# CGP105

# CONSENT POLICY AND PROCEDURE

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## 1. POLICY INTRODUCTION

This policy provides the key points of valid consent and the process for assessing the need for consent as applicable to National Ambulance (NA) staff.

The policy explains the requirements of patient consent, including definitions, documentation requirements and, where consent, in accordance with regulations is not required in the case of relevant care and treatment for specific circumstances.

The policy ensures compliance with regulatory requirements from Department of Health (DOH) and Ministry of Health (MOH).

This policy is related to the National Ambulance Patients' Rights and Responsibilities Policy and Charter and with the NA Clinical Practice Guidelines, CGP 134 NA Patient Care Protocols and CGP 108 EMT and Physician Clinical policy which lists all relevant clinical policies and procedures.

This Policy is related to Management components of Leadership and Commitment and Continuous Improvement.

## 2. SCOPE

This policy includes all elements of consent that are appropriate to the pre-hospital emergency healthcare environment; it includes rules and guidance on documentation of consent to supplement your professional clinical judgment.

It applies to all staff that provide care for patients or are responsible for implementation and monitoring compliance with NA Policies and Procedures.

## 3. ROLES AND RESPONSIBILITIES

Define who is responsible for implementation of the policy and procedures.

### 1. Chief Operations Officer

The Chief Operations Officer is responsible for implementation and monitoring of this policy and for raising any need for review and revision to the Medical Director.

### 2. Medical Director

The Medical Director is responsible for development and revision of the policy and of any Key Performance Indicators.

### 3. Clinical Governance and Audit Officer

The Clinical Governance and Audit Officer is responsible for oversight of the implementation and monitoring of this policy and for raising any concerns to Medical Director.

### 4. Managers

All Managers are responsible for ensuring that their staff have access to training and for compliance with this policy.

### 5. Staff

All staff that provide care for patients are responsible for acting according to this policy.

## 4. POLICY STATEMENT

**When is consent required?**

Consent is required for all interventions, procedures or treatments, except in an emergency situation to preserve life or in cases involving contagious diseases threatening public health or safety or where authority to treat is granted under appropriate legislation e.g. mental health act or a court order. The consent of an incompetent patient may be accepted for physical examination, diagnosis and administration of the first dose of treatment, provided that one of the family members or attendants of that patient is notified of the treatment plan.

Consent is also required when treating a patient of different gender other than the treating clinician in the absence of third party unless the necessity requires otherwise.

For ambulance services the majority of situations will involve implied or verbal consent using the definitions below. The definitions, main principles and elements of obtaining consent and the relevant order of priority for substitute consent givers are detailed below.

### 4.1. Policy Definitions

| DEFINITIONS | |
|---|---|
| Adult | A person who has reached the age of 18 years |

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|---|---|
| Consent | A declaration (written or oral) of willingness to undergo a procedure, treatment or other intervention. Consent is normally "informed", that is, given only after receipt and understanding of all relevant information regarding the risks and benefits of the proposed treatment (s). |
| Implied consent | This is established when a patient's conduct indicates a willingness to submit to general medical treatment such as basic examination or monitoring of vital signs. |
| Lacking Mental Capacity | A person may be judged as lacking mental capacity if, for any reason, it is felt that he/she is unable to understand and or retain the information provided in the process of obtaining consent.<br>Reasons for declaring lack of mental capacity may include, but are not limited to, inability to give or receive communication, inadequate age, mental or intellectual capacity or disability, impairment of judgment by drugs or medications and acute disturbances of consciousness, reasoning or memory caused by disease. |
| Legal/Cultural Guardian | A person who is authorized to consent based on UAE National law and/or local culture. |
| Minor | A person who is not adult. |
| Non-invasive procedure | A diagnostic effort or treatment that does not require entering the body or puncturing the skin. Or procedures that do not require insertion of an instrument or device through the skin or bodily orifice for diagnosis or treatment. |
| Substitute consent giver | A person who may act as the consent giver in the event that the patient is unable to do so. See Appendix 1 for full details and order of priority |
| High Risk Procedures | Procedures involving entering the body or puncturing the skin which may include but is not limited to the following:<br>• Surgical Airway<br>• Rapid Sequence Induction<br>• Femoral Vein Cannulation<br>• Trans Cutaneous Pacing<br>• Thoracotomy<br>(See also CGP112 for High Risk Procedures) |

## 4.2. ELEMENTS OF A VALID CONSENT

4.2.1.Competency (decision making ability) - Is the patient able to communicate or receive communication regarding decisions about their care? For example the patient may be

unconscious, unable to speak or hear. This refers to the ability to understand the nature and likely consequences of treatment.

