



Institute of Podiatrists / College of Foot Health

Consent, Mental Capacity and Best-Interests Policy

1. Purpose

This policy provides guidance for podiatrists and Foot Health Practitioners (FHPs) when treating adults whose ability to give valid consent may be impaired, including people living with dementia, cognitive impairment, learning disability, acquired brain injury, acute confusion or communication difficulties.

It is particularly intended to support clinicians where:

- a patient appears unable to understand or consent to proposed treatment;
- a patient refuses or resists treatment;
- relatives or carers request treatment that the patient does not appear to want;
- there is disagreement about whether treatment should proceed;
- restraint or sedation is being suggested to enable treatment.

The central principle is that **the patient remains at the centre of the decision.**

2. Scope

This policy applies to IoP and CoFH members providing foot healthcare in private practice, care homes, domiciliary settings and other clinical environments.

HCPC-registered podiatrists must also comply with HCPC Standards of Conduct, Performance and Ethics. HCPC standard 1.4 requires registrants to obtain valid, voluntary and informed consent from a patient who has capacity, or appropriate authority where they do not.

FHPs should follow the same principles of consent, dignity, autonomy, best interests and appropriate escalation within their own scope of practice.

3. Legal framework

For patients in **England and Wales**, this policy reflects the Mental Capacity Act 2005 and its Code of Practice.

The Act is based on five key principles:

1. A person must be presumed to have capacity unless it is established otherwise.
2. A person must be given all practicable help to make their own decision before being regarded as lacking capacity.

3. A person is not to be regarded as lacking capacity simply because they make a decision others consider unwise.
4. Any decision made for someone who lacks capacity must be in their **best interests**.
5. The least restrictive effective option should be chosen.

Members practising in Scotland or Northern Ireland must follow the relevant legislation applicable in those jurisdictions.

4. Capacity is decision-specific

A diagnosis of dementia or any other condition does **not automatically mean that a patient lacks capacity**.

Capacity must be considered in relation to the particular decision required at that particular time.

A patient may, for example, be unable to manage complex financial decisions but still be perfectly capable of deciding whether they wish to have their toenails treated.

Before deciding that a person lacks capacity, the clinician should consider whether the patient can:

- understand the information relevant to the decision;
- retain that information long enough to make the decision;
- use or weigh the information when making their decision; and
- communicate their decision by any means.

Where uncertainty remains, treatment should normally be deferred where clinically safe and advice sought from an appropriate healthcare professional.

5. Supporting patients to make their own decision

Reasonable steps should be taken to help the patient participate.

This may include:

- explaining treatment in simple language;
- demonstrating what is proposed;
- allowing additional time;
- treating at the patient's best time of day;
- reducing noise and distractions;
- using visual or communication aids;
- ensuring hearing aids or glasses are available;
- involving a familiar carer where appropriate;
- breaking treatment into shorter stages;
- postponing non-urgent treatment.

The Mental Capacity Act requires patients to be supported to participate as fully as reasonably possible in decisions affecting them.

6. Consent and refusal

Where a patient has capacity, their decision must be respected.

This includes a decision to **refuse treatment**, even where:

- the clinician believes treatment would be beneficial;
- the patient's relative disagrees;
- treatment has previously been accepted;
- the refusal may result in deterioration.

Consent should remain voluntary and must not arise from pressure from clinicians, relatives, carers or others. HCPC guidance specifically states that valid consent must be voluntary and informed.

Consent is an ongoing process. A patient may withdraw consent at any time during treatment.

7. Family members and carers

Family members and carers should be listened to and their knowledge of the patient may be extremely valuable.

However:

Being a spouse, partner, son, daughter, relative, carer or “next of kin” does not automatically give someone legal authority to consent to healthcare on behalf of another adult.

Where someone states that they have authority to make health and welfare decisions, clinicians should establish whether they hold an appropriate:

- Health and Welfare Lasting Power of Attorney;
- Court of Protection deputyship; or
- other lawful authority relevant to that decision.

Even where such authority exists, the patient's own wishes, feelings and behaviour remain relevant.

8. When the patient lacks capacity

Where a patient lacks capacity to decide about the proposed treatment, treatment must only be provided where it is reasonably considered to be in that patient's **best interests**.

Factors should include:

- the clinical necessity of treatment;
- pain or discomfort;

- risk of infection, ulceration or deterioration;
- consequences of delaying or withholding treatment;
- the patient's past and present wishes and feelings;
- their beliefs and values;
- views of relatives, carers and professionals involved;
- whether capacity may return;
- whether a less restrictive alternative is available.

Best interests are not determined solely by what relatives or healthcare professionals would prefer. The patient's known wishes and reactions should be given proper consideration.

9. Distress, refusal and resistance

Particular caution is required where a patient who lacks capacity appears to resist treatment.

