical Practice: Good communication http://www.gmc-uk.org/guidance/good_medical_practice.asp
- Good practice in consent: achieving the NHS plan commitment to patient centred consent practice (Health Service Circular HSC 2001/023)
- Guide to the public sector equalities duties (Equality and Human Rights Commission, 2009)
- Human Rights in Health Care – A Framework for Local Action (DH)
- Independence, Choice and Risk: A Framework for Supported Decision Making (DH, 2007)
- JRCALC (2006). Clinical Practice Guidelines.
- Mental Capacity Act Code of Practice (2008)
- Mental Capacity Act, 2005 (www.legislation.gov.uk/ukpga/2005/9/contents)
- Real involvement: working with people to improve services (DH, 2008)
- Research governance framework for health and social care: Second edition (DH, 2005)
- Seeking Consent: working with children (DH, 2001)
- Self Harm CG16 NICE
- The NHS Constitution (DH, 2009)
- Valuing People Now: a new three-year strategy for people with learning disabilities – Making it happen for everyone (HM Government, 2009)
- West Midlands Ambulance Service NHS Trust Consent Policy 2010



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Appendix 1

SAD PERSONS: Suicide and self-harm risk assessment

Mnemonic	Characteristic	Score
S	Sex Male	1
A	Age <19 or >45	1
D	Depression, hopelessness	1
P	Previous attempts at self harm	1
E	Ethanol (evidence of excess alcohol) or illicit drug use	1
R	Rational thinking absent	1
S	Separated, widowed, divorced	1
O	Organised, serious attempt / life-threatening presentation	1
N	No social support – no close/reliable family, job or active religious affiliation	1
S	Stated future attempt (determined to repeat), or ambivalent	1

Scores (JRCALC):

- < 3 = **Low Risk** indicates that the patient may probably be discharged
- 3 - 6 = **Medium Risk** or more requires psychiatric referral for consultation
- > 6 = **High Risk** means that the patient will require hospital admission



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Appendix 2 Information on Consent in PRF booklet

Before we examine or treat you, we need your consent. If you later change your mind, you're entitled to withdraw consent at any time.

We will explain:

- ◆ How we intend to examine, or treat you.
- ◆ What the main treatment options are.
- ◆ What alternative treatments are available (*including no treatment*).
- ◆ What the intended benefits are.
- ◆ What risks (if any) may be associated with these treatments.
- ◆ Any extra procedures which may become necessary during the treatment.
- ◆ How you can expect to feel afterwards.

We will ask you:

- ◆ If you have any illnesses, or allergies which you may have, or have suffered from in the past.
- ◆ If you have any particular concerns.
- ◆ If there is any procedure you don't want to happen.
- ◆ If you consent to treatment.



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Appendix 3: Ten Principles Of Being Open adapted from National Patient Safety Agency

1. Principle of acknowledgement

- All patient safety incidents should be acknowledged and reported as soon as they are identified.
- Any untoward incident must be taken seriously from the outset.
- Any concerns should be treated with compassion and understanding.

2. Principle of truthfulness, timeliness and clarity of communication

- Information about a patient safety incident must be given to patients and/or their carers in a truthful and open manner by an appropriately nominated person.
- Patients want a step-by-step explanation of what happened, that considers their individual needs and is delivered openly.
- Communication should also be timely: patients and/or their carers should be provided with information about what happened as soon as practicable. It is also essential that any information given is based solely on the facts known at the time.
- Healthcare providers should explain that new information may emerge as an incident investigation is undertaken, and patients and/or their carers should be kept up-to date with the progress of an investigation.
- Patients and/or their carers should not receive conflicting information from different volunteers, and using medical jargon which they may not understand should be avoided.

3. Principle of apology

- Patients and/or their carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded and agreed manner of apology, as early as possible.
- Both verbal and written apologies should be given. Based on local circumstances, by the most appropriate HFR volunteer to issue these apologies to patients and/or their carers. The decision should consider seniority, relationship to the patient, and experience and expertise in the type of patient safety incident that has occurred.
- Verbal apologies are essential because they allow face-to-face contact between the patient and/or their carers and the healthcare team. This should be given as soon as healthcare providers are aware an incident has occurred. It is important not to delay for any reason, including: setting up a more formal multidisciplinary *Being Open* discussion with the patient and/or their carers; fear and apprehension; or lack of healthcare provider availability. Delays are likely to increase the patient's and/or their carer's sense of anxiety, anger or frustration.
- A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident must also be given.

