



Title
Client consent to care and treatment Policy and Procedure
Principle
Homekare Community Service's believes that every client that we support with care is at the centre of everything we do for them. We believe in the empowerment of our clients and that they are encouraged to remain in control and confident that they are supported to make their own decisions and consent to care and support offered.
Objectives
This policy sets out HomeKare Community Services commitment to obtaining, recording and respecting our clients consent before any care and support is provided • This policy is designed to enable Homekare Community services to create bespoke, personalised plans of care for our clients in which they are in full control and consent to all aspects of care and support delivered to enhance their daily living and ensure the correct care and support whilst encouraging independence and recognising individual human rights • What is consent? • Mental Capacity and the Mental Capacity Act 2005 • Consent in Practice: Care Visit Procedures • Shared Decision Making • Refusal of Care • Specific Consent Situations • Consent, Safeguarding, and Information Sharing • Recording, Documentation, and Audit • Training • Complaints, Incidents, and Duty of Candour
Scope
This policy applies to: • All clients of Homekare Community Services • All team members employed by Homekare Community Services including Care team, Senior team, Care Manager, HR & Compliance Lead, Registered Manager and Director/ Nominated Individual • All visitors, contract and agency workers that are working on behalf of Homekare Community Service's • All visitors and contractor on Homekare Community Service's premises

All regulated activities carried out as part of our provision of care and support to others

Responsibilities

Director/ Nominated Individual: Receives monthly Governance reports that include consent data. Holds the Registered Manager accountable for consent compliance. Approves this policy and any materials revisions

Registered Manager: Overall accountability for compliance with this policy. Conducts or oversee capacity assessments and best interest decisions. Lead consent- related audits. Ensures all team members are trained and competent. Acts as the responsible person for CQC reporting on consent- related incidents

HR & Compliance Lead- Maintains and updates this policy. Monitors team members training compliance and escalate any gaps. Maintains consent audit records. Ensures policy is reviewed in a timely manner

Care Manager: Reviews and updates care plan consent documentation. Escalates persistent refusals or emerging capacity concerns to the Registered Manager within 1 working day. Ensures daily care notes are recorded at each visit. Conduct observed competency assessments on consent practice during care visits

Senior Team- Support team members in understanding consent principles. Act as first line advisors when a team member is concerned or unsure how to respond to a refusal or capacity concern. Conduct observed competency assessments on consent practice during care visits

Care Team- Seek verbal consent before each care task at each visit. Accept and record refusals immediately. Report concerns or refusals to the Care Manager. Complete all consent- related training within timescales required

Procedure

1. WHAT IS CONSENT-

1.1 The Four Elements of Valid Consent

For consent to be legally valid, all four of the following elements must be present:

Element	Explanation	Homekare Practice
Informed	The person must understand the nature of the care or treatment being offered, its purpose, its risks and benefits, and what will happen if they decline.	Team member's explain each task clearly before carrying it out, in plain language or using communication aids where needed. Care plans contain written information about each care task.
Voluntary	Consent must be given freely, without pressure, coercion, threat, or undue influence from any person	Team members are trained to recognise and report any situation where a person may be under pressure to consent or refuse. Concerns are escalated as a potential safeguarding issue.

	— including family members, care workers, or professionals.	
Capacity	The person must have the mental capacity to make the specific decision at the time consent is required. Capacity is presumed unless assessed otherwise.	Team members follow the two-stage MCA test (Section 4) for any situation where capacity is in doubt. Capacity is never assumed absent on the basis of diagnosis or age alone.
Specific	Consent must be given for each specific act or type of care. Consent to one act does not imply consent to all care tasks.	Each care task requiring physical contact (personal care, medication support, etc.) is listed separately in the care plan. Consent is recorded for each.

1.2 Forms of Consent

Consent in community care can be expressed in different ways. All are valid, but all must be recorded.

- Written consent: Recorded in the care plan and signed by the client. Required for all new care arrangements, changes to care, and any delegated healthcare tasks.
- Verbal consent: Given in words at the start of each care visit or individual task. Always recorded in the daily care notes.
- Non-verbal / behavioural consent: A person may indicate consent by cooperating with care, extending a limb, nodding, or other actions. This must be interpreted carefully and recorded. Any sign of distress or withdrawal of cooperation must be treated as potential refusal.

