THE SCOUTMED POLICY COVERING:

- ***PATIENT REPORT FORMS***
- ***DUTY OF CARE***
- ***CONFIDENTIALITY and DISCLOSURE***
- ***FITNESS TO PRACTICE and CONDUCT***
- ***CONSENT***
- ***TRAINING & RECRUITMENT***
- ***DISCIPLINARY PROCEDURE***

NOTE; THIS POLICY WILL APPLY TO ALL MEMBERS OF SCOUTMED. WHERE THE MALE GENDER IS MENTIONED IT APPLIES EQUALLY TO THE FEMALE GENDER.

THE TERM "MEMBER" WILL APPLY TO ANY MEMBER OF SCOUTMED WHO WORKS EITHER IN AN OPERATIONAL OR SUPPORT ROLE.

THIS POLICY HAS BEEN REVIEWED AND UPDATED AS A RESULT OF THE EVOLVING NATURE, AND THE INCREASING RECOGNITION OF THE PROFESSIONALISM, OF OUR ORGANISATION.

IF FOLLOWED IT WILL HELP KEEP OUR PATIENTS, MEMBERS OF SCOUTMED AND THE SCOUT ASSOCIATION SAFE.

Version 2: Revised May 2006.

INTRODUCTION.

This policy has been introduced to ensure that ScoutMed maintains its reputation as a competent and professionally run and staffed organisation.

Members of ScoutMed are obviously in positions of trust. There will be occasions when members of ScoutMed will have access to confidential information regarding patient's medical histories and social problems.

In addition members of ScoutMed may well have to undertake examinations of patients and render treatments. Many of our patients will be children and young people. In effect this places ScoutMed members in the same position as health care professionals, that is in a **unique position of trust**.

It should be remembered that you will often be dealing with people who are at their most vulnerable time, and who may be additionally vulnerable anyway because of who they are; the elderly and children are examples.

Therefore, a policy covering conduct is required for the protection of both patients and members. This is in line with other organisations that care for patients.

ScoutMed members should do nothing that brings them, ScoutMed or the Scout Association into disrepute. Following this policy will help to ensure that this does not happen.

SECTION 1: PATIENT REPORT FORMS.

1. A **Patient Report Form** (PRF) is a legal record of your actions at an incident and your actions with regard to patient care. It allows you to document your actions: **what you saw, what you found, what you did**, and just as importantly, **what you didn't do!**

1.1. If the patient is sent to hospital or referred to a doctor the PRF will become part of the patient's medical records, which will be viewed by those involved in the patient's ongoing care. It can also be used in court under certain circumstances. It is, therefore, very important that a PRF is filled out for every patient that you attend even if the patient refuses treatment.

1.2. Once completed, a copy of the PRF must be handed to any health care professional that takes over the patients care. E.g. ambulance crew, nurse etc. If the patient refuses treatment a note must be made on the PRF to this effect and the patient asked to sign a disclaimer.

1.3. ScoutMed should retain a copy of the PRF for its records. This will enable members of ScoutMed involved in the treatment of the patient to refer back to the PRF at a later date in the event of a query arising.

1.4. The PRF could form the basis of a defence should a matter proceed to court against a ScoutMed member, or in the event of the patient and the circumstances surrounding an incident ending up before a court it will act as an aide memoir and a factual record as well as a legal one.

1.5. The legal view of medical records generally is that **if it wasn't recorded it wasn't done!**

2. All the relevant information relating to the patient should be filled in on the PRF. This typically would include:

2.1. The age and sex of the patient

2.2. The circumstances leading up to the incident

2.3. The patients presenting complaint (what is it that has made them call for or seek help).

2.4. The patients past medical history (a brief history will do).

2.5. Any medications that the patient is on and any allergies.

2.6. What examination of the patient revealed including your observations: pulse, respiration's etc, any injuries found and so on.

2.7. What treatment did you carry out and at what time?

2.8. Also include **pertinent negatives**. A pertinent negative is what you didn't do or couldn't find and the reasons for this - if it is relevant to your care of the patient.

> E.g. "The patient refused to let me examine him and the patient's breath smelled of alcohol. Because of this I was unable to assess the extent of his injuries" Note: that the patient has not been accused of being "drunk" because this is hard to prove without the necessary tests. However, the reasons for NOT being able to examine the patient (pertinent negative) have been recorded and the reasons why.

2.9. Specific training on how to fill in a PRF will be given on their introduction or in the event of the PRF changing.

SECTION 2: DUTY OF CARE.

1. A very real concern of people going out to assist others is the fear (real or perceived) of litigation in the event of things going wrong.

The grounds that are frequently used in legal cases are usually a ***failure in the duty of care towards the patient*** resulting in a claim for ***negligence.***

In actual fact only a very small percentage of negligence cases are successful in court.

Indeed most patients who are unhappy at any aspect of their care usually find that they have no case for legal action. Therefore, most patients who are unhappy at the way in which they have been treated usually resort to the complaints procedures that the various service providers have in place.

