PROCEDURE FOR PATIENT INVOLVEMENT IN HEALTH CARE

Approved by Senior Management Team:	**26 April 2004**
Review Date:	**April 2007**
Responsible Officer:	**Assistant Director of Patient Services**

Shetland NHS Board

Patient Involvement in Health Care

(1) Introduction and Purpose.

(1.1) Shetland NHS Board's (the Board) commitment to patient, carer and relative involvement in health care is already stated in the Board's policies on Admission, Discharge and in its Communications Strategy. The Board is also actively committed to Patient Focus Public Involvement (PFPI). The purpose of this procedure is to reinforce the importance of involving patients, and where appropriate with the patient's consent, also seeking opinions and support from carers and relatives.

(1.2) This procedure also highlights how such involvement may be encouraged and achieved by Health Care Practitioners employed by the Board.

(2.0) Definition.

(2.1) These definitions apply to terms used in this procedure.

- **Patient**. An individual receiving a course of treatment either as an in-patient or out patient in the Gilbert Bain Hospital or Montfield Hospital or in a primary care setting.
- **Carer**. An individual that provides formal care for a patient but who may provide such care on an informal basis. Such an individual is usually, but not exclusively, a close relative of the patient and may or may not receive payment for providing such care (but not as a Board employee).
- **Relative**. An individual who is closely related to the patient and may also be the patients Next of Kin (NOK)
- **Health Care Practitioner**. An employee of the Board employed in the direct provision of health care to patients. Such individuals may be employed on a substantive or temporary contract and may include locum, bank or agency staff.

(3.0) Procedure

(3.1) In its admission and discharge policies, the Board states its commitment to patient involvement in health care. All staff should be aware of these polices and their contents.

(3.2) Some Health Care Practitioners are additionally bound by codes of professional conduct regarding matters of patient involvement in health care. For example, the Nursing and Midwifery Council (NMC) states:

"You must recognise and respect the role of patients and clients as partners in their care and the contribution they can make to it. This involves

identifying their preferences regarding care and respecting these within the limits of professional practice, existing legislation, resources and the goals of the therapeutic relationship." (Nursing Midwifery Code of Conduct. Page 2. Section 2.1 April 2002.)

The General Medical Council states:
"respect the rights of patients to be fully involved in decisions about their care;"

The importance of patient involvement is stated in the Generic Standards for Clinical Governance produced by Quality Improvement Scotland (QIS).

"All patients are enabled to be partners in making decisions about their own care." (Generic Standards for Clinical Governance. Standard 1.2 (1) 2002)

Health Care Practitioners should be familiar with their respective codes of conducts requirements to involve patients in their health care as well as the Board's requirement to meet QIS standards and to achieve Clinical Negligence and other Risks Indemnity Scheme (CNORIS) accreditation at levels 1,2, and 3. Staff should also be familiar with the Board's strategic documents on the developing PFPI agenda.

(3.3) Health Care Practitioners should ensure that patients, and where appropriate with the patient's consent, carers and relatives, receive a full explanation of the treatment that they will receive either as an inpatient, out patient or in the community. Whilst this explanation may be given verbally, it should also be supplemented with information booklets / leaflets, which may be internally or externally produced. For more information, please refer to the Board's procedure on the Production of Patient information.

(3.4) If consent for a surgical or medical procedure is required as part of the patient's treatment, then Health Care Practitioners should ensure that this consent is obtained meeting the standards noted in the Boards policy on **Informed Consent** using the Boards **Consent Form**.

(3.5) Health Care Practitioners should ensure that Patients, and where appropriate with the patient's consent, carers and relatives, should be fully involved in the planning of their care and treatment. Health Care Practitioners should discuss with the patient the care or treatment they propose to deliver and why. If the patient has any questions about the proposed options, these should be answered as fully as possible. Health Care Practitioners should be prepared to discuss patient concerns and fears about care that is being proposed, and, if appropriate and possible, explore other options to achieve desired outcomes.

(3.6) Health Care Practitioners should remember the importance of multi-disciplinary working to help achieve the most appropriate outcomes for each patient. When planning care on a wider scale, the patient's right to confidentiality must be respected.

(3.7) Health Care practitioners should ensure that communication with patients' carers and relatives is fully and accurately recorded in the patient's clinical notes. Such records must show that the patient has been fully involved in the process of planning their care.

(3.8) Health Care Practitioners must respect the patient's right to refuse care, even if this is against medical advice and may be detrimental to a patient's health and well being. A patient's reason/s for refusal, along with the advice Health Care Practitioners have offered in such cases, must be fully documented in the patient's clinical notes. The patient's consultant must also be contacted at the first opportunity.

(4.0) Monitoring Procedures.

(4.1) The Quality Department will be responsible for monitoring patient involvement in their care. Patient involvement audits will be conducted at six monthly intervals and the results reported to the Clinical Governance Coordinating Group.

Reference
Review date

Approved at a Meeting of the Senior Management Team on 26 April 2004