Important — Implied Consent

In community care, a person's cooperation with a routine task is not automatically implied consent. Before beginning any task that involves physical contact or intervention, care workers must always seek and obtain consent verbally, even if the client has consented in writing in their care plan. Written care plan consent sets the framework; verbal confirmation at each visit confirms ongoing agreement.

1.3 Who Can Give Consent

- An adult (18 or over) with mental capacity may give or withhold consent for themselves.
- A person under 18 may consent if they have sufficient understanding (Gillick competence), subject to safeguarding considerations.
- A registered Lasting Power of Attorney (Health and Welfare) may consent on behalf of a person who lacks capacity — but only if the LPA is registered with the Office of the Public Guardian AND the specific decision falls within the scope of the LPA.
- A court-appointed deputy may consent within the scope of their appointment.

- A family member or friend CANNOT consent on behalf of an adult who lacks capacity unless they hold a registered LPA or court deputyship. Being a next of kin gives no legal authority to consent.

2 — Mental Capacity and the Mental Capacity Act 2005

2.1 The Five Statutory Principles (Mental Capacity Act 2005)

All team member's must understand and apply the five statutory principles of the Mental Capacity Act 2005 in every situation where consent or capacity is relevant:

Principle	What It Means
1. Presumption of Capacity	Every adult must be assumed to have capacity unless it is established otherwise. A person is not to be treated as lacking capacity merely because they make an unwise decision.
2. Supported Decision Making	A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success. This includes providing information in accessible formats and allowing extra time.
3. Unwise Decisions	A person is not to be treated as lacking capacity merely because they make a decision that others consider unwise. People have the right to make decisions others disagree with.
4. Best Interests	Any act done or decision made for a person who lacks capacity must be done or made in their best interests.
5. Least Restrictive Option	Before any act or decision, consideration must be given to whether the purpose can be achieved in a way that is less restrictive of the person's rights and freedoms.

2.2 The Two-Stage Capacity Test

Both stages must be satisfied before a person can be assessed as lacking capacity for a specific decision

Stage 1: Is there an impairment of, or disturbance in, the functioning of the person's mind or brain? This may include dementia, a learning disability, a mental health condition, a brain injury, or the temporary effects of alcohol, drugs, or severe illness. Stage 2: Does that impairment mean the person is unable to: (a) understand the information relevant to the decision; (b) retain that information long enough to make the decision; (c) use or weigh that information as part of the decision-making process; or (d) communicate their decision (by any means)? If YES to both: the person lacks capacity for that specific decision at that time. Capacity is always decision-specific and time-specific — it is never a blanket finding.

Capacity assessments must be:

- Documented in the care file with the date, the specific decision in question, the evidence considered, and the outcome
- Signed by the person carrying out the assessment (Registered Manager or a professional with appropriate competence)

- Based on the individual's functioning at the time, not on diagnosis, age, or appearance
- Reviewed when circumstances change

2.3 Supporting a Person to Make Their Own Decision — Practical Steps

Before concluding a person lacks capacity, team member's and the registered manager must take all practicable steps to support the person to make the decision themselves. These steps include:

- Providing information in accessible formats (easy-read, pictures, large print, translated materials, British Sign Language interpreter)
- Choosing the right time and place — when the person is alert, comfortable, and free from pain or distress
- Allowing extra time — do not rush a person to decide
- Involving a trusted person (family member, friend, or advocate) if the person wishes
- Involving an Independent Mental Capacity Advocate (IMCA) where there is no appropriate person to consult and the decision is a significant one
- Trying different communication methods — spoken word, written, pictures, gestures, interpreter
- Breaking down complex decisions into smaller, simpler questions

2.4 Best Interests Decisions

Where a client has been assessed as lacking capacity for a specific decision, a best interests decision must be made. This must:

- Involve all relevant parties: the GP or relevant clinician, the Registered Manager, and wherever possible the client themselves
- Consider the views of family members, carers, and any advocate (including an IMCA where appropriate)
- Take into account the client's past wishes, values, preferences, and beliefs — including any previously expressed views, written statements, or care plan records of preferences
- Check whether a valid and applicable Advance Decision to Refuse Treatment (ADRT) exists — an ADRT must be respected and overrides a best interests decision
- Check whether a Lasting Power of Attorney (Health and Welfare) is registered — the LPA attorney must be involved if the LPA is in force
- Be the least restrictive option that meets the person's best interests
- Be fully documented in the care file, signed by the Registered Manager and the relevant clinician

Best interests decisions must be reviewed regularly and whenever circumstances change.