2. Complaints should always be taken seriously as this may be one way in which major faults in a system, or a persons abilities, are raised and drawn to the attention of the organisation concerned. Failure to take complaints seriously may lead to future patients being able to take action for negligence in the courts.

The fact that legal cases for negligence are not as common, or as successful, as people like to think should not lull health care providers into a false sense of security, because where the cases do succeed the damages awarded are usually huge!

This policy cannot possibly hope to cover all aspects of the law relating to the care of patients. However, it will attempt to cover some basic principles to guide ScoutMed members carrying out their duties.

3. Patients who are aggrieved at their standard of care and who think that they have a case in law will almost certainly attempt to bring an action for negligence. They will resort to the ***Tort*** system or civil law. That is they will have to bring an action themselves through the civil courts as the individual feels that they have been wronged. This is opposed to the criminal law where the action is brought by society (the Crown), irrespective of the position of the individual, because it is society that has been wronged.

There are also two standards of proof depending on which court system is used:

3.1. Criminal cases (those that are brought by the Crown) have to be proved **beyond reasonable doubt.**

3.2. In cases under the Tort system (civil law) cases have to be proved on the **balance of probabilities.**

3.3. The standard of proof in the civil courts is lower than in the criminal courts.

3.4. For a negligence action to succeed the person bringing the action **(the plaintiff)** must be able to prove three things:

3.4.1. That the persons being sued had the responsibility for the patients care at the time of the alleged mishap. In other words the person(s) being sued (the **defendant(s)**) owed the patient a **DUTY OF CARE.**

3.4.2. The plaintiff has to show that the standard of care given by the defendant(s) fell short of that prescribed by law. The law will frequently use the standards set by the defendants peers to assess whether the standard of care fell short. For example, if a paramedic was being sued for some alleged failure, the courts will ask and seek clarification as to what other reasonable paramedics (the peers of the defendant) would have done under the same circumstances. If

the body of opinion amongst the paramedic profession states that they would have taken the same course of action under the same circumstances, then this area of the plaintiff's case may very well fail. Thus the defendant would not be held to be negligent.

3.4.3. The plaintiff has to show that their injuries that they are suing for were as a result of, and caused by, the defendant(s) failure to practise properly. This is usually very difficult to prove.

3.5. The main issues at stake with regard to negligence are: firstly, do you owe someone a duty of care and secondly, has the health care provider carried out the standard of care reasonably required. In this country there is no legal obligation to stop and offer help to someone requiring medical assistance, although in some cases there may be a professional and arguably a moral requirement to do so.

3.6. The only legal duty of care to a patient by a health care provider is when they are contracted to provide care as part of their job. For example a General Practitioner is required to offer emergency assistance to any persons in his or her practice area. These obligations mention health care *professionals* who are under *contract as part of their job.*

3.6.1. If you decide to stop at an incident, whilst off duty, and *offer* some form of first aid assistance you are probably then under a duty of care to the patient (as any member of the public would be) You are, however, not under any contractual obligation and therefore owe no duty of care to stop in the first place, or even offer the assistance once you have stopped. Provided that you have not offered assistance you are quite free to get in your car and drive off.

3.6.2. However, if you are *on duty* as a ScoutMed member you are almost certainly under an obligation because you have offered assistance by stating what you do. You will certainly be under obligation if you respond to a call for medical and/or first aid assistance, and once you have indicated that you will respond to that request for help ScoutMed will then owe that patient a duty of care.

3.6.3. The standard of care that you provide would be subject to the **BOLAM TEST.** This very important standard was established in a case in 1957. In ***Bolam v. Freirn Barnet HMC*** it was held that: "*A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art*".

3.6.4. The Bolam test has been used by the courts in a number of cases and basically means that health care professionals will be judged against the standards of their peers. ScoutMed members are not necessarily professional health care providers but are still under obligation not to do anything outside the scope of their training. In the event of mishap ScoutMed members would be judged against the standards of their peers, in other words other ScoutMed members, or other similar reasonable body. The extent of the training and experience of the members concerned would also have to be taken into account.

3.6.5. Members of ScoutMed who are health care professionals would still be accountable against the standards set by their professional peers (as they would be in their usual professional role). As the ScoutMed scheme has been successful and runs to a very high standard it may itself be the benchmark standard that other organisations are judged by in the future.

3.6.6. To summarise: if you are off duty (unless you are under a contractual obligation to stop, e.g. health care professional) you do not have to stop and offer any assistance at an incident. But if you do so, and **offer assistance,** then you may well find that you owe a duty of care to the patient. This will only extend to the limits of your training, experience, and equipment at the time and what you can reasonably do. This applies to anyone who stops and offers assistance. Obviously someone who knows first aid will owe more of a duty of care then someone who does not. Whilst on duty as a ScoutMed member, you are probably under an obligation and owe people a duty of care in the area that you are covering. This again will only extend to the limits of your training, experience, equipment available and what is reasonably possible.

