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POLICY DOCUMENT

Consent to Care & Treatment Policy

UT Compliance

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This policy has been developed in accordance with the Mental Capacity Act 2005, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and associated statutory guidance. It applies to all supported living services operated by and establishes a comprehensive framework for obtaining, recording, and respecting consent in all aspects of care and treatment delivery.

1. Scope

1.1 Purpose

The purpose of this policy is to set out the approach of to obtaining and recording consent from individuals receiving care and support within our supported living services. Consent is a fundamental legal and ethical requirement in care delivery. Every person has the right to agree to, refuse, or withdraw their agreement to any aspect of care or treatment, and this right must be respected at all times.

This policy provides a clear and consistent framework to ensure that:

- All care and treatment is provided only with the individual's valid, informed consent or, where the individual lacks capacity, in accordance with the Mental Capacity Act 2005.
- Staff understand their legal obligations in relation to consent and are confident and competent to apply them in practice.
- The rights of individuals to make decisions about their own lives are upheld, promoted, and never unnecessarily overridden.
- Consent processes are transparent, well-documented, and capable of withstanding scrutiny by the CQC, commissioners, and courts.

1.2 Application

This policy applies to all staff employed or engaged by , including permanent, part-time, bank, and agency workers, as well as volunteers and work placement students operating under supervision. It applies across all supported living services and to all individuals receiving care and support from the organisation, regardless of the nature or complexity of their support needs.

This policy applies to consent in relation to all aspects of care and support delivery, including but not limited to:

- Personal care activities such as washing, dressing, oral hygiene, and continence support.
- Medical treatment, health monitoring, and medication administration.
- Participation in activities, community engagement, and social interaction.
- Sharing personal information with third parties, including health professionals and family members.
- The use of assistive technology, monitoring equipment, or any form of surveillance within the individual's home.
- Physical interventions or any form of restrictive practice.

1.3 Policy Aims

The principal aims of this policy are to:

1. Ensure that operates a culture in which consent is genuinely sought and respected, and in which staff never proceed with

care or treatment without authorisation to do so.

2. Equip staff with the knowledge, skills, and confidence to obtain valid consent in a range of situations, including where the individual has communication difficulties or fluctuating capacity.
3. Provide a legally robust framework for decision-making when an individual lacks or may lack the capacity to consent to a specific aspect of their care or treatment.
4. Ensure that all consent decisions are accurately documented and that records are maintained in accordance with information governance requirements.
5. Promote and protect the autonomy, dignity, and human rights of every individual supported by .

1.4 Who This Policy Applies To

All staff are required to read, understand, and comply with this policy as part of their induction programme and at every subsequent review. Line managers are responsible for ensuring that their teams are familiar with and correctly apply the principles set out in this policy. The Registered Manager holds overall accountability for ensuring that consent processes across the service are lawful, effective, and consistently applied.

1.5 Exclusions and Limitations

This policy does not address:

- Consent to participation in research, which is governed by a separate research ethics framework and must comply with the Health Research Authority’s requirements.
- Consent in relation to children under the age of 16, which is subject to separate legislation and guidance.
- Consent to financial arrangements or appointeeship, which is addressed in the organisation’s Financial Management Policy.

1.6 Relationship to Other Policies

This policy should be read alongside the following organisational policies:

- Mental Capacity Act and Best Interests Decision-Making Policy
- Deprivation of Liberty Safeguards and Liberty Protection Safeguards Policy
- Care Planning and Risk Management Policy
- Safeguarding Adults at Risk Policy
- Medication Management Policy
- Positive Behaviour Support Policy
- Information Governance and Data Protection Policy
- Equality, Diversity, and Inclusion Policy
- Complaints and Compliments Policy

2. Legal and Regulatory Framework

The following legislation and regulatory guidance underpins this policy. will ensure that all consent-related activity fully complies with the obligations set out below.