2.5 Lasting Power of Attorney and Advance Decisions

Lasting Power of Attorney (LPA) — Health and Welfare

- Homecare Community Service's must verify that an LPA is registered with the Office of the Public Guardian before acting on any instruction from an LPA holder.
- A certified copy of the registered LPA must be held in the care file.
- The LPA holder's instructions must be documented in the care plan.
- An LPA holder cannot instruct Homecare to act against the client's best interests or to take any action that amounts to abuse or neglect.

Advance Decisions to Refuse Treatment (ADRT)

- A valid and applicable ADRT is legally binding and must be respected, even if it results in the person's death.
- An ADRT must be: made by a person aged 18 or over, when they had capacity; specific about the treatment being refused; and — if refusing life-sustaining treatment — must be in writing, signed and witnessed.
- ADRTs must be recorded in the care plan and communicated to all care workers and relevant healthcare professionals.
- If there is any doubt about the validity or applicability of an ADRT, the Registered Manager must seek urgent legal or clinical advice.

3 — Consent in Practice: Care Visit Procedures

3.1 Before the First Care Visit — Pre-Assessment Consent

Before Homecare Community Service's begins delivering care to a new client, the following must be completed and documented:

- A full assessment of the client's needs, preferences, and communication requirements, conducted with the client's involvement and consent.
- An assessment of the client's mental capacity to consent to the care and support package (using the two-stage MCA test if there is any doubt).
- A clear and accessible explanation of all proposed care tasks, their purpose, and what they involve.
- A written care plan reviewed and agreed by the client (or their LPA/deputy if the client lacks capacity).
- Written consent recorded in the care plan, signed and dated by the client (or their LPA/deputy) and the Registered Manager or Care Manager.
- Communication support arrangements documented (interpreter, easy-read materials, BSL, etc.).

3.2 At Every Care Visit — Ongoing Consent

Consent is not a one-off event. It must be sought at every visit for each care task. Care workers must:

- Introduce themselves clearly and state the purpose of the visit
- Explain each task before carrying it out, in plain language the person understands
- Ask the person if they are happy to proceed before beginning any task involving physical contact
- Watch for signs of non-verbal refusal or distress (withdrawal, agitation, facial expression, physical resistance)
- Accept any refusal — verbal or non-verbal — without argument or pressure
- Record consent, compliance, and any refusal in the daily care notes immediately after the visit

Golden Rule for Team Member's

Before you touch: explain and ask. If the person says no, or indicates no, stop. Record what happened and report it. A person's right to say no is absolute if they have capacity.

3.3 Consent to Personal Care

Personal care tasks (washing, bathing, dressing, continence care, oral hygiene) are the most intimate forms of care and require particular sensitivity. Team member's must:

- Explain the task, the reason it is needed, and how it will be carried out before beginning
- Offer choices wherever possible (e.g. shower or bath, morning or evening, which clothes to wear)
- Maintain privacy and dignity throughout
- Adjust the approach if the person shows signs of discomfort, even if they do not verbally refuse
- Document the person's engagement, cooperation, or any refusal in the daily care record

3.4 Consent to Medicines Support

Separate, specific consent is required for all medicines-related support. Medicines support consent must be:

- Documented separately in the care plan with each medicine and the level of support being provided (prompting, assisting, administering)
- Obtained in accordance with the Homekare Medicines Management Policy
- Reviewed at every medicines support assessment review

A person with capacity has an absolute right to refuse any medicine at any time. Where a refusal occurs, care workers must record the refusal and report it to the Care Manager.

3.5 Consent to Delegated Healthcare Tasks

Where team member's are asked to carry out delegated healthcare tasks (e.g. catheter care, peg feeding, wound care), specific written consent is required from the client. The relevant healthcare professional (district nurse, GP) must also have authorised the delegation. Consent for delegated healthcare tasks is recorded in both the care plan and the healthcare delegation record.

4 — Shared Decision Making**4.1 What Shared Decision Making Means at Homekare Community Services**

In line with NICE Guideline NG197 (Shared Decision Making, 2021), Homekare Community Service's is committed to embedding shared decision making across all aspects of care. Shared decision making means that the person receiving care and the team member's and/ or Care Manager/ Senior work together as equal partners to make decisions about care and support.