3.6.7. Remember: what you do would be judged against the standards of your peers in the event of action being taken. These matters would be dealt with in the civil courts and not the criminal courts, unless the act of negligence that was committed was so gross it could be held that it was criminal negligence, e.g. a criminal act had been committed by the act of negligence itself.

SECTION 3: CONFIDENTIALITY.

1. It is good practice to have a policy on confidentiality and this section will deal with this area.

2. **The over riding principle when dealing with patients is to ensure their safety and to respect their privacy. Sometimes these two principles will conflict.**

3. A breach of patient confidentiality, except in specified circumstances, will be dealt with as an act of **gross misconduct.**

4. **An individual breaching confidentiality, except in specified circumstances, will be liable to dismissal from ScoutMed.**

5. Following the guidelines within this policy will help maintain patient confidentiality and will protect patients and ScoutMed members.

6. Members of ScoutMed will not disclose any information about patients to others except in the following circumstances:

6.1. Information relevant to a patients care should be passed on to others taking over this care. E.g. ambulance crew, doctor, nurse etc. Indeed it is important to relay as much relevant information as possible to others taking over a patients care.

6.2. It is recognised that from time to time information may have to be passed onto various sections within the Scout Association regarding patients with whom ScoutMed has had to deal with. General information (gender, age, details of the incident, rough outline of the problem) etc may be given to Scout Association Officials, provided it does not identify anything of a *personal* nature. It will be up to the discretion of ScoutMed members if the patients name is released. The patients name may be required in the event of formal investigations.

6.3. Generally it is not acceptable to state anything that will give away details about any personnel problems, “preferences”, past medical history, etc.

6.4. The overriding concern of ScoutMed is the safety of young people, patients and members of the Scout Association. In the event of any incident where there have been concerns with regard to health and safety, it would be acceptable to release any necessary details to enable an investigation to take place following an incident. As a rough guide the information that ScoutMed should provide will be in line with the information that is required when filling in the various HSE reporting forms that are in use. Under these circumstances the release of the patient’s name, address and general details of injuries, plus a full report into the circumstances will be allowed, but details of the patients past medical history, any personal problems etc, which have come to light, will not.

6.5. Wherever possible the consent of the patient will be sought prior to discussing the patient’s problems with any relatives, leaders etc, unless implied consent is given. E.g. if a patients next of kin (or leader) is present whilst you deal with the patient and the patient has no objection to him/her being there.

6.6. If the patients consent cannot be gained due to incapacity it will be acceptable to discuss the patient’s condition with the next of kin or another close relative, or if on a scout duty with the responsible leader, in order to obtain information about the patient to assist in their care.

6.7. It is a matter of good practice to inform parents whenever a child is conveyed to hospital as the hospital may require the parents consent to treat under certain circumstances. However, if a young person is Gillick competent and they specifically ask that you do not discuss their problems with a parent (or anyone else) you should not do so except as outlined below. However, you should still inform the parent if the child is going to hospital.

6.8. Members of ScoutMed will have a duty to disclose where it is in the **interests of the patient or society to do so.** For example, if it becomes apparent during your dealings with a patient, that he or she intends to harm another person, or indeed has harmed another person, the matter should be reported. If you genuinely believe that the patient may have intentions of harming himself or herself this again should be disclosed to the appropriate agencies.

6.8.1. **In suspected cases of child abuse it will be ScoutMed policy to report and disclose all information to the relevant authorities.**

6.8.2. It is now generally accepted that drug abuse by an *adult* patient will remain confidential unless there is an overriding reason why it should be reported. Any ScoutMed members reporting an *adult* patient's drug abuse habits to the relevant authorities would have to show an overriding reason for doing so.

6.8.3. The rights of the patient need to be balanced against the rights of society; therefore co-operation with the police may be necessary at some incidents. However, only information strictly necessary in the course of the police investigation should be released.

6.8.4. It will be acceptable to give an outline of the circumstances and the patient's details (name, address etc), rough idea of injuries/illness. It will not usually be acceptable to give out information with regard to previous medical history, personnel problems and other sensitive information.

6.8.5. The exception to his rule is where the patient is **deceased** and the police are acting as **coroner's officers. HM Coroner** is all-powerful and a basic rule of thumb is that: **what the coroner asks for in the way of information the coroner gets!** This will, obviously, only be in cases where the patient is deceased. The coroner and his or her representatives are sensitive to the needs of the patient's relatives and will usually only seek information that is really necessary.

7. All information about a patient should be recorded on a PRF. The PRF is confidential to the patient and any copies will remain secure at all times.

7.1. The following guidance should be followed with regard to PRF's.

7.1.1. It will be ScoutMed policy that the patient will be entitled to see their medical records (PRF) and have a copy of it at the time of treatment if they request this.

7.1.2. They will also be entitled to obtain a copy of the PRF at a later date after an incident for which an administration charge may be payable. The administration charge will be decided by the ScoutMed Executive and periodically reviewed.

