Pav Dental

Consent and Mental Capacity Policy

Contents

Scope of Policy

This policy covers consent to examination or treatment as part of routine dental care.

Patients have a fundamental legal and ethical right to determine what happens to them. Valid consent to treatment is therefore essential for all forms of healthcare, from providing personal care to undertaking surgery. Seeking consent is also a matter of common courtesy between Health Care Professionals and patients.

This policy aims to ensure best practice in consent by describing that patients must be provided with sufficient information to ensure they understand the nature of the proposed treatment and any

alternatives, risks, benefits, and anticipated outcomes of treatment before they give their consent to it and that the patient-clinician discussion and agreement is clearly documented.

The Department of Health has issued a range of guidance documents on consent. These should be consulted for details of the law and good practice standards on consent. This document sets out our dental practice procedures, which aim to ensure that all staff members comply with or exceed these standards.

Informed Consent (Montgomery Ruling)

The law on 'informed' consent was changed in 2017 following a Supreme Court Judgement. For the purposes of consent, the ruling from 'Montgomery replaces the previous tests founded in the 'Bolam case and re-defined because of the Sidaway case. **The key passage from the Montgomery ruling involves what a patient would consider to be a material risk. Therefore, the doctor or dentist is or should reasonably be aware that the patient would be likely to attach significance to it.**

Dentists now have a duty to take reasonable care to ensure that patients are aware of any "material risks" involved in a proposed treatment, and of reasonable alternatives.

"Consent" is a patient's agreement for a Health Care Professional to provide care. Patients may indicate consent orally or in writing.

For the consent to be valid, the patient must:

- Be competent to take the decision.
- Understand information relevant to the decision, be able to retain that information and use and weigh that information in the balance as part of the process of making the decision.
- Have received enough information to make the decision.
- Be acting under no duress.
- Be able to communicate their decision.

The context of consent can take many different forms, ranging from the active request by a patient for a treatment (which may or may not be appropriate or available) to the passive acceptance of a Health Care Professional's advice. In some cases, the Health Care Professional will suggest a form of treatment or investigation, and after discussion, the patient may agree to accept it. In others, there may be several ways of treating a condition, and the Health Care Professional will help the patient to decide between them.

In many cases 'seeking consent' is better described as 'joint decision making': the patient and Dentist need to come to an agreement on the best way forward, based on the patient's values and preferences and on the Dentist's clinical knowledge.

Who May Give Consent?

Adults

Adults are always assumed to be competent to give consent unless demonstrated otherwise. A patient who is competent to consent to a procedure must have the mental capacity to understand the nature of the procedure to which he/she is consenting AND be in possession of all the material facts regarding the nature of the procedure, the substantial risks involved and the ongoing management after the procedure. They must also be able to communicate their decision to the treating team in some way, by speech, writing or signalling.

Adults with Learning Disabilities

Adults with learning disabilities are presumed to be able to be capable of making healthcare decisions, including giving or refusing consent unless the opposite has been demonstrated. Where any doubt exists, appropriate professionals should assess the capacity of the person. This assessment of the capacity to consider a proposed treatment and to give or refuse consent to it should be recorded in the patient's notes.

The Mental Capacity Act

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes clear who can make decisions, in which situations, and how they should go about this. Dentists are placed under a duty to have regard to the Act's Code of Practice (https://www.gov.uk/government/publications/health-and-social-care-workers-mental-capacity-act-decisions)

MCA Principles

The Act is underpinned by five key principles:

- A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have the capacity to do so unless it is proved otherwise.
- The right for individuals to be supported to make their own decisions –people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
- Individuals have the right to make what might be seen as eccentric or unwise decisions.
- Best interests –anything done for (or on behalf of) people without capacity must be in their best interests.
- Least restrictive intervention –anything done for (or on behalf of) people without capacity should be the action or course which is least restrictive of their basic rights and freedoms.

Dental practitioners are able to assess a patient's mental capacity to consent.

Does the patient have capacity under the Mental Capacity Act 2005 to give consent? There is a two-stage test for assessing this:

- Stage 1: be aware of impairments that could affect capacity, such as dementia.
- Stage 2: can the patient:
    - understand the relevant information?
    - retain that information, even for a short while?
    - use or weigh up the relevant information as part of the decision-making process?
    - communicate their decision to the dental practitioner?

Lasting Power of Attorney

The major impact of the MCA on Consent to Treatment is that, for the first time in healthcare, a designated decision-maker can act on behalf of someone who lacks capacity. This can be either an individual appointed by a person to act on their behalf if they should lose capacity in the future (i.e., granted a Lasting Powers of Attorney or LPA) or a Court-appointed deputy.

Independent Mental Capacity Advocates (IMCAs)

The MCA saw the introduction of Independent Mental Capacity Advocates. IMCAs are individuals appointed to support a person who lacks capacity but who has no one (e.g., a relative or close friend) to speak for them. The IMCA makes representations about the person's wishes, feelings, beliefs, and values, and brings to the attention of the decision-maker all factors that are relevant to the decision.