Shared decision making is not simply obtaining consent — it is an ongoing, collaborative process in which:

- The person is fully informed about the options available to them
- Their preferences, values, and life goals inform the decisions made
- The risks, benefits, and consequences of all reasonable options are explained in plain language
- The person is supported to express their views, ask questions, and change their mind
- Decisions are made with the person, not for them

4.2 Communicating Risks, Benefits, and Consequences

When discussing care options, Homekare team member's must:

- Present information in a way the person can understand, using plain language and avoiding jargon
- Use accessible formats where needed (easy-read, pictures, translated materials, interpreter)
- Explain the realistic consequences of accepting or declining a specific care option
- Not use pressure, threat, or emotional manipulation to influence the person's decision
- Allow the person to involve family members, carers, or advocates if they wish (being aware of safeguarding considerations)
- Allow adequate time for the person to consider information before making a decision
- Record the discussion and the person's decision in the care plan

4.3 When a Person Chooses a Risky Option

Adults with capacity have the right to make decisions others consider risky or unwise — this is a fundamental principle of the Mental Capacity Act 2005. Where a person with capacity chooses a care arrangement that may carry personal risk, Homekare Community Service team member's must:

- Ensure the person has been given full and accurate information about the risks
- Respect the person's decision without pressure or argument
- Document the decision, the information provided, and the person's understanding in the care plan
- Consider whether a risk assessment and management plan is appropriate
- Report any concern that the decision may be the result of coercion or undue influence from a third party to the Registered Manager as a potential safeguarding concern

5 — Refusal of Care

5.1 The Right to Refuse

A person with mental capacity has an absolute right to refuse any care, treatment, or support at any time — even if that refusal may be harmful. This right must be respected by all Homekare Community Service's team member's.

5.2 Responding to a Refusal

When a client refuses a care task or visit, the team member's must:

- Accept the refusal calmly and without pressure or argument
- Acknowledge the person's decision and their right to make it

- Check whether the person understands the consequences of their refusal (without pressuring them)
- Record the refusal in the daily care notes immediately, including the reason given if stated and the time
- Report the refusal to the Care Manager at the end of the visit — or immediately if the refused care is related to medication, health monitoring, or safety-critical support
- Not document the task as completed if it was refused

Persistent Refusal — Action Required

Where a client consistently refuses a specific care task or type of support, the Care Manager must: review the care plan within 5 working days; discuss the pattern of refusal with the client; consult the GP or relevant professional if health or safety is at risk; update the care plan to reflect the client's current wishes; and consider whether a safeguarding or welfare concern requires escalation.

5.3 Refusal That May Indicate Risk

Where a person's refusal of care places them at serious risk, the Registered Manager must:

- Assess whether the person has capacity to make the decision to refuse
- If capacity is present: document the assessment, inform the GP and any other relevant professionals, record that the risks were explained, and respect the decision
- If capacity is absent: initiate a best interests decision process involving all relevant parties, including the local authority where required
- If there is any concern that the refusal is the result of abuse, coercion, or undue influence: make a safeguarding referral to Nottinghamshire or Nottingham City MASH

6 — Specific Consent Situations

6.1 Clients with Dementia

Dementia does not automatically mean a person lacks capacity. Many people living with dementia retain capacity to consent to day-to-day care decisions for much of their illness. Homekare Community Service team member's must:

- Never assume a person with dementia cannot consent
- Assess capacity for each specific decision, at the time the decision needs to be made
- Use clear, simple language, familiar cues, and repetition where helpful
- Seek consent at the start of each task, even if the person consented earlier in the visit or in the care plan
- Recognise that capacity may fluctuate — a person may have capacity in the morning but not later in the day
- Record capacity assessments and consent carefully at each visit

6.2 Clients with Learning Disabilities

People with learning disabilities have the same right to consent as any other adult. The right to accessible information and supported decision making is especially important. Homekare Community Service's must:

- Provide care plan information and consent forms in easy-read or pictorial format where appropriate
- Allow additional time for discussions and decisions
- Involve the person's support network with the person's agreement
- Ensure staff are aware of the Oliver McGowan Mandatory Training standards for learning disability and autism

6.3 Clients with Mental Health Conditions

A mental health diagnosis does not mean a person lacks capacity. Team member's must assess capacity for each decision separately. Where a client is subject to the Mental Health Act 1983, the registered manager must take specialist advice to understand how consent rules apply in that context.