Legislation / Regulation	**Requirements and Relevance**
Mental Capacity Act 2005 (MCA)	The primary legislative framework governing consent and decision-making for adults in England and Wales. Establishes five statutory principles, including the presumption of capacity, the right to make unwise decisions, and the requirement that any act done for a person who lacks capacity must be in their best interests and least restrictive of their rights. Sections 24–26 govern Advance Decisions to Refuse Treatment.
Mental Capacity Act 2005: Code of Practice	Statutory guidance that staff and organisations must have regard to when applying the MCA. Provides detailed guidance on capacity assessment, best interests decision-making, and the role of Independent Mental Capacity Advocates.
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	Regulation 11 (Need for Consent) requires providers to ensure care and treatment is only provided with the legally valid consent of the relevant person, or in accordance with the MCA where the person lacks capacity. Regulation 9 (Person-Centred Care) requires that care reflects individual needs, wishes, and preferences.
Care Act 2014	Establishes the wellbeing principle and a duty on local authorities and care providers to promote individual choice and control. Supports the right of adults with care needs to make their own decisions about how those needs are met.
Human Rights Act 1998	Article 3 (Freedom from Inhuman or Degrading Treatment) and Article 8 (Right to Private and Family Life) are directly relevant to consent. Providing care or treatment without consent may constitute a violation of these rights. Article 5 (Right to Liberty) is engaged where care arrangements amount to a deprivation of liberty.
Equality Act 2010	Requires that consent processes are accessible and do not discriminate against individuals on the grounds of protected characteristics. Reasonable adjustments must be made to ensure individuals with disabilities, communication difficulties, or language barriers can participate fully in consent processes.
Mental Capacity (Amendment) Act 2019 – Liberty Protection Safeguards	Where care arrangements may amount to a deprivation of liberty for a person who lacks capacity to consent to those arrangements, an LPS (or existing DoLS) authorisation is required. The absence of consent to care arrangements is a key trigger for considering whether a deprivation of liberty is occurring.
Mental Health Act 1983 (as amended 2007)	Where an individual is detained under the Mental Health Act, specific provisions apply regarding consent to treatment. These provisions override the general consent framework in certain circumstances and require specific documentation and second opinion procedures.
UK General Data Protection Regulation and Data Protection Act 2018	Governs the processing of personal data and special category health data within consent records. Consent under data protection law is a distinct concept from consent to care and treatment, but both must be addressed in care planning documentation.
Common Law – Duty of Care and Battery	At common law, any touching of a person without their consent may constitute battery. Care staff must therefore ensure that valid consent is obtained before any physical contact in the course of care delivery. The duty of care requires that individuals are provided with sufficient information to make informed decisions.

Legislation / Regulation	Requirements and Relevance
Care Quality Commission (CQC) Fundamental Standards	The CQC assesses compliance with Regulation 11 (Need for Consent) as part of its inspection framework under the Key Question ‘Is the service safe and responsive?’. Inspectors will review consent records, capacity assessments, and staff understanding of consent principles.
NICE Guidelines NG108 and NG206	NICE guidance on decision-making and mental capacity (NG108) and on the care and support of adults with learning disabilities in health settings (NG206) provides best practice recommendations on supported decision-making and communication-accessible consent processes.

3. Definitions of Key Terms

The following definitions apply throughout this policy and all associated procedures and documentation.

Term	Definition
Consent	A voluntary, informed agreement by a person with capacity to a proposed act, intervention, or course of action. For consent to be legally valid, it must be given freely, by a person with the mental capacity to make the specific decision, and on the basis of adequate information.
Valid Consent	Consent that is legally effective. For consent to be valid it must be: (1) given voluntarily without coercion or undue influence; (2) given by a person who has the mental capacity to make the relevant decision; and (3) given on the basis of sufficient information about what is proposed, including the risks, benefits, and available alternatives.
Informed Consent	Consent that is based on a clear explanation of the proposed care or treatment, its likely effects, any material risks involved, and the alternatives available. Information must be provided in a format and language accessible to the individual.
Express Consent	Consent that is given explicitly, either verbally or in writing. Express consent is required for significant interventions, medical procedures, and any care that involves an element of risk or that the individual may find intrusive or distressing.
Implied Consent	Consent that is inferred from an individual’s actions or behaviour rather than explicitly stated. For example, holding out an arm to receive medication may imply consent to that procedure. Implied consent is only appropriate for routine, low-risk care activities where the individual clearly understands what is being offered.
Mental Capacity	The ability to make a specific decision at a specific point in time. Under the MCA 2005, a person lacks capacity if they have an impairment or disturbance in the functioning of their mind or brain that prevents them from understanding, retaining, using, weighing, or communicating the information relevant to the decision.
Supported Decision-Making	The provision of appropriate assistance, information, and communication support to enable an individual to make their own decisions wherever possible. Support may include the use of easy-read materials, communication aids, advocacy services, or the involvement of trusted persons.
Advance Decision to Refuse Treatment (ADRT)	A legally binding document made by a person with capacity that sets out specific treatments they do not wish to receive in specified circumstances in the future, should they lose capacity. An ADRT refusing life-sustaining treatment must be in writing, signed, and witnessed.

Term	Definition
Lasting Power of Attorney – Health and Welfare (LPA)	A legal document appointing a named person (the attorney) to make decisions about health and welfare on behalf of the donor, including decisions about care and treatment, if the donor lacks capacity. An LPA must be registered with the Office of the Public Guardian to be legally effective.
Independent Mental Capacity Advocate (IMCA)	A statutory advocacy role under the MCA 2005. An IMCA must be instructed where a person who lacks capacity and has no one appropriate to consult (other than paid carers) is facing a decision about serious medical treatment, a change of accommodation, or (in some cases) a safeguarding enquiry.
Court of Protection	The specialist court that has jurisdiction under the MCA 2005 to make decisions on behalf of adults who lack capacity. The court can also appoint a deputy to make ongoing decisions for a person who lacks capacity in relation to their personal welfare, health care, or property and financial affairs.
Coercion / Undue Influence	Any pressure, threat, manipulation, or abuse of power that removes the voluntariness of a person’s agreement. Consent obtained through coercion or undue influence is not valid. Staff must be vigilant to the risk that family members, other residents, or even well-meaning professionals may unduly influence an individual’s decision.
Nominated Person (LPS)	Under the Liberty Protection Safeguards framework, the cared-for person can nominate a person to represent them. This person has the right to request a review and must be consulted where appropriate in the authorisation process.
Best Interests Decision	A decision made on behalf of a person who lacks capacity to make it themselves. It must involve the person as far as possible, consider their past and present wishes, and be the least restrictive option that meets the identified care need. It must not be motivated by the convenience of the service or the preferences of those making the decision.