4. Principle of recognising patient and carer expectations

- Patients and/or their carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident, and its consequences.
- Confidentiality must be maintained at all times. Patients and/or their carers should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator.
- Where appropriate, information on Support Agencies should be given to the patient as soon as it is possible.

5. Principle of professional support

- All HFR volunteers are encouraged to report patient safety incidents.
- Volunteers should feel supported throughout the incident investigation process because they too may have been traumatised by being involved. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration.
- Where there is reason for HFR to believe a volunteer has committed a punitive or criminal act, HFR should at early stage obtain separate legal/insurance advice.

6. Principle of risk management and systems improvement



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- Root cause analysis (RCA), or similar techniques should be used to uncover the underlying causes of a patient safety incident. Investigations should focus on improving systems of care, which will then be reviewed for their effectiveness.

7. Principle of multidisciplinary responsibility

- Most healthcare provision involves multidisciplinary teams and communication with patients and/or their carers following an incident that led to harm, should reflect this.
- To ensure multidisciplinary involvement in the *Being Open* process, it is important to identify a mixture of relevant volunteers who will champion it and participate in incident investigation and clinical risk management.

8. Principle of clinical governance

- *Being Open* requires the support of patient safety and quality improvement processes through clinical governance frameworks, in which patient safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence.
- It also involves a system of accountability through the Chair to the Exec to ensure these changes are implemented and their effectiveness reviewed.
- These findings should be disseminated to healthcare volunteers so that they can learn from patient safety incidents.
- Continuous learning programmes and audits should be developed that allow learning from the patient's experience of *Being Open* and that monitor the implementation and effects of changes in practice following a patient safety incident.

9. Principle of confidentiality

- Policies and procedures for Being Open should give full consideration of, and respect for, the patient's and/or their carer's and healthcare provider privacy and confidentiality.
- The consent of the individual concerned should be sought prior to disclosing information beyond the healthcare providers involved in treating the patient. Where this is not practicable or an individual refuses to consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information.
- Communications with parties outside of the HFR team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous. In addition, it is good practice to inform the patient and/or their carers about who will be involved in the investigation before it takes place, and give them the opportunity to raise any objections.

10. Principle of continuity of care

- Patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion.
- If a patient expresses a preference for their healthcare needs to be taken over by another volunteer this must be respected.



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Appendix 4 SBAR - Situation-Background-Assessment-Recommendation

S Situation – explain the reason (AS)

- Identify yourself
- Identify the patient by name (age and sex)
- Describe your concern

B Background – tell the story (HI / SAMPLE)

- Give the patient's reason for seeking help: events leading up to /mechanism of injury /chief complaint / injury/ illness / signs / symptoms
- Detail the patient's previous medical history: allergies, current medications

A Assessment – give vital signs (C)

- ABCD - Vital signs eg Respirations, O2 saturation, Pulse, Cap refill, skin colour, BP, AVPU/ GCS, BM, pain score, temperature,
- Contraction pattern
- Clinical impressions, concerns, improvements or deteriorations
- Detail the treatment given

R Recommendation – plan of action (E)

- Explain what you need - be specific about request and time frame
- Make suggestions
- Clarify expectations (Recap)



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Appendix 5 Equality Impact Assessment

Impact	Age	Disability	Race	Gender	Religion or Belief	Sexual Orientation
Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups?	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?	N	N	N	N	N	N
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups?	N	N	N	N	N	N

Do different groups (age, disability, race, sexual orientation, gender, religion or belief) have different needs, experiences, issues and priorities in relation to the proposed policy?	We have no statistical or anecdotal evidence, at this stage, to show that this policy will affect the groups mentioned differently.
Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups (age, disability, race, sexual orientation, gender, religion or belief)?	We have no statistical or anecdotal evidence, at this stage, to show that this policy will not promote equality of opportunity or good relations between different groups.
Is there potential for or evidence that the proposed policy will affect different population groups (age, disability, race, sexual orientation, gender, religion or belief) differently (including possibly discriminating against certain groups)?	We have no statistical or anecdotal evidence, at this stage, to show that this policy will affect the groups mentioned differently
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups (age, disability, race, sexual orientation, gender, religion or belief)?	We have no statistical or anecdotal evidence, at this stage, to show that this policy will affect the groups mentioned differently

Based on the information set out above the HFR Executive has decided that a full equality impact assessment is not necessary.