7.1.3. If the patient is requesting to view a copy of the PRF later on after an incident, or wishes to collect a copy, an appointment should be made and the patient requested to bring some form of identification to verify who they are.

7.1.4. Acceptable forms of identification are:

Passport.
Driving licence with photograph.
A known works identification card

Or

At the discretion of the Fellowship any other form of secure identification that can clear identify the patient without any reasonable doubt, and that can be easily validated.

The patient may also apply for a copy of their records to be sent to them in the post. All applications must be in writing.

7.1.5. Patient's medical records can be released to others if the patient gives their written consent for this to be done.

7.1.6. A copy of the PRF should always be passed on to other health care providers taking over the patient's care.

7.1.7. Copies of PRF's will be kept secure at all times. They must not be left laying around in general view.

7.1.8. PRF's will be kept for ten years, and in the case of children for ten years after they reach the age of majority.

7.1.9. Once this time limit has expired, copies of the PRF must either be shredded or incinerated. **Under no circumstances should the PRF's be disposed of in domestic refuse**

SECTION 4: FITNESS TO PRACTICE AND CONDUCT.

1. Because those who are called upon to help people in their hour of need are in a unique position of trust, and the fact that it may be quite hard for a patient to prove negligence, it is incumbent on those organisations that provide this care to rigorously "police themselves". Indeed the courts look to the health care provider organisations to regulate themselves, have proper procedures in place to deal with complaints, and ensure that the highest standards of best practice are maintained.

2. The patient has a right to expect to be treated with respect and dignity by individuals who are of the highest integrity. Patients will trust you and it is up to all members of ScoutMed to ensure that this trust is not misplaced.

3. Therefore, it is necessary to specify criteria within which ScoutMed members will be expected to work.

3.1. A member of ScoutMed will automatically be removed from first aid duties, **permanently**, if they either receive a **criminal conviction** or accept a **police caution** for the following offences:

3.1.1. Theft or fraud, whether or not arising during the course of ScoutMed duties.

3.1.2. Indecency or sexual offences, whether or not arising during the course of ScoutMed duties.

3.1.3. Violence or assault upon a member of the public or patient arising during the course of ScoutMed duties.

3.2. Consideration will be given to removing ScoutMed personnel from first aid duties, either temporarily or permanently, if an act of gross misconduct is committed whether it results in formal police and/or court action or not.

3.3. Gross misconduct will be defined as follows:

3.3.1. Sexual, racial or other unlawful harassment contravening statute or accepted codes of practice during the course of ScoutMed duties.

3.3.2. Malicious damage to ScoutMed property.

3.3.3. Carelessness or negligence resulting in harm to the patient during the course of ScoutMed duties. This includes harm induced by practising outside the scope of your training or through using equipment on which you have not been formally trained, assessed and formally deemed competent to use.

3.3.4. Unjustified breach of confidentiality during the course of ScoutMed duties.

3.3.5. Provocative, turbulent or abusive behaviour towards the patient, bystanders, relatives or colleagues during the course of ScoutMed duties. This includes conduct that can be construed as bullying, harassing or demeaning towards colleagues.

3.3.6. Being under the influence of alcohol or illegal drugs whilst on duty.

3.3.7. Bringing ScoutMed into disrepute.

4. To promote the professionalism of ScoutMed, personnel should always conduct themselves in a polite, tactful and calm manner and should introduce themselves to the patient.

5. Remember that restraint and control are the hallmark of a professional even in the face of patients who may not be particularly pleasant or polite! However, this does not mean that you have to stand for verbal abuse; it means that the patient is allowed to over-react but you are not.

6. It is also necessary to consider the modesty and privacy of your patient and to protect their safety and well-being. It is good practice to follow a few simple guidelines in this regard:

6.1. Only undress a patient as much as is necessary to examine or treat them and then try to protect their modesty at all times. It is sometimes necessary to undress a patient fully to thoroughly examine them and by not doing so important information may be missed, and this could be seen as being negligent. A sensible balance between modesty on the one hand and patient welfare on the other has to be struck.

6.2. Always have a chaperon present when you examine a patient especially children and people of the opposite sex to the examiner. The chaperon should be another member of ScoutMed wherever possible, and ideally in the case of females being examined by a male member the chaperon should be female.

6.3. Always explain to the patient what you are going to do and the reasons for doing it. (See section on consent).

6.4. ScoutMed members must never act outside the scope of their training even if they come under pressure from others to do so.

6.5. ScoutMed should always fully cooperate with other health care professionals who will be involved in the care of the patient, and *if necessary* hand over responsibility to those who possess a higher skill level.

7. In the event of a distressing incident there will need to be a debrief. Each member of ScoutMed who attended the incident should be given the opportunity to discuss what he or she did in detail in an **atmosphere free from blame and recrimination.** This will enable personnel to learn from their mistakes so that lessons can be learned. This debrief may be opened up to members who were not involved directly in the incident (provided that this is practical and those involved do not object) as others may learn from the experience. This could also act as a counselling session to enable personnel to “offload” some of the stress.