4. Policy Statement

4.1 Commitment

is committed to a culture in which the right of every individual to consent to, refuse, or withdraw consent from any aspect of their care or treatment is unconditionally respected. We recognise that respecting consent is not merely a legal requirement: it is a fundamental expression of our commitment to treating every person we support as an autonomous individual with inherent dignity and the right to self-determination.

We will ensure that:

- No care or treatment is provided without the individual’s valid consent or, where the individual lacks capacity, in accordance with the Mental Capacity Act 2005 and a documented best interests decision.
- Consent is never assumed, coerced, or obtained under conditions that compromise the individual’s free will.
- Every individual receives sufficient information, in a format accessible to them, to enable genuinely informed decision-making.
- Staff are trained, supervised, and supported to apply consent principles consistently and confidently across all care settings and situations.
- Consent records are accurate, complete, and maintained in accordance with this policy and the organisation’s information governance standards.

4.2 Core Principles

The following five principles, drawn from the Mental Capacity Act 2005, underpin all consent-related practice within :

- **Principle 1 – Presumption of Capacity:** Every adult must be presumed to have capacity to make their own decisions unless it is established by evidence that they lack capacity to make a specific decision at a specific time. Staff must never assume that an individual lacks capacity because of their diagnosis, age, appearance, or past behaviour.
- **Principle 2 – Supported Decision-Making:** A person must not be treated as lacking capacity unless all practicable steps have been taken to support them to make the decision themselves. This includes providing information in accessible formats, using communication aids, arranging an advocate, and choosing the right time and environment for the conversation.
- **Principle 3 – Right to Make Unwise Decisions:** A person with capacity has the absolute right to make a decision that others may consider unwise or contrary to their best interests. Staff must respect this right and must not withhold care or support on the grounds that they disagree with the individual's choice, provided there is no risk to others.
- **Principle 4 – Best Interests:** Any act done, or decision made, for or on behalf of a person who lacks capacity must be done in their best interests. This requires a genuine consideration of the person's past and present wishes, values, and preferences, as well as the views of people close to them.
- **Principle 5 – Least Restrictive Option:** Before providing care or treatment to a person who lacks capacity, consideration must be given to whether the purpose for which it is needed could be achieved in a way that is less restrictive of the person's rights and freedoms.

4.3 Person-Centred Approach to Consent

recognises that the process of seeking and obtaining consent is itself an act of care. The way in which staff communicate with individuals about proposed care or treatment must be respectful, unhurried, and genuinely responsive to each person's individual communication style and preferences. We will invest in communication tools, easy-read resources, and specialist advocacy support to ensure that every person we support is able to participate meaningfully in decisions about their own care.

4.4 Zero Tolerance of Unlawful Practice

operates a zero-tolerance approach to any care or treatment provided without valid consent or lawful authority. Any member of staff found to have provided care or treatment without consent, other than in a genuine emergency, will be subject to disciplinary proceedings and may be reported to the relevant professional regulatory body. Such conduct may also constitute a criminal offence and/or a safeguarding concern under the Care Act 2014.

5. Roles and Responsibilities

The table below sets out the key responsibilities for each role in relation to consent to care and treatment. These responsibilities are in addition to general duties set out in individual job descriptions and employment contracts.

