## **DOCUMENTING CONSENT**

Table 12. Written consent		
Written consent obtained	Total	(%)
Yes	979	(79)
No	254	(21)
Sub-total Sub-total	1,233	
Not answered	585	
Total	1,818	

NCEPOD asked whether written consent was obtained (Table 12) and 32% (585/1,818) of responders did not answer this question. It may be that the respondents failed to locate the document in what may on occasions be bulky casenotes. Consent for a medical intervention is a legal requirement, and the casenotes should contain a copy of the written consent. If the patient is not able to provide consent the clinical notes should explain the circumstances. There should be a record of why they are unable to, any discussions with the patient and their level of understanding, and any discussions that took place with the patient's relatives or carers. The medical notes should be able to demonstrate that the decision to proceed without the patient's consent was taken by the medical staff in the patient's best interest. It became apparent during the advisors' review of casenotes that some did contain this information, but many did not.

The written consent should accurately reflect the planned procedure. Review of the casenotes revealed a spectrum of detail on the consent forms, from those that included the risks of the procedure to some which stated "gastroscopy", with no indication as to the therapeutic procedure that was planned, or the risks. Examples of consent forms that provide information, including specifically the risks of gastroscopy, colonoscopy and ERCP, are published in the BSG guidelines for consent for endoscopic procedures<sup>2</sup>. This document gives valuable standards on the risks that should be discussed with the patients and what should be recorded. There is a case for standardised endoscopy consent forms for most endoscopy procedures – both diagnostic and therapeutic.

A number of centres use computer-generated reports for procedures and some state by default that written consent has been obtained. If written consent has not been obtained the endoscopist should adjust the computer record accordingly; not leave an erroneous entry.