New templates Appendices 6, 7, 8 and Q & A.

HSE National Consent Policy 2022 v1.2
29th January 2024

National Office for Human Rights and Equality Policy

HSE National Consent Policy 2022 v1.2 Q & A

Thank you for the questions and scenarios submitted.

Recording of this event will be available on hse.ie/nationalconsentpolicy

2 CPD points from the RCPI

1.5 CEU points from the NMBI

Dr Philip Crowley, National Director of Strategy and Research

National Office for Human Rights and Equality Policy

Prof Mary Donnelly (chair), School of Law, UCC

- Prof Shaun O’Keeffe, Consultant Geriatrician, Galway University Hospitals
- Caroline Howorth, Director of Adult Clinical Services in St Michael’s House
- Joanne Condon, National Manager, National Advocacy Service for People with Disabilities

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Can one proceed with an intervention if the person’s will and preference is known as wishing to proceed, however it is known the individual does not understand the risks associated with the intervention?

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Hi folks I would just like to address the fact that a lot of healthcare professionals are as yet, not fully on board with the HSE consent policy it seems. There are still barriers to accessing procedures for individuals with Intellectual Disabilities where consultants etc. are seeking consent forms from NOK and refusing to proceed with procedures even though this in direct contravention to the HSE consent policy that now exists.

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John is in his 30s and has a severe ID and doesn't talk. Previously his brother was key in making decisions, but staff now want to figure out how to support John to make his own decisions. Can you give any advice about how to support someone like this who doesn't talk?

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I sit on the local placement panel forum and I would like to know how the ADM act effects our task in approving or not approving a person’s application for Long Term Care under the Fair Deal NHSS system. In particular those applicants who have a diagnosis of advanced dementia. We are challenged by the top section of the CSAR form “I confirm that the assessment process and purpose has been explained to me. I consent that information may be shared as appropriate by relevant health and social care professionals in the processing of this application”- who can and can’t sign it (apart from the applicant?) and CSAR Section 4.

We are currently approving such people in good faith and for the benefit of the person - based on their obvious need for 24hr care and in the absence of any dissenting voices. I’d appreciate some clarity our legal position if our decision were to be legally challenged.

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Regarding consent for discussion at MDT or Clinical team meetings. In our area we currently obtain verbal consent from client for discussion at these meetings. Is this considered rolling consent or if a person is discussed for example once a month for 6 months, does consent need to be sought prior to discussion each month? Does verbal consent withhold? Or is written consent required?

Clinical Co-ordinator is trying to standardise our consent/referrals/paper work across clinical teams in our area.

Is consent at referral stage required?

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The HSE's primary legal basis for processing special category data is when processing is necessary for the purposes of:

- *preventative or occupational medicine*
- *medical diagnosis*
- *provision of healthcare*
- *treatment or social care*
- *management of health or social care systems and services or pursuant to a contract with a health professional*

(Article 9(2) (h) GDPR). Please see link to memo in chat box.

https://healthservice.hse.ie/staff/procedures-guidelines/data-protection/legal-basis-to-use-personal-information/#:~:text=The%20HSE%20legal%20bases%20for,relates%20to%20providing%20health care%20services

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In some cases a person's will and preference is not necessarily in their best interest, what is the guidance in this case?

From a legal perspective what is legal view or understanding as to what is 'benefit to the patient'. Is 'benefit of the patient' synonymous with 'doctrine of necessity'?

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If a person has no appointed ‘NOK’ officially (by courts or legally through solicitor etc), and no close family/no children/ niece/siblings, and there is a query regarding a person’s ability to comprehend information, or lack of safety awareness and self neglect. A neighbour brings to medical appointments only. Where do we obtain or know we are obtaining informed consent? What needs to be put in place or commenced for future planning?

Case Scenario:

68yr old, lives alone no family. Lives in a portacabin by choice. Not linked to disability services but would appear to have a mild learning disability. History of alcohol consumption and goes away for days at a time on binges. Has a wound requiring frequent nursing care and diabetic-poor self management. Neighbour brings client to medical appts, brings dinners, but if neighbour not around there is nobody. Neighbour concerned regarding future planning. If self neglect is apparent, at what point is it considered the client doesn’t or does have capacity for this self neglect? What needs to be in place legally to show that the persons wishes are for self neglect and they have the capacity to make that decision. If the client becomes unwell or professional concerns regarding safety awareness for this client what needs to be in place or sought? What area of Policy or Act can this be referred to?

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Capacity assessment regarding making a decision for a resident- if they are transfer to another nursing home. Is a resident's meeting more than enough? Supporting the residents in making a decision. Family involved too to ensure they are aware of the situation. Family always says that the resident can't make a decision, that they have to approve prior to transfer. Even though the resident agreed and understood during the meeting. what's your take on this?

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Client with cognitive impairment living with elderly wife, children living abroad. GP referral received as client declining to attend geriatrician review. Client declines primary care input but wife is extremely stressed and is not coping as client is awake and trying to leave the house in the middle of the night.

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Could Shaun please speak a little regarding the definition of capacity as opposed to one’s insight. Have come across a case where person had capacity to make a specific decision i.e. refused hospitalisation and further treatment, however this was over ruled when a psychiatrist deemed the person (no history of mental illness) lacked capacity in understanding consequences of refusal. The person was hospitalised and treated. Could put staff in precarious position re: presuming capacity or/and then on assessment deems has capacity to make perhaps very unwise decision but later over-ruled.

This webinar will be available to watch back on

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