Role	Key Responsibilities
All Staff	Presume that every individual has capacity to make their own decisions unless there is specific evidence to the contrary.Seek valid consent before undertaking any aspect of care or treatment, including routine personal care activities.Provide clear, accessible information to enable informed decision-making.Never proceed with care or treatment in the face of a refusal from a person with capacity.Document consent, refusal, and any capacity concerns accurately and promptly.Recognise when a capacity assessment may be required and escalate to a senior colleague without delay.Respect and comply with any valid Advance Decision to Refuse Treatment or Lasting Power of Attorney.Participate in all required consent-related training.
Registered Manager	Hold overall responsibility for the lawfulness and quality of consent processes across the service.Ensure that this policy is fully embedded in practice through induction, training, supervision, and audit.Approve and oversee all formal mental capacity assessments and best interests decisions relating to significant care and treatment decisions.Ensure that all LPA documents and ADRTs held on behalf of individuals are verified, recorded, and acted upon.Notify the CQC of any serious incidents arising from consent failures, as required by Regulation 11 and the duty of candour.Review and update this policy at least annually or following any significant change in legislation or guidance.Create an environment in which staff feel confident and supported to raise consent-related concerns.
Duty Manager (Operational Lead)	Provide frontline operational guidance to staff on consent issues arising during shifts.Act as the immediate point of escalation when a consent concern is identified during care delivery.Ensure that any refusal of care or treatment by an individual with capacity is respected, recorded, and appropriately risk-managed.Coordinate an immediate response where a capacity concern arises unexpectedly, ensuring that a capacity assessment is initiated and interim care measures are considered.Brief staff during handovers on any known consent requirements, restrictions, or changes relating to individuals on the shift.Escalate consent concerns that cannot be resolved during the shift to the Registered Manager without delay.Document decisions and actions taken in response to consent or capacity concerns during their operational period.
Safeguarding Lead	Ensure that consent-related safeguarding concerns, including coercion, financial exploitation, or consent obtained by deception, are identified and responded to appropriately.Advise on the interface between consent, deprivation of liberty, and safeguarding duty.Liaise with the local authority safeguarding team where a consent failure may constitute or contribute to abuse or neglect.Review consent and capacity records following any safeguarding incident to identify learning.Promote awareness of coercion and undue influence as a barrier to valid consent across the staff team.
Health and Safety Officer	Ensure that health and safety risk assessments reflect individuals’ consent decisions, including decisions to decline recommended safety measures.Advise on the management of risk arising from a person with capacity exercising their right to make decisions that carry a risk of physical harm.Ensure that any physical intervention or restrictive practice arising in an emergency without consent is documented and reported in accordance with the organisation’s incident procedures.
Data Protection Officer	Ensure that all consent records, capacity assessments, and best interests documentation are processed and stored in compliance with the UK GDPR and Data Protection Act 2018.Advise on the lawful basis for processing health and care data within consent records.Ensure that individuals are aware of their right to access records relating to their consent and any associated mental capacity assessments.Manage any subject access requests relating to consent documentation.
Named Worker / Key Worker	Take lead responsibility for ensuring that the individual’s consent preferences and any advance decisions or LPA arrangements are accurately reflected in their care plan.Develop and maintain communication profiles and consent records for each person on their caseload.Coordinate any formal mental capacity assessment or best interests consultation required in relation to care planning.Act as the primary contact for the individual and their representatives in relation to consent matters.Monitor and respond to any changes in the individual’s capacity or consent status over time.

6. Procedures

6.1 Principles of Valid Consent

Before proceeding with any care or treatment activity, staff must be satisfied that the following conditions for valid consent are met:

- **Voluntariness:** The individual has agreed freely and without coercion, undue influence, or manipulation. Staff must be alert to situations where a family member, another resident, or a professional may be pressuring the individual to consent or to refuse.
- **Capacity:** The individual has the mental capacity to make the specific decision at the specific time. Capacity must never be assumed from diagnosis alone, and must be assessed in relation to each individual decision.
- **Information:** The individual has been given sufficient, relevant information about the proposed care or treatment, including what it involves, its likely effects and benefits, and any significant risks or alternatives. Information must be provided in a format and language accessible to the individual.

If any of these three conditions is not met, the consent is not valid and care or treatment must not proceed unless an alternative legal authority applies (such as an MCA best interests decision, an LPA, or an emergency situation under Section 5 of the Mental Capacity Act 2005).

6.2 Obtaining Consent in Practice

The following steps must be followed when seeking consent from an individual:

- Choose an appropriate time and environment. Consent conversations should take place in a private, comfortable setting when the individual is relaxed and not unduly tired, unwell, or distressed.
- Identify the correct person. Only the individual themselves can give consent to their own care or treatment. Family members, carers, and representatives cannot consent on behalf of an adult with capacity, regardless of their relationship to the individual.
- Provide information accessibly. Explain what is proposed, why it is being offered, what will happen during the activity, and what the likely outcomes are. Use the individual’s preferred communication method, including easy-read materials, pictures, Makaton, or a communication aid if required.
- Allow time. Give the individual adequate time to consider the information and ask questions. Do not rush or pressure the decision.
- Check understanding. Confirm that the individual has understood what has been explained. Ask them to tell you in their own words what they understand the proposal to involve.
- Respect the decision. Whether the individual agrees or declines, accept their decision with respect. A person with capacity has the right to decline care or treatment for any reason, including no reason at all.
- Document the outcome. Record the consent decision promptly in the individual’s care record, including what was explained, how it was communicated, whether consent was given or withheld, and any conditions attached.

6.3 Consent to Personal Care

Personal care activities, including washing, dressing, oral hygiene, shaving, continence support, and moving and positioning, require consent on each occasion they are carried out. Staff must not assume that because an individual consented to a personal care activity on a previous occasion, they consent to it again now.

In practice, consent to routine personal care may often be implied through the individual's behaviour and cooperation. However, where an individual indicates withdrawal of consent through verbal or non-verbal means, staff must stop immediately, even if the care activity is only partially completed, and seek guidance from a senior colleague.

Where an individual regularly declines a specific personal care activity and this poses a risk to their health, the Named Worker must review the care plan, consult the individual, and if necessary seek advice from a health professional. If there is concern that the individual may lack capacity to make the decision, a formal capacity assessment must be initiated.