8. ScoutMed members should also be aware of the risks of cross infection between themselves and their patients. Given the scope that ScoutMed members operate within it is unlikely that they will transfer any serious infections to the patient should a member be suffering from one.

8.1. However, as a precaution if a member of ScoutMed is unsure whether they are suffering from a potentially infectious illness, they should seek medical guidance before attending duties and treating patients.

8.2. If a member of ScoutMed becomes aware that they may be suffering from Hepatitis (B & C strain especially) or HIV/AIDS infection, their practice will need to be modified in accordance with **medical** advice. It may be necessary for that individual to cease to treat patients.

8.3. An individual who suspects that they may have, or who knows they actually have, a serious ***infectious*** condition, **MUST** seek medical advice and not treat patients until they have been advised that it is okay to do so. Members so affected **MUST** inform the member in charge of ScoutMed. This information will be treated in the strictest confidence.

8.4. Although sensible precautions (wearing of personal protective equipment) will usually more than suffice in preventing any infection being transferred to ScoutMed personnel, it is a sensible precaution to ensure that vaccinations are up to date.

8.5. It is recommended that personnel ensure that they are covered for the following:

8.5.1. Tuberculosis cover by means of the BCG vaccination.

8.5.2. Polio.

8.5.3. Tetanus & low dose diphtheria.

8.5.4. Hepatitis B

8.5.5. Annual flu vaccination

9. Following the guidelines in this section will help to ensure that the patients that ScoutMed are called upon to treat will receive a high standard of care by people displaying the highest levels of integrity and professionalism.

SECTION 5: CONSENT

1. It is necessary, not only from a legal viewpoint, but from the point of good practice to obtain the consent of patients before examining and treating them.

2. There are ranges of laws covering the issue of consent including much Case Law. Most will not apply in the pre hospital/first aid situation but certain principles will, and the most important areas are summarised below.

3. Consent should be obtained from the patient *wherever possible* for the treatment and probably the examination to be lawful. Except in certain circumstances it would be unlawful to treat the patient without their consent, as you would be committing a crime (the offence of battery) and a Tort (trespass against the person).

4. Not only should consent be obtained but it should be informed, that is the patient is told about the treatment (and the examination) and why you are doing it. However, English Law does not require the consent to be fully informed. Only a broad outline of the treatment need be given. This may be important in an emergency where there isn't time to explain everything.

5. The law of consent differs somewhat between adults and children and the main differences that relate to the pre hospital/first aid situation are outlined below:

5.1**. Adults:**

5.1.1. Consent can only be given by the person receiving care (the patient) and cannot be given by proxy (by someone else).

5.1.2. The patient is entitled to reject advice and treatment even if the rejection seems irrational.

5.1.3. Just because a patient rejects treatment it does not make them irrational or mad. The law does allow people to make choices that may be to their detriment. On the other hand if you feel that the patient is incapable of

understanding the situation, and is likely to deteriorate without treatment, then advice should be sought. It is almost certain that an ambulance will attend these incidents, and therefore you should liase with the ambulance crew. Other sources of advice are the patient's own doctor (if this is practicable) or the police. You also have a duty to inform the police if you genuinely believe that the patient may harm others.

5.1.4. Where consent is obtained it is the reality of the consent that matters not the form that it is given in. In other words there is no legal distinction to be drawn between the efficacies of written, oral or implied consent.

5.1.5. There are situations when it may not be possible to obtain the consent of the patient because they are **incompetent** to make the decision. That is the patient is not in a position to give their consent and there is no one else to do it for them.

5.1.6. This would include situations where the patient is unconscious or severely incapacitated. However, pain and distress are not enough on there own to invalidate the patient's wishes.

5.1.7. It may also be that they do not have the capacity to understand the consequences of refusing treatment. E.g. if they are under the influence of alcohol or drugs. Whether the patient lacks capacity or not under these circumstances is frequently down to the judgement of the health care provider. If the health care provider genuinely believes that the patient lacks capacity, or is incompetent to consent, the health care provider may administer treatment without the specific consent of the patient as they are acting in the patient's best interests. This is known as **imputed consent** and the law would support you on this.

5.1.8. Under the **Common Law of Necessity** you may treat a patient who does not have capacity to consent against their will (and ask the police to assist you if need be), if not to do so would be to the patients detriment. Contrary to popular belief a patient may also be transported to hospital against their will under the Common Law of Necessity if they do not have capacity to consent, if not to do so would be to the patient's detriment. If, however, the patient was *fully competent* and refused to consent, and you treated the patient against their wishes, the law would not support you.