6.4 Clients Who Do Not Speak English as a First Language

- Homekare Community Services must provide a qualified interpreter for all assessments, care plan reviews, and consent discussions where the client's preferred language is not English.
- Family members should not be used as interpreters for consent discussions unless there is no alternative and no safeguarding concern — their involvement must be documented.
- Written consent documentation should be available in translation where this is practicable.

6.5 Clients Who Are Deafblind or Have Complex Communication Needs

- The Registered Manager must ensure appropriate specialist communication support is arranged.
- This may include a deafblind communicator, Makaton, communication passports, or other augmentative and alternative communication (AAC) methods.
- The communication method used to obtain consent must be recorded in the care plan.

6.6 End-of-Life Care Situations

In end-of-life care, consent remains essential. Homekare Community Services must:

- Respect any existing advance care plan, ADRT, or Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order — these must be clearly documented and accessible to all team member's.
- Ensure all team member's delivering end-of-life care are aware of the person's documented wishes and legal directives.
- Liaise with the GP, district nurse, and palliative care team regarding any changes to care that require renewed consent.

7— Consent, Safeguarding, and Information Sharing

7.1 Consent and Safeguarding

There is an important relationship between consent and safeguarding. Homekare Community Services follows the Nottinghamshire and Nottingham City Safeguarding Adults Boards' commitment to Making Safeguarding Personal — which means working with the person's consent and centring their views, wishes, and outcomes in any safeguarding response.

In most safeguarding situations, Homekare Community Services will:

- Seek the consent of the person at risk before taking any action
- Explain what safeguarding is, why a concern is being raised, and what will happen next
- Respect the person's wishes about what outcome they want from a safeguarding process

7.2 When Consent to Share Information May Be Overridden

Exceptionally, Homekare Community Services may need to share information or raise a safeguarding referral without the person's consent. This applies where:

- The person lacks mental capacity to consent to the sharing of information and it is in their best interests
- There is a serious risk to the person's life or to the life or safety of others
- A crime has been committed, or there is reason to believe a crime may be committed
- The public interest in sharing the information outweighs the person's right to confidentiality

Where information is shared without consent, the Registered Manager must document the reasons in writing, inform the person afterwards where it is safe to do so, and record the referral in the care file.

7.3 Safeguarding Referral Contacts — Nottinghamshire

Organisation	Contact for Adult Safeguarding Referrals
Nottinghamshire County Council MASH	0300 500 8080 (adults at risk)
Nottingham City Council MASH	0115 876 1000
Nottinghamshire Safeguarding Adults Board (NSAB)	nsab.nottinghamshire.gov.uk
Nottingham City Safeguarding Adults Board (NCSAB)	nottinghamcitysab.org
Emergency / Immediate Risk	999 (Police / Ambulance)
CQC (concerns about regulated providers)	03000 616161

8 — Recording, Documentation, and Audit

8.1 What Must Be Recorded

All consent-related information must be recorded clearly, accurately, and without delay. The following must be documented:

- Initial written consent — in the care plan, signed and dated by the client (or LPA/deputy if applicable), witnessed by the Registered Manager or Care Manager
- Capacity assessments — using the two-stage MCA test, with full rationale and outcome

- Best interests decisions — all participants, information considered, and the decision reached
- LPA or court deputyship details — including a copy of the registered document
- Advance Decisions to Refuse Treatment — including a copy and the date confirmed valid
- Daily consent at visits — recorded in the daily care notes (compliance, partial compliance, or refusal, with reason if given)
- Refusals — recorded immediately, with the reason if stated, and any action taken
- Changes to consent — whenever a client changes their mind, extends or withdraws consent, this must be documented and the care plan updated

8.2 Record Keeping Standards

- All records must be clear, factual, and written in plain English
- Records must be signed, dated, and timed
- Electronic records must meet the same standards as paper records
- No record may be altered after the fact without a clear note of the amendment (who made it, when, and why)
- Records must be stored securely in line with the Homekare Community Service Data Protection and Records Management Policy
- Consent records are retained for a minimum of 7 years (or until the client is 25 where they became a client as a minor)

8.3 Audit and Monitoring

The Registered Manager is responsible for ensuring that consent practice is audited regularly. The following audits apply:

Audit	Frequency	Responsible	Standard
Care plan consent documentation audit	Monthly (as part of care plan quality audit)	Registered Manager / HR & Compliance Lead	100% of active care plans have a signed consent record
Daily care note consent recording audit	Monthly (sample of 20% of daily notes)	Registered Manager	100% of audited notes record visit compliance or refusal
Capacity assessment audit	Quarterly	Registered Manager	100% of clients with a known capacity concern have a documented, current capacity assessment
Best interests decision audit	Quarterly	Registered Manager	100% of best interests decisions are fully documented with all required elements
Consent training compliance	Monthly (via training matrix)	HR & Compliance Lead	100% of team member's complete MCA/consent training within 12 weeks of start

9 — Training

9.1 Required Training

All team member's must receive training in consent, mental capacity, and person-centred care as part of their induction and ongoing development, in line with the Homekare Community Service Workforce Training Plan. Required training includes:

Training	Who Must Complete	When Required	Refresh Frequency
Mental Capacity Act Awareness (Level 1 — e-learning)	All staff	Within first 2 weeks of employment	Every 2 years
Mental Capacity Act and Consent (Level 2 — face-to-face)	All care workers, senior care workers, care co-ordinators, registered manager	Within first 12 weeks of employment (as part of Care Certificate)	Every 2 years
Care Certificate Standard 5: Work in a Person-Centred Way	All care workers	Within 12-week probation period	Annual competency review
Care Certificate Standard 7: Privacy and Dignity	All care workers	Within 12-week probation period	Annual competency review
Oliver McGowan Mandatory Training (Tiers 1 and 2 — learning disability and autism)	All staff	Tier 1 on Day 1; Tier 2 within first 3 weeks	Every 3 years
Safeguarding Adults (Levels 1 and 2)	All staff	Within first 2 weeks of employment	Every 2 years
Dementia Awareness	All care workers and above	Within 12 weeks of employment	Every 2 years

9.2 Competency Assessment

Knowledge of consent and MCA principles is assessed through the Care Certificate completion process. Observed practice competency — demonstrating consent in actual care delivery — is assessed by the Senior Care Worker during supervised practice visits within the first 12 weeks of employment, and thereafter at each annual appraisal.

10— Complaints, Incidents, and Duty of Candour

10.1 Incidents Involving Breach of Consent

Any incident in which care is delivered without valid consent — or in which a person's refusal is not respected — is a serious incident and must be:

- Reported immediately to the Registered Manager by the team member concerned

- Recorded on the HomeKare Community Service incident report form- accessible by all team members through the Nurse Buddy app- once this is completed will send an automatic notification to both the Registered Manager and Crae Manager
- Investigated by the Registered Manager
- Subject to the Duty of Candour — the client and/or their family must be notified of the incident in accordance with Regulation 20 of the Health and Social Care Act 2008
- Considered for safeguarding referral — any breach of consent involving physical contact may constitute a safeguarding concern (inappropriate physical contact under the Care Act 2014)
- Notified to CQC where it meets the threshold for a statutory notification

10.2 Complaints

Any client, family member, or advocate who wishes to complain about the way consent has been handled may do so under the HomeKare Complaints Policy. Complaints about consent are handled with the same priority as safety complaints. The Registered Manager reviews all consent-related complaints personally and includes consent complaint trends in the monthly governance report.

Linked Legislation and Guidance

Health and Social Care Act 2008 (Regulated Activities) Regulation 2014- Regulation 11 (Need for Consent) and Regulation 9 (Person Centred Care)

Mental Capacity Act 2005 and its statutory code of Practice

Care Act 2014 and associated statutory guidance

Human Rights Act 1998 (Articles 3.5.8- dignity, liberty and private life)

Care Quality Commission Fundamental Standards and the Single Assessment Framework (CQC)

NICE Guidance NG197: Shared Decision Making

SCIE Guidance on person centred consent in adult social care

Nottinghamshire and Nottingham City Safeguarding Adults Board (NSAB/ NCSAB) procedures

Skills for Care Certificate Standards (Particularly Standard 5: Work in person Centred Way and Standard 7- Privacy and Dignity)

Document Control

Policy Name:	Client consent to care and treatment Policy and Procedure
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Service Name:	HomeKare Community Services
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Policy Reference:	HCS-SCP- 002
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Version Number:	01
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Date Approved:	01.06.2026
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