6.4 Consent to Medical Treatment and Health Interventions

Consent to medical treatment, including medication administration, health monitoring, nursing procedures, and referrals to health services, is a specific and important area of consent practice. The following requirements apply:

- Written consent is required for all significant health interventions, including consent to GP referral, hospital admission, surgical procedures, and the commencement of new prescribed medications.
- Verbal consent, documented in the care record, is appropriate for routine health monitoring activities such as blood pressure checks, blood glucose monitoring, and wound dressing changes.
- Medication must only be administered with the individual's consent on each occasion. Covert medication – the administration of medication without the individual's knowledge – is never permissible without a documented best interests decision approved by the Registered Manager and, where appropriate, supported by a prescriber.
- Where an individual refuses prescribed medication, the refusal must be recorded, the prescriber informed, and a risk assessment completed. Staff must not use persuasion, deception, or physical force to administer medication to a person who has refused.
- Individuals must be supported to attend health appointments and to make informed decisions about their healthcare in collaboration with health professionals.

6.5 Consent and Mental Capacity

Where there is any reason to believe that an individual may lack capacity to make a specific decision, the following process must be followed:

1. Identify the specific decision. Capacity is always decision-specific. The question is not whether the individual generally lacks capacity but whether they lack capacity to make this particular decision at this particular time.
2. Take all practicable steps to support capacity. Before conducting a formal assessment, ensure that all reasonable steps have been taken to maximise the individual's ability to make the decision. This may include providing information in a different format, involving a communication specialist, or choosing a different time when the individual may be more able to engage.
3. Conduct a two-stage capacity assessment. Apply the two-stage test under Section 2 of the MCA 2005: (Stage 1) Is there an impairment or disturbance in the functioning of the individual's mind or brain? (Stage 2) Does this impairment or disturbance prevent the individual from making the specific decision?

4. Document the assessment. Record the assessment in the individual’s care record, including the decision being considered, the evidence of impairment, the steps taken to support capacity, and the outcome of the assessment.
5. Where capacity is lacking, proceed to best interests process. See Section 6.6 below.

Capacity assessments must be completed by the most appropriate person for the decision in question. For significant health and welfare decisions, this will typically be the Named Worker in consultation with the Registered Manager and, where relevant, a health professional. The Registered Manager retains overall responsibility for the quality and lawfulness of all capacity assessments.

6.6 Best Interests Decision-Making When Capacity is Absent

Where a person is assessed as lacking capacity to consent to a specific care or treatment activity, the decision must be made in their best interests in accordance with Section 4 of the MCA 2005. The following process must be followed:

1. Identify who should be involved. Consult with anyone named by the individual as someone they would want involved, any appointed LPA (Health and Welfare), any court-appointed deputy, and, where appropriate, family members and carers. Where no one appropriate to consult is available, instruct an IMCA.
2. Consider the individual’s wishes. Give particular weight to any written statement made by the individual when they had capacity, any known preferences or values, and the individual’s current behaviour and reactions.
3. Evaluate all available options. Consider the full range of options, including doing nothing, and identify the option that is least restrictive while still meeting the identified care need.
4. Make and record the decision. Document the decision in the care record, including all persons consulted, the options considered, the reasons for the decision reached, and the review date.
5. Review the decision. Best interests decisions are not permanent. They must be reviewed at each care plan review, following any change in the individual’s circumstances or presentation, or when the individual challenges the decision.

6.7 Advance Decisions to Refuse Treatment (ADRTs)

will ensure that any Advance Decision to Refuse Treatment made by an individual is identified, verified, recorded, and respected. The following requirements apply:

- Upon commencement of support, staff must establish whether the individual has made any ADRT and obtain a copy for the care record.
- An ADRT refusing life-sustaining treatment must be in writing, signed by the individual, and witnessed. Staff must verify that these requirements are met before treating an ADRT as legally binding.
- An ADRT is legally binding provided it satisfies the requirements of the MCA 2005 and applies to the situation that has arisen. A valid, applicable ADRT has the same legal force as a contemporaneous refusal by a person with capacity.
- If there is any doubt about the validity or applicability of an ADRT, the Registered Manager must seek legal advice or apply to the Court of Protection.
- Any changes made by the individual to an existing ADRT must be recorded and the relevant documentation updated immediately.

6.8 Lasting Powers of Attorney

Where an individual has appointed an attorney under a registered Lasting Power of Attorney (Health and Welfare), the following requirements apply:

- Staff must verify that the LPA is registered with the Office of the Public Guardian before acting on any decisions made by the attorney. An unregistered LPA has no legal force.
- The LPA document must be reviewed to confirm the scope of the attorney's authority. An LPA that does not specifically authorise decisions about life-sustaining treatment does not give the attorney authority to refuse such treatment.
- The attorney can only make decisions on behalf of the donor if the donor lacks capacity to make that specific decision at that specific time. Where the individual has capacity, the attorney has no authority to override their decision.
- Any disagreement between the attorney's instructions and what staff believe to be in the individual's best interests must be escalated to the Registered Manager, who may seek legal advice or apply to the Court of Protection for a determination.
- The name and contact details of any registered attorney must be recorded in the individual's care plan and made available to all staff involved in their care.