5.1.9. In the case where the patient is clearly incapacitated or unconscious then health care providers are expected to carry out their obligations to the best of their abilities, provided that a group of their peers would have done the same or similar thing under the same circumstances. So in the case of a cardiac arrest you will not have the patients consent to carry out resuscitation, but it is perfectly acceptable for you to do so because a group of your peers would do the same thing under the same circumstances. This is a clear example of **imputed consent.**

5.1.10. It may not be necessary for the patient to verbally agree to you treating them; their actions alone may signal consent. For example the patient who is asked

to consent to having their blood pressure taken may not verbally agree to it, but may roll up their sleeve and hold out their arm for it to be done. Therefore, the act of preparing for the examination is in itself an act of consent. This is an example of **implied consent.**

5.2. **Children:**

5.2.1. The law regarding children's consent in the pre hospital situation is not as complicated as people may think, not at least when compared to the hospital situation. The subject of children's consent surrounding hospital treatment has created some nightmare dilemmas for the law, health care staff and parents alike, not to mention the child.

5.2.2. As a result of Case Law resulting from numerous moral and ethical dilemmas some guiding principles have now been established.

5.2.3. The law generally considers anyone under the age of eighteen years to be a child or "minor". However, this view has been modified in respect to consent to treatment by *Section 8 of the Family Law Reform Act 1969***.** This provides that at the age of **sixteen years** the child's consent becomes as effective as if he or she were an adult. This would seem to apply to **giving consent** rather than withholding it.

5.2.4. Once a child reaches the age of sixteen years they can *fully consent* to treatment in the same way that an adult would. However, under common law parents still have responsibility for their children up to the age of eighteen years. So what is the position if a child is under the age of eighteen and refuses to consent? There are basically two groups of people who can give consent against the child's wishes**.**

5.2.5. A person with parental responsibility may consent to a child under the age of eighteen years being treated against their wishes. People with parental responsibility are usually the child's parents.

5.2.6. A person without parental responsibility but who has care of the child (perhaps a grandparent with whom the child is staying) can give consent on the child's behalf. *Section 3 (5) of the 1989 Children's Act* states that a person who has care of a child but has no parental responsibility can do: "What is reasonable in all circumstances of the case for the purpose of safe guarding or promoting the child's welfare".

5.2.7. Therefore, if the child refuses treatment but a parent, or someone with care of the child, consents this will be sufficient to go against the child's wishes but only as far as is necessary.

5.2.8. However, just because you have consent from the parent, or person with care, do not ignore the child. Wherever possible you should still encourage the child to cooperate and consent. It will be much easier to deal with a cooperative child then one who is not.

5.2.9. Furthermore, it may be detrimental to the patient’s condition to force treatment or examination upon them. Just because you have consent does not necessarily mean that you should proceed. You will have to balance what you want to do against the welfare of the child (risks versus benefits) at all times. **The patient’s welfare will take precedence at all times.**

5.2.10. If you have a non-consenting child but have consent from others it will probably be better only to force treatment on the child where “life or limb” is at stake. However, with patience and tact it will usually be possible to obtain consent from the child and examine and treat them for non-life or limb threatening conditions.

5.2.11. In an emergency where there is no one to give, or it is not possible to obtain, consent it will be permissible to carry out emergency treatment on the child without consent, because a reasonable body of your peers would undoubtedly do the same thing under the same circumstances.

5.2.12. In practice most children and parents are only too happy to be helped and the issue of consent is rarely, if ever, a problem in the pre hospital situation. Far less so in fact than when dealing with adults.

5.2.13. It is rare for a parent or a person with care to withhold consent in an emergency. In fact most ambulance staff will never come across a case of this happening in many years of service. However, in this unlikely event what is the legal position?

5.2.14. If the child is *over sixteen years* provided the child consents willingly to treatment (even if the person with parental authority disagrees), there will be no problem in law because the child’s consent is a valid as an adult.

5.2.15. However, if the child is *under sixteen* and the parents or person with care refuse treatment on the child’s behalf, then an assessment will have to made to see if the child is ***Gillick Competent.*** Gillick is the name of the case that set this precedent. There have been a number of interpretations of this case and the Department of Health have issued guidelines (which some consider to be wrong and vice versa).

5.2.16. The general view is that provided a child is old enough (they do not have to be morally mature) to understand the reasons for treatment (and examination), and the possible consequences of not accepting the treatment, they can give their consent even if they are under sixteen years of age. This means the child can be treated even in the face of opposition from the person with parental responsibility or care. Clearly this would be a difficult situation and would require tact and diplomacy. You may also have to seek assistance form the relevant agencies.

5.2.17. If both the child and the person with parental responsibility/care refuse to allow you to treat the child you may still act in a *life-threatening* situation, as you are acting in the best interests of the child. You may need assistance from the statutory authorities under these circumstances.

5.2.18. The law would take a common sense view if you were trying to help a child who was seriously ill or injured. In practice refusal from a parent usually occurs in the hospital environment when the child is perhaps chronically ill, has been undergoing painful and distressing treatment for some time without much hope of recovery, and the parent(s) decide that they want the doctors to withhold further treatment.