4.2.2. Capacity to make treatment and transport option decisions in line with their values and beliefs – Does the patient have the intellectual ability to sufficiently understand the communication from the healthcare provider and reach a reasoned choice about treatment. The healthcare provider who doubts the capacity of a patient to make a decision is responsible for assessing the situation and documenting their professional judgement.

4.2.3. Disclosure of information – Where possible the healthcare provider must give details of the nature of his/her disease, its severity or degree of seriousness, the nature and purpose of the proposed intervention including high risk procedures, the risks and benefits of the intervention, any reasonable alternatives, the consequences of refusing and treatment and who is to administer the care or treatment. The urgency of the patient's situation may limit the quantity of information that they can be given but should not affect the quality.

4.2.4. Specificity – The consent authorization must be specific for the procedure to be performed. A healthcare provider has no right to exceed the interventions that are deemed to be necessary in the course of treatment as determined by the treating professional.

4.2.5. Opportunity for questions and answers – The process is dependent on good communication; opportunity must be given, where possible to have questions answered in an understandable fashion giving clear and accurate information provided in a language understandable to the patient.

4.2.6. Voluntariness – Consent must be free of undue influence or coercion. The goal for the healthcare provider is to present the relevant information in a way that allows the consent giver to reach an independent and reasoned choice about care.

4.2.7. Accuracy – The healthcare provider must always give accurate information about proposed treatments potential outcomes and risks Intentional withholding of information, coercion or undue influence invalidates the consent.

4.2.8. To be treated with dignity and respect, consistent with professional standards regardless of race, sex, nationality, religion, culture, disability or any other factor[2]

## 4.3. CONSENT FOR THOSE LESS THAN 18 YEARS OLD

Consent for those less than 18 years old must be signed by the father, legal guardian or substitute as per the above definitions and details in Appendix 1.

A substitute consent giver must fulfill the criteria stated in the definition and is expected to act in the best interests of the minor.

### 4.4. CONSENT IN AN EMERGENCY SITUATION

An intervention may be initiated without consent when an emergency situation exists.

Where all the following criteria are fulfilled, consent is not required for treatment;

- There is an immediate threat to life or health
- Treatment cannot be delayed
- The patient is not capable of consenting
- For minors, the person legally capable of consenting on behalf of the minor is not available

In an emergency situation, where consent cannot be given the justification of the emergency must be annotated on the PCR.

### 4.5. REFUSAL OF TREATMENT OR TRANSPORTATION

If a patient, after communication and discussion of treatment and transportation options, with NA Staff giving relevant information refuses treatment or a particular intervention or refuses transportation against National Ambulance staff advice the healthcare provider must inform the patient of the potential consequences, clearly document this and, if possible obtain the signature of the patient or substitute consent giver so they understand that they take responsibility.

Patient Transportation and any related issues should take place in accordance with CGP 115 Patient Transportation policy. If a patient is not transported they should be given relevant advice and education to assist them in identifying any need for further medical assistance.

### 4.6. CONSENT AND CONFIDENTIALITY

Consent and confidentiality are linked in that each patient owns the information that is recorded about them; it is good practice to obtain approval from the patient prior to sharing confidential information. However there may be legal requirements to disclose data where consent is not mandatory, if it is in the best interests of the patient or the general public, for example where a patient lacks capacity to give the information to other relevant parties or if a person has a suspected or confirmed notifiable disease.

National Ambulance information management policies and specifically COP 403 General Confidentiality Policy refer to the requirements for confidentiality.

### 4.7. DOCUMENTATION OF CONSENT

Where possible a patient signature will be obtained for any high risk procedures that are carried out as defined above and for all patients signature will indicate consent for use of information required for data collection and analysis as well as for purposes of health insurance claims

management. Appropriate family members may participate in decision making and this must be documented.

Implied consent for assessments and interventions should also be documented. Implied consent is established when a patient's conduct indicates a willingness to submit to general medical treatment such as basic examination, skin care or monitoring of vital signs.