Young People (Over 16 and Under 18)

As soon as a child reaches the age of 16, he/she has the right to be treated as an adult. However, until their 18th birthday, a parent can still consent on his/her behalf. The refusal of a competent person aged 16 or 17 may therefore in certain circumstances be overridden by a person with parental responsibility or by the court. This power to overrule must be exercised on the basis that the mental and physical welfare of the young person are considered first and foremost in the decision-making process.

Children (under 16)

Following the case of Gillick, the courts have held that children who have enough understanding and mental capacity to enable them to understand fully what is involved in a proposed procedure will also have the capacity to consent (or refuse) that procedure. The concept of Gillick competence is considered to reflect a child's increasing development to maturity. In some cases, for example, because of a mental disorder, a child's mental state and capacity may fluctuate significantly so that on some occasions the child appears Gillick competent in respect of a decision and on other occasions does not.

In cases such as these, careful consideration should be given to whether the child is truly Gillick competent at any time to take this decision. As the understanding required for different procedures will vary, a child under 16 may therefore have the capacity to consent to some procedures but not others. Where a child under 16 but Gillick competent refuses treatment such refusal can be overruled by a person with parental responsibility or by the court. This power to overrule must be exercised on the basis that the mental and physical welfare of the child are considered first and foremost in the decision-making process.

Children With Learning Disabilities

As with adults, a child with a learning disability should not be assumed to be incapable of making healthcare decisions including giving or refusing consent unless the opposite has been demonstrated. Where any doubts exist, an appropriate professional should assess the capacity of the child.

Sources of Guidance on Consent

The Department of Health has issued several guidance documents on consent. These may be consulted for advice on the current law and good practice requirements in seeking consent. Healthcare Professionals must also be aware of any guidance on consent issued by their own regulatory bodies.

England and Wales - Refer to the Mental Capacity Act (2005)

Scotland - Refer to the Adults with Incapacity Act (2000)

Northern Ireland - Refer to the Mental Capacity Act (Northern Ireland) (2016)

Documenting Written and Verbal Consent

It is essential that Healthcare professionals document clearly both a patient's agreement to the treatment and the discussions that led up to that agreement. This may be done either using a consent form or through documenting in patient's notes that they have given oral consent.

Written Consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is evidence that the patient has given consent but is not proof of valid consent. If a patient is rushed into signing a form, based on too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment.

Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract. It is rarely a legal requirement to seek written consent, but it is good practice to do so, particularly if any of the following circumstances apply:

- The treatment or procedure is complex or involves significant risks (the term risk issued throughout to refer to any adverse outcome, including those which some Healthcare Professionals would describe as 'side-effects' or 'complications')
- The procedure involves a regional anaesthetic or sedation If any change is proposed to a consent described on a 'consent form' the dentist agreeing the change with the patient must ensure that:
- A new consent form is completed.
- The previous consent form is made void –but retained.

Procedures When a Patient Lacks the Capacity to Give or Withhold Consent

Where an adult patient does not have the capacity to give or withhold consent to a specific treatment, this fact should be documented as to why the Healthcare Professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient.

Assessments of the patient's capacity must be clearly recorded on the patient's clinical notes. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine lack of capacity. The Healthcare Professional should involve appropriate colleagues such as specialist learning disability teams and speech and language

therapists in making assessments of capacity where communication difficulties are suspected unless the urgency of the patient's situation prevents this.

Procedure For Agreeing Consent Single Stage Process

In many cases, it will be appropriate for a Healthcare Professional to initiate a procedure immediately after discussing it with the patient. If a proposed procedure carries significant risks, it will be appropriate to seek written consent, the dentist must take into consideration whether the patient has had sufficient time to absorb and consider the information necessary for them to make their decision. If the patient understands and has sufficient opportunity to form a judgment, the patient's consent can be considered valid, and the dentist may proceed.

Two or More Stage Process

In most cases where written consent is being sought, treatment options will generally be discussed well in advance of the actual treatment being carried out. This may be on just one occasion, or it may be over a series of appointments. Therefore, the consent process will have at least two stages: the first being the provision of information, and discussion of options. The second is the description or confirmation that the patient wants to proceed.

The consent form should be used as a means of documenting the information stages, as well as the confirmation stage. If a form is signed before patients arrive for treatment a member of the healthcare team MUST check with the patient at the point when they arrive for the treatment whether they have any further concerns, whether their condition has changed, and whether they are still in agreement.

This is particularly important where there has been a lapse of time between the form being signed and the procedure.

Duration of Consent

When a patient gives valid consent to a procedure, that consent remains valid for an indefinite duration unless the patient withdraws it.

Treatment of Children & Parental Consent

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children. Below outlines who may have parental responsibility.

Who can have parental responsibility?

Mothers have automatic parental responsibility from birth.