5.2.19. It can also result from a moral dilemma as in the Gillick case. This parental challenge was as a result of contraceptives and contraceptive advice being given out to underage girls by doctors without their parent's knowledge. Therefore, it is virtually unheard off for a parent to withhold consent in an emergency in the pre hospital environment, and rarer still for both parent and child to refuse to consent under these circumstances. In practice you will find that the parent(s), or person with responsibility, and the child will only be too pleased to see you in the event of an emergency.

SECTION 6: RECRUITMENT AND TRAINING.

1. Recruitment.

1.1. It is recognised that ScoutMed needs to recruit sufficient numbers of *suitable* personal to meet the growing demands placed on our organisation. It is also important to recognise this must not be at the expense of maintaining clinical quality and standards, or jeopardising good inter team relations and harmony.

1.2. While ScoutMed does not discriminate on the grounds of gender, race, religious belief or sexuality, and will wherever possible accommodate the less able bodied within the organisation, ScoutMed reserves the absolute right to refuse membership to any individual whom it deems unsuitable. Unlike any other section in scouting members of ScoutMed will by definition be coming into regular physical contact both with children and adults on a regular basis, undertaking investigations and examinations, carrying out treatments, and on occasions helping children undress.

1.3. Treatments carried out will on occasions need to be of a high clinical standard and at other times may be painful and distressing for the patient.

1.4. Only individuals of high personal integrity, judged to be suitable for the training and demands of the job, willing and able to commit themselves to the organisation, and able to work as part of a team need apply or will be accepted.

1.5. There will be no exceptions to these requirements. Young people and their parents, as well as our adult patients, deserve nothing less as they are placing their complete trust in us.

1.6. The following recruitment process will be followed:

1.6.1. Potential applicants to ScoutMed should put their application in writing also stating any relevant qualifications that they will bring to the organisation. Any professional qualifications will be reviewed by the Clinical Manager or nominated deputy for relevance and applicability.

1.6.2. The application will be considered by the Executive Committee and the applicant either invited for interview, or turned down at this stage.

1.6.3. At interview the Executive Committee will outline the functions of ScoutMed and the commitment required. The applicant will be free to ask questions.

1.6.4. The minimum standard for undertaking ScoutMed operational duties is a current First Aid at Work Certificate. The applicant must agree to undertake this training as soon as practicable if they do not possess this qualification and wish to undertake first aid duties.

1.6.5. If there is any doubt as to the physical or mental fitness of the applicant they will be required to undergo a medical examination at their expense, and obtain a letter from a medical practitioner deeming them fit.

1.6.6. The applicant must agree to undergo the recommended course of vaccinations (flu vaccine excepted) unless there is a medical reason why they cannot do so.

1.6.7. The applicant must understand that any convictions or cautions for dishonesty, assault, or sexual offences will be an automatic bar to joining ScoutMed. This includes any "spent convictions".

1.6.8. Potential applicants to ScoutMed are required to undergo an enhanced CRB disclosure check in accordance with the Policy, Operations and Rules of the Scout Association. This applies to all applicants even if they are currently members of the Scout Association. Applying to join ScoutMed will be deemed as applying for a "new position" within the Association.

1.6.9. Subject to successful interview, CRB check, and references if applicable, the applicant will be offered a position within ScoutMed for a trial period of one year and on satisfactory completion will be offered a permanent position.

1.6.10. If the applicant is deemed unsuitable either at interview or during the trial period they will be unable to continue service with ScoutMed.

<u>2. Training.</u>

2.1. Current members of ScoutMed undertaking operational first aid duties need to maintain a minimum qualification of First Aid at Work.

2.2. Support staff are encouraged, but it is not a requirement as a condition of their membership, to maintain a first aid qualification of some description. <u>Support staff are equally valued for the additional skills that they bring to the organisation.</u>

2.3. There is no requirement for operational members to undergo advanced first aid training although they are encouraged to do so. Each component of advanced first aid training is in stand-alone modular form. Only members completing a training module, and successfully passing the module assessment, may practise the procedures and use the equipment covered in the module. If you are not signed off to do something then do not do it.

2.4. Members need to stay efficient in their basic skills. Efficiency may take the form of attending duties regularly, teaching first aid, attending training sessions, professional health care employment etc. Operational members who are absent from ScoutMed duties for long periods may be deemed inefficient and taken off operational duties until they have undergone suitable refresher training/supervised duty periods. The Clinical Manager or his nominated deputy will judge each case on its merits.

SECTION 7: DISCIPLINARY PROCEDURE.

1. Scope of the procedure.

1.1. ScoutMed is a National Scout Fellowship and as such its members are required to abide by the requirements as laid down in the Scout Associations Policies and Rules, and are subject to sanction as laid down in those Polices and Rules.

1.2. Given that ScoutMed members are in a unique position this procedure will operate in addition to the Scout Associations Polices and Rules. It should be remembered that an action that would not necessarily carry a sanction under the Scout Associations Policies and Rules may carry a sanction under this procedure.