National Ambulance staff must document details of refusal of treatment or transportation including full details of any consent given for patients without capacity or where consent is given by a substitute consent giver. Documentation must also reflect situations where treatment is given but transportation is not required. In situations where the patient edits the text of the waiver after refusing treatment or transport, NA staff should then obtain a witness signature in the documentation, if possible and document why patient has chosen to edit the text. All attempt must be made to explain actions of the patient. Remember if the patient does not understand then they do not have capacity. The obligation is on the clinician to make sure the patient understands.

### 4.8. PATIENTS' RIGHTS TO OBTAIN A COPY OF THEIR PATIENT CARE RECORD

Patients who have been treated and/or transported by NA should be given a copy of their patient care record (PCR). In cases where the patient does not receive a copy of their PCR can apply for a copy by using CGF 137 Patient Care Record Request Form.

### 4.9. TRAINING

Training in the implementation of this policy is provided by the Education Department through both core courses and the eLearning packages.

## 5. RELEVANT LEGISLATION

International, federal or local legislation and circulars relevant to this Policy. Full detail on this legislation can be found in QHP109 Legal Register.

| Code, Name of Legislation | Jurisdiction |
|---|---|
| GUIDELINES FOR PATIENT CONSENT - HAAD/Guidelines/Patient Consent/V1 - January, 2016 | DOH |
| Patient and Family Rights (PFR) – PFR.4 & 4.1 | JCI |

## 6. RELATED POLICIES AND FORMS

List related policies and procedures to the created/updated policy.

| Policy & Procedure /Form |
|---|
| CGP 103 - National Ambulance Patients' Rights and Responsibilities Policy and Charter |
| CGP 134 - NA Patient Care Protocols |
| CGP 108 - EMT and Physician Clinical policy |

## 7. FEEDBACK

Any feedback or suggestions for improvement to this Policy, Processes or Procedures can be submitted to qhse@nationalambulance.ae

## 8. DOCUMENT CONTROL AND OWNERSHIP

A review and update of this document will take place as necessary, when changes occur that identify the need to revise this Policy such as changes in roles and responsibilities, release of new legislative or technical guidance, or identification of a new policy area.

This document ownership for editing is identified as:

- Medical Director

This controlled document is managed / overseen by [Procurement and Tendering Committee and/or Audit and Risk Management Committee and/or HR and Compensation Committee].

**Change Brief**

| Version No. | Date | Change |
|---|---|---|
| 1.0 | 22 August 2014 | New Document |
| 2.0 | 01 January 2014 | Alignment with other policies and clarification of language |
| 3.0 | 18 February 2015 | Clarity of language and addition of reference to CGF 137 Patient Care Record request form |
| 4.0 | 19 April 2016 | Review of HAAD consent guidelines for numerous elements including documenting consent and substitute consent giver definition and priority order. |

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|---|---|---|
| 5.0 | November 2016 | Documentation in case of patient refusal<br>Inclusion of Medical Director terminology<br>Alignment to HAAD Consent Guidelines V1 Jan 2016<br>Documentation for implied consent<br>Alignment to Federal Decree No.4 2016 on Medical Liability |
| 6.0 | April 2019 | Terminology of MD, DOH and Clinical Governance & Audit Officer<br>Add last billet point in the “Appendix 1” |
| 7.0 | May 2021 | Due for review<br>Delete word “Directors & Supervisors” |

MD Approval

**Appendix 1**

## SUBSTITUTE CONSENT GIVER

A person who is authorised to consent for another person based on UAE law and who may act as the substitute consent giver in the event that the patient is unable to do so. This person is ideally a close relative and should have familiarity with the patients presumed wishes regarding their medical care. In accordance with the law the substitute consent giver can be:

- A relative up to the fourth degree in the following order of priority:
  - Father
  - Mother
  - Husband
  - Wife
  - Son
  - Daughter
  - Grandfather
  - Grandmother
  - Son's children
  - Daughter's children
  - Paternal Uncle
  - Paternal Aunt
  - Maternal Uncle
  - Maternal Aunt
  - Paternal Uncle's children
  - Maternal Aunt's children
- A court appointed guardian in UAE or elsewhere
- A parent for a minor (less than 18years of age)
- The father, even if he is less than 18 years of age
- The mother, even if she is less than 18 years of age (in the absence of the father)
- If the substitute Consent Giver is deemed incompetent an alternate consent giver should be sought