6.9 Refusal of Care or Treatment by a Person with Capacity

A person with mental capacity has an absolute right to refuse any care or treatment, including care that is necessary to sustain their life. Where an individual with capacity refuses care or treatment, the following applies:

- Accept and respect the refusal. Stop the activity immediately and record the refusal in the care record.
- Ensure the individual is informed. Confirm that the individual understands the likely consequences of their refusal and that this has been explained to them in an accessible format.
- Complete a risk assessment. Assess the implications of the refusal for the individual's health and safety and document this in the care record.
- Inform relevant professionals. Notify the individual's GP or other relevant health professional of the refusal, with the individual's consent where possible, or in accordance with information sharing protocols where there is significant risk.
- Respect the decision. Do not attempt to change the individual's mind through repeated requests, emotional pressure, or by withholding other aspects of care or support.
- Escalate if there is a capacity concern. If there is any reason to believe that the refusal may not reflect a capacitous decision, escalate to the Registered Manager for a capacity assessment without delay.
- Review regularly. If the refusal is ongoing, revisit the individual's decision at regular intervals and ensure the risk assessment remains current.

6.10 Documenting Consent

Accurate documentation of consent is an essential component of safe, legally compliant care delivery. The following standards apply to all consent records:

- The fact of consent, the form in which it was given (verbal or written), and the date must be recorded in the individual's care record.
- Where written consent is obtained, the signed consent form must be stored in the care record.

- Where consent was implied through the individual’s behaviour, the specific behaviour from which consent was inferred must be described.
- Any refusal of consent must be recorded in full, including the individual’s stated reasons if given, the information provided about the consequences, and any risk management action taken.
- Capacity assessments and best interests decisions must be recorded in full in the format prescribed by the organisation.
- Consent records must be stored securely and in accordance with the organisation’s data protection and information governance policy.
- All consent records must be accessible to authorised staff at all times and available for inspection by the CQC and other regulatory bodies.

7. Training and Development

7.1 Mandatory Training Requirements

All staff are required to complete the following consent-related training at the intervals specified:

Training Subject	Frequency	Applicable Staff
Consent to Care and Treatment – Principles and Practice	Induction, then every 2 years	All staff
Mental Capacity Act 2005 – Awareness	Induction, then every 2 years	All staff
Mental Capacity Act 2005 – Assessments and Best Interests	Induction, then every 2 years	Named Workers, Senior Support Workers, Managers
Advance Decisions and Lasting Powers of Attorney	Induction, then every 2 years	Named Workers, Senior Support Workers, Managers
Liberty Protection Safeguards / Deprivation of Liberty	Induction, then every 2 years	All staff
Supported Decision-Making and Communication	Induction, then every 3 years	All staff
Covert Medication – Policy and Lawful Practice	Induction	All care staff involved in medication administration
Safeguarding and Consent – Interface Training	Annually	All staff

7.2 Competency Assessment

In addition to formal training, staff competency in relation to consent will be assessed through:

- Observation of consent practice during induction and subsequently at annual appraisal.
- Review of consent documentation completed by the member of staff, assessed against organisational quality standards.

- Case-based discussion during formal supervision, focused on how the member of staff has approached consent in specific situations.
- Scenario-based testing as part of e-learning or in-house training programmes.

Where a competency gap is identified, a development plan will be agreed, implemented, and monitored. Staff will not be permitted to conduct formal capacity assessments or make best interests decisions until competency has been assessed as satisfactory.

7.3 Specialist Development

will ensure that staff who regularly support individuals with complex communication needs or fluctuating capacity have access to specialist development opportunities, including:

- Training in total communication approaches, including Makaton, PECS, AAC devices, and Talking Mats.
- Advanced mental capacity assessment training for Named Workers and managers.
- Participation in specialist networks, conferences, and learning events focused on supported decision-making.
- Access to supervision with a suitably qualified clinician or MCA specialist where complex cases arise.

8. Monitoring and Review

8.1 Monitoring Framework

operates a robust monitoring framework to ensure the quality and lawfulness of consent practice across all services:

- **Monthly consent audits:** A random sample of consent records, capacity assessments, and best interests decisions will be audited each month against the organisation’s quality standards. Audit findings will be recorded and any required actions will be tracked to completion.
- **Supervision:** Staff will discuss consent-related practice as a standing item in formal supervision, with particular attention to any situations where consent has been withheld, where capacity has been in question, or where staff have felt uncertain about how to proceed.
- **CQC compliance checks:** The Registered Manager will review consent documentation in preparation for CQC inspections and will ensure that records are complete, accessible, and compliant with Regulation 11.
- **Incident analysis:** All incidents involving consent failures, including provision of care without valid consent and failures to act on a valid refusal, will be subject to root cause analysis and the findings shared with the wider staff team.
- **Service user feedback:** Individuals will be regularly invited to provide feedback on whether they feel their decisions are respected and whether they feel supported to make their own choices.