England and Wales

- Fathers who were married to the mother before the birth
- A father who is named on the birth certificate

Scotland

- Fathers who were married to the mother at conception, or marry any time afterwards
- A father who is named on the birth certificate

Northern Ireland

- Fathers who were married to the mother at the time of birth
- A father has parental responsibility if he marries the mother after the birth and they are living in Northern Ireland
- A father who is named on the birth certificate

Same-sex couples

- Both parents would have parental responsibility if they were in a civil partnership or married at the time of conception
- If the parents were not in a civil partnership at the time of conception, the second parent can apply for parental responsibility

Responsibilities of the Health Care Professional in Obtaining and Documenting Consent

The Healthcare Professional carrying out the procedure is ultimately responsible for ensuring that the patient validly consents to what is being done; it is they who will be held responsible in law if this is challenged later.

The Healthcare Professional providing the information must be competent to do so: this competence can be evidenced by their competence to carry out the procedure.

it may be appropriate for other members of the clinical team, who may not be competent or scheduled to do the procedure itself, to participate in the process of obtaining consent if they are in a position to provide all the appropriate information and advice. The Healthcare Professional responsible for carrying out the treatment may in this way delegate aspects of the consent process, but he/she retains accountability for the consent's validity and must be satisfied that the team member is competent to participate in the process of consent.

Healthcare Professionals must be aware of the limits of their knowledge and competencies.

Refusal of Treatment

If, after discussion of possible treatment options, a patient refuses all treatment, the dentist with overall responsibility must be informed and the facts should be clearly documented in the patient's notes. If the patient has signed the consent form but subsequently changed their mind, the Healthcare Professional should note this on the form.

Where a patient has refused a particular procedure, the dentist must ensure that they continue to provide any other appropriate care to which the patient has consented and that the patient realises

that they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, patients should be advised accordingly.

The Appropriate Use of Restrictive Interventions

The use of restrictive practices, including restraint, seclusion, and segregation, can have a devastating impact on people and cause trauma.

Context and Rationale

On occasion, the clinical team can determine that a patient's assessment or course of treatment cannot be carried out safely and or effectively as a result of the behaviour presented by the patient, Whilst there can be numerous factors that may be influencing the patient's behaviours, it is the professional responsibility of the Dentist and Dental Staff involved to consider their own general conduct and make an informed decision whether to continue or cease using clinical holding. Generally, this behaviour is uncommon but may arise in patients who lack mental capacity and may not be able to comply due to their own personal characteristics, Examples of when clinical holding may be appropriate are:

- Patients with dementia
- Patients with ill mental health
- Patients with learning disabilities/Autistic Spectrum disorder
- Patients with involuntary movements
- Patients with severe anxiety
- Patients with specific medical conditions (e.g.: Brain injuries, Brain tumours)
- Patients who lack the capacity and ability to understand and cooperate with specific dental interventions or treatments.

What is restrictive practice?

Restrictive practice is defined as making someone do something they do not want to do or stopping them from doing something they do want to do, by restricting or restraining them, or depriving them of their liberty.

When restrictive practices are used, they can have a significant impact on a person’s mental health, physical health, and emotional well-being. They could even breach their human rights.

We’re aware that there are limited situations where restrictive practice could be needed to keep people safe. However, restrictive practice must only be used to prevent serious harm. It must be the least restrictive option, applied for the shortest possible time.

Although we may not be directly at this side of care in a dental setting, we may also be subject to notice restrictive practice when patients are attending visits along with a secondary person - A care assistant for example, and it is our duty to understand what this looks like and act appropriately if we feel it is unjustified.

Before considering any kind of restrictive practice we should first consider:

- Is this in the best interest of the patient?
- Are there any alternatives that could be available?

- What would happen if we didn’t complete the proposed treatment today?

Other than in a dental emergency, doing nothing, and referring onwards to secondary care/community services or delaying treatment may be preferable to having to conduct any form of restrictive practice.

Express Consent

For procedures other than dental examinations, including radiographs, the patient's express consent (oral or written) is needed.

When a patient has given oral consent to treatment, you should make a note in their clinical record of the advice given, including any risks and benefits and likely outcomes, and the fact that the patient has understood and consented. This is particularly important where treatment is significant and not routine.

Written consent must be obtained for treatment under conscious sedation or general anaesthetic, as set out in the GDC's guidance. It is also advisable to gain written consent for photographs which are to be used outside of a patient record e.g., on a social media post, practice website, or in a presentation. This allows patients to be clear about what their photos will be used for.

Document Control

Title:	Consent and Mental Capacity Act
Author/s:	DCME Team

Owner:	DCME Team
Approver:	DCME Team
Date Approved:	27/10/23
Next Review Date:	27/10/24

Change History				
Version	**Status**	**Date**	**Author / Editor**	**Details of Change** (Brief detailed summary of all updates/changes)
0.1	Final	07/09/23	PG	Combined consent and MCA policy onto new format, additional info regarding restrictive practice added
0.2	Final	10/11/2023	PG	Document gone live

The latest approved version of this document supersedes all other versions, upon receipt of the latest approved version all other versions should be destroyed, unless specifically stated that previous version(s) are to remain extant. If in any doubt, please contact the document Author.

Approved By: Hassan Bhojani, Waleed Javed
Date Published: 19/09/2024