Signs may include:

- saying “no” or “stop”;
- withdrawing the foot or leg;
- crying or becoming frightened;
- shouting;
- attempting to leave;
- pushing the clinician away;
- striking or kicking;
- marked agitation.

These behaviours should not be dismissed merely because the patient lacks capacity.

If the patient becomes significantly distressed or actively resists treatment, clinicians should **normally stop treatment and reassess the situation**.

Consider whether:

- the treatment is urgent;
- only essential treatment could be undertaken;
- the appointment could be rearranged;
- a different approach or setting could help;
- another healthcare service would be more appropriate.

10. Restraint

Routine foot care should not normally involve physical restraint to overcome a patient's resistance.

Under the Mental Capacity Act, restraint may include the use or threat of force where a person resists an act, or restricting a person's movement.

Where restraint might be required, it must be necessary to prevent harm and proportionate to the likelihood and seriousness of that harm.

It should **not be used simply because completing treatment would otherwise be difficult or inconvenient.**

Where significant restraint would be required, the clinician should stop and seek appropriate medical, safeguarding or professional advice before proceeding.

11. Sedation

Sedation should **not be regarded as a routine solution** for a patient who cannot tolerate foot treatment.

Previous sedation for dental, hospital or other procedures does not automatically justify sedation for podiatry or foot healthcare.

Where sedation is proposed specifically to enable foot treatment, there should be:

- a clear clinical reason for the treatment;
- consideration of less restrictive alternatives;
- an appropriate capacity and best-interests decision;
- medical responsibility for prescribing the sedative;
- clear arrangements for administration and monitoring;
- an appropriate clinical environment;
- emergency and aftercare arrangements;
- confirmation that the clinician's proposed treatment remains within their competence and indemnity.

A verbal statement that “the GP is happy for sedation” is not, by itself, sufficient clinical governance for the treating podiatrist or FHP.

Where there is uncertainty, the clinician should seek written clarification from the medical team before agreeing to proceed.

12. Urgent treatment

There may occasionally be situations where failure to treat could result in significant harm, for example:

- serious infection;
- rapidly deteriorating ulceration;
- significant pain;
- suspected limb-threatening pathology.

In such circumstances, clinicians should not attempt to manage a complex capacity dispute alone.

Urgent referral to the appropriate medical, podiatry, safeguarding or emergency service should be considered.

13. Documentation

Good documentation is particularly important where capacity or consent is uncertain.

The clinical record should include, where relevant:

- treatment proposed;
- how treatment was explained;
- steps taken to support decision-making;
- the patient's response;
- evidence supporting any concern about capacity;
- views expressed by the patient;
- family/carer involvement;
- details of any legal authority claimed;
- clinical risks of treatment and non-treatment;
- best-interests reasoning;
- alternatives considered;
- reasons treatment was provided, limited, deferred or stopped;
- referrals or advice sought.

The **IoP/CoFH Capacity, Consent and Best-Interests Record** should be used where the situation is sufficiently complex to require additional documentation.

14. When to seek further advice

Clinicians should seek further advice where:

- capacity remains uncertain;
- there is disagreement between family members or professionals;
- a patient is actively resisting clinically necessary treatment;
- restraint or sedation is being proposed;
- there is concern about coercion or undue influence;
- the patient's representative's legal authority is unclear;
- treatment may involve significant risk;
- safeguarding concerns arise;
- the clinician does not feel confident that proceeding is lawful, ethical or within their competence.

Appropriate sources may include:

- GP or responsible medical practitioner;
- specialist podiatry team;
- care-home clinical lead;
- district/community nursing;
- safeguarding team;
- patient's attorney or advocate where appropriate;
- professional indemnity provider;

- IoP professional support;
- legal advice where necessary.

15. Safeguarding

Disagreement about treatment does not automatically constitute a safeguarding concern.

However, safeguarding advice should be sought where there is concern that a patient may be:

- coerced;
- neglected;
- subjected to unnecessary treatment;
- denied necessary treatment;
- subjected to inappropriate restraint;
- otherwise at risk of abuse or harm.

16. Key practice principles

Remember:

- Dementia does not automatically mean lack of capacity.
- Capacity relates to the specific decision at the specific time.
- Help the patient make their own decision wherever possible.
- A capable adult can refuse treatment.
- “Next of kin” does not automatically have authority to consent.
- Family views are important but do not replace the patient's rights.
- Best-interests decisions must focus on the individual patient.
- Choose the least restrictive reasonable option.
- Significant distress or active resistance is a reason to stop and reconsider.
- Do not use sedation or restraint simply to make routine foot care possible.
- If uncertain, defer non-urgent treatment and seek advice.

17. Policy review

Policy owner: Institute of Podiatrists / College of Foot Health

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