8.2 Quality Indicators

The following indicators will be used to evaluate the quality of consent practice:

- Percentage of care records containing a current, completed consent profile for each care activity.

- Percentage of capacity assessments completed in the required format and with appropriate sign-off.
- Number of incidents attributable to consent failures, with trend analysis over time.
- Staff survey results indicating confidence in applying consent principles.
- Individual and family feedback indicating that decisions are consistently respected.
- CQC inspection ratings and feedback in relation to Regulation 11 compliance.

8.3 Policy Review Schedule

This policy will be reviewed at least annually by the Registered Manager. A review will also be triggered by changes to relevant legislation, CQC inspection findings, learning from incidents or complaints, or at the request of a commissioner, regulator, or senior manager. All revisions will be documented in the version history, and updated copies distributed to all staff. Previous versions will be archived for a minimum of ten years.

9. Reporting Concerns

9.1 Staff Duty to Report

All staff have a professional and contractual duty to report any concern they have about consent practice, including any situation in which they believe that care or treatment may have been provided without valid consent, or in which they have witnessed coercion, undue influence, or a failure to respect a valid refusal. This duty applies regardless of the staff member's seniority or length of service.

Reportable concerns include:

- Care or treatment provided to an individual who has not been asked for consent or whose refusal has been overridden.
- A colleague who routinely proceeds with care activities without seeking consent.
- Pressure being applied to an individual to consent to care or treatment against their wishes.
- Failure to act on a valid ADRT or LPA decision.
- Covert medication administration without a lawful best interests decision in place.
- Any situation in which the consent of a person with capacity appears to have been undermined by a third party, including a family member or another professional.

9.2 Reporting Channels

Concerns should be reported as follows:

- **Immediate risk concerns:** Report directly to the Duty Manager, and if necessary the Registered Manager, without delay. Where there is an immediate risk of harm and no manager is contactable, contact the emergency services.
- **Non-urgent concerns:** Report to the Named Worker or line manager at the earliest opportunity using the organisation's concern reporting system.
- **Concerns about systemic failures:** Report in writing to the Registered Manager. Where the concern involves the Registered Manager, escalate to the responsible individual or Directors.

- **External escalation:** Where concerns are not addressed internally, staff may escalate to the CQC, the local authority, or, in matters of public interest, to prescribed persons under the Public Interest Disclosure Act 1998.

9.3 Whistleblowing Protection

is committed to an open, transparent culture in which staff feel safe to raise concerns. Staff who raise concerns about consent practice in good faith are protected under the organisation’s Whistleblowing Policy and will not be subject to any detriment as a result of raising their concern. Any act of retaliation against a whistleblower will be treated as a serious disciplinary matter.

9.4 Investigation and Learning

All consent-related concerns will be investigated in a timely and proportionate manner. Outcomes will be communicated to the person who raised the concern, and any learning will be incorporated into training, supervision, and the policy review cycle. Where an investigation reveals a pattern of consent failures, the Registered Manager will take immediate steps to address organisational risk and will notify the CQC if appropriate.

10. Consent and Communication

10.1 Accessible Communication and Information

Many individuals supported by will have communication support needs that require specific adjustments to be made to the way in which information about consent is provided. This may include individuals with learning disabilities, autism, acquired brain injury, dementia, or sensory impairments. The following requirements apply:

- Every individual must have a communication profile within their care plan that identifies their preferred communication method, any communication aids used, and how staff should support their communication in relation to consent.
- Staff must use the individual’s preferred communication method when seeking consent. Written consent forms must be available in easy-read or large-print formats as required.
- Visual consent tools, including picture boards, symbol systems, and Talking Mats, should be used where they support the individual’s understanding and expression.
- The organisation will maintain a library of easy-read consent information sheets covering common care and treatment activities.
- Where the individual communicates in a language other than English, an accredited interpreter must be arranged. Family members must not be used as interpreters for consent conversations.

10.2 Fluctuating Capacity

Some individuals experience capacity that fluctuates over time or in relation to specific circumstances. This may occur in conditions including bipolar disorder, epilepsy, dementia, and substance misuse. Where an individual has fluctuating capacity, the following applies:

- Staff must assess capacity at the time the specific decision is needed and must not rely on a previous assessment.
- Where possible, significant decisions should be timed to coincide with periods when the individual is most likely to have

capacity.

- Individuals with fluctuating capacity should be encouraged to make advance statements about their preferences for care and treatment during periods of capacity, to inform best interests decision-making during periods when capacity is absent.
- Care plans must clearly identify the signs that may indicate a period of reduced capacity and the steps staff should take in response.

10.3 Consent, Culture, and Diversity

recognises that cultural, religious, and personal values can significantly influence an individual’s approach to consent and their attitude to specific forms of care and treatment. Staff must:

- Respect the right of individuals to make decisions that reflect their cultural or religious beliefs, even where these decisions differ from prevailing clinical or social care guidance.
- Ensure that any care plan reflects the individual’s cultural identity and any specific consent preferences arising from their values or beliefs.
- Seek specialist advice or advocacy where cultural, language, or religious factors create barriers to the consent process.
- Ensure that gender preferences relating to personal care are recorded and respected at all times.

11. Information Governance

11.1 Consent Records

Consent records and associated documentation, including capacity assessments, best interests decisions, ADRTs, and LPA documents, constitute sensitive personal data and must be handled in accordance with the UK GDPR and Data Protection Act 2018. These records must be:

- Stored securely, whether in electronic or paper format, with access restricted to authorised personnel.
- Accurate, complete, and updated promptly following any change in the individual’s consent status or capacity.
- Retained for a minimum of seven years following the conclusion of the individual’s support, in accordance with the organisation’s records retention schedule.
- Made available to the individual upon request, in accordance with their subject access rights under the UK GDPR.

11.2 Sharing Consent Information

Consent records may be shared with other professionals involved in the individual’s care, including health professionals, social workers, and advocates, on a need-to-know basis and in accordance with information sharing agreements or protocols. The Data Protection Officer () must be consulted where there is any uncertainty about the lawfulness of a proposed sharing arrangement. Consent records must not be shared with family members or representatives without the individual’s permission, unless disclosure is required to protect the individual’s vital interests.

12. Safeguarding Interface

12.1 Consent and Abuse

A failure to respect consent can itself constitute a form of abuse under the Care Act 2014. Physical abuse, sexual abuse, and psychological abuse may all be perpetrated through ignoring or overriding an individual's consent. Where any member of staff suspects that an individual has been subjected to care or treatment without valid consent, or that their consent has been obtained through coercion, deception, or undue influence, they must:

- Report the concern to the Safeguarding Lead () and the Registered Manager without delay.
- Record their observations and the basis for their concern accurately and contemporaneously.
- Not investigate the concern themselves or discuss it with the person suspected of the abuse.
- Follow the organisation's Safeguarding Adults at Risk Policy for all subsequent steps.

12.2 Consent and Deprivation of Liberty

Where a person lacks capacity to consent to their care arrangements and those arrangements involve continuous supervision and control from which the person is not free to leave, a deprivation of liberty may be occurring. In such circumstances, the Safeguarding Lead and the Registered Manager must:

- Assess whether the arrangement meets the threshold for a deprivation of liberty in accordance with current case law.
- Apply for an authorisation under the existing Deprivation of Liberty Safeguards or, when in force, the Liberty Protection Safeguards framework.
- Ensure that the individual's nominated person and any relevant representative is informed and involved.
- Review the care plan to identify whether any less restrictive alternative is available.

13. External Notifications

will meet all statutory notification obligations in relation to consent-related matters. These include:

- **Care Quality Commission (CQC):** The Registered Manager must notify the CQC under Regulation 11 and the duty of candour where a consent failure has resulted or may have resulted in harm to an individual. Notification must be made as soon as reasonably practicable and in the prescribed format.
- **Local Authority Safeguarding:** The Safeguarding Lead must make a referral to the local authority safeguarding adults team where a consent failure constitutes or contributes to a safeguarding concern under the Care Act 2014.
- **Court of Protection:** The Registered Manager must seek a determination from the Court of Protection in any case where there is a serious dispute about a best interests decision or the validity of an LPA or ADRT that cannot be resolved through local consultation.
- **Office of the Public Guardian:** Where there is concern that an LPA attorney is not acting in the donor's best interests, this must be reported to the Office of the Public Guardian.

14. Related Policies

This policy forms part of ‘s governance framework and should be read in conjunction with the following:

Policy / Document	**Relevance**
Mental Capacity Act and Best Interests Policy	Detailed operational guidance on conducting capacity assessments and making best interests decisions in line with the MCA 2005.
Deprivation of Liberty / LPS Policy	Framework for identifying and authorising deprivation of liberty arising from care arrangements where consent is absent.
Care Planning and Risk Management Policy	Establishes how individual consent preferences and capacity information are documented within the care plan.
Safeguarding Adults at Risk Policy	Addresses the interface between consent failures, coercion, and safeguarding duty under the Care Act 2014.
Medication Management Policy	Includes procedures for obtaining consent to medication administration and for managing refusals, including the lawful use of covert medication.
Positive Behaviour Support Policy	Governs the use of restrictive interventions and the consent or best interests authorisation required for any restrictive practice.
Information Governance and Data Protection Policy	Sets out the framework for storing, processing, and sharing consent and capacity documentation in accordance with UK GDPR.
Equality, Diversity, and Inclusion Policy	Ensures that consent processes are accessible and free from discrimination, with reasonable adjustments made for protected characteristics.
Whistleblowing Policy	Provides staff with guidance and protection for raising consent-related concerns, including concerns about colleagues or managers.
Complaints and Compliments Policy	Provides a mechanism for individuals and families to raise concerns about the handling of consent during care delivery.

Policy Approval & Review

APPROVED BY **Not Specified**	SIGNATURE *No signature on file*
REVIEW DATE **1 January 1970**	NEXT REVIEW DATE **22 April 2027**