2. General principles.

2.1. This policy will apply in cases of:

2.1.1. Suspected misconduct.

2.1.2. Suspected acts of carelessness or negligence resulting in actual or potential harm to a patient or colleague

2.2. This policy will not apply to acts resulting in a “clinical near miss” where the member concerned has made a genuine error and has not attempted to hide the facts. This will be dealt with as a clinical governance issue within a no blame atmosphere in order that any lessons can be learnt and mistakes avoided in future.

2.3. ScoutMed is an open and democratic organisation underpinned by the principles of natural justice. This will be reflected within this policy.

2.4. Any member who comes under investigation will be assumed innocent until proven otherwise no matter how serious the allegation.

2.5. It will be deemed an act of gross misconduct if any attempt is made by a member to smear or defame, either directly or by innuendo, any other member of ScoutMed who finds themselves under investigation.

2.6. Where there are reasonable grounds for suspicion of misconduct a through investigation of all the facts must be undertaken without delay. Once the facts have been established a view must be taken to see if there is a case to answer.

2.7. In the event of an investigation being required the Executive Committee will appoint a member with suitable experience to carry out an investigation. The Committee reserves the right to ask an outside agency or independent individual with suitable experience to undertake this investigation.

2.8. Evidence gathering from witnesses must be in written statement form.

2.9. During the course of any investigation the member(s) concerned must be informed that they are under investigation.

2.10. It may be necessary to suspend a member of ScoutMed during the course of an investigation. Suspension is not to be used or seen as a disciplinary sanction. **Suspension is always done without prejudice to a member's case.**

2.11. Suspension would ordinarily only be carried out in the following circumstances:

2.11.1. When the alleged misconduct or alleged act of negligence/carelessness is serious enough to warrant the immediate removal of a member from ScoutMed duties.

2.11.2. Where the member is thought to be danger to himself or others.

2.11.3. An allegation involving dishonesty, indecency, or violence will automatically result in suspension until investigations are complete.

2.12. An alternative to suspension in less serious cases is restricting the activities that a member may undertake until such time as the investigation is complete.

2.13. During the course of an investigation the member under investigation has the right to appoint a representative to act on their behalf.

2.14. If a member is subject to a police investigation and/or criminal court proceedings any disciplinary hearing cannot be held until such time as the legal proceedings are concluded.

2.15. The decision to suspend a member will be taken by the Chair of the ScoutMed Executive Committee or nominated deputy.

3. Stages of the Procedure.

3.1. *Informal Action*: In instances of minor acts of carelessness or minor acts of

misconduct a member may be spoken to by his or her peers holding supervisory or managerial responsibility. This should be done discretely and should be seen as part of the day to day process of managing a good organisation. This does not count as disciplinary action.

3.2. *Formal Action:* This can only be taken after an investigation and a hearing has taken place. If following an investigation it is apparent a formal hearing is required one will be convened. The following procedural provisions will be observed:

3.2.1. The member under investigation will be informed prior to the hearing of all the evidence gathered during the investigation, and will be given time to prepare a defence.

3.2.2. A mutually agreeable venue, time and date will be arranged for the hearing to be held. This should not be less than seven days and not more than three months after the member under investigation has been given the evidence.

3.2.3. Members of the Executive Committee will appoint a Hearing Panel one of whom will act as Chair. The Panel can be members of the Executive, or independent individuals asked to sit because they have specialised knowledge of the subject matter. In cases involving clinical issues at least one member of the panel must have professional experience in the area concerned. No member of the panel will have been involved in the original investigation. The meeting should be minuted and it is permissible to use the services of an individual agreeable to all parties to undertake this task.

3.2.4. The member under investigation has the right to bring along a representative to any hearing to act on his or her behalf.

3.2.5. The member under investigation does not have to give evidence at the hearing and no inference of guilt may be made if this is the case.

3.2.6. A person giving written evidence during the investigation will be invited to attend the hearing. If they decline to do so their written evidence will not be admissible at the hearing unless both the Panel and member under investigation agree.

3.2.7. The Chair of the Panel will open the hearing and ask for details of the case.

3.2.8. The individual carrying out the investigation will be outline the case and submit evidence.

3.2.9. The Panel will then ask the investigator any questions they may have followed by the member under investigation and/or their representative.

3.2.10. Any witnesses will then be called and questioned by members of the Panel and by the member under investigation and/or their representative.

3.2.11. Finally the member under investigation will be asked to answer relevant questions firstly by the Panel and then by their representative. The member under investigation can decline to answer and no inference may be made from this.

3.2.12. The panel will then retire to consider whether the case is proved or not. If the case is proved the Panel will decide on the appropriate sanction.

3.2.13. Ideally the Panel will reach a decision and deliver it on the same day. This should also be confirmed in writing not less than seven days from the date of the Panels decision.

3.2.14. In the event that the Panel cannot reach a decision on the same day they will consider the matter further and send their decision to the member under investigation in writing as soon as possible.

3.2.15. Copies of written Panel decisions will be sent to the Chair of the ScoutMed Executive Committee.

3.2.16. Where ever possible the Panel should reach a decision unanimously. If it becomes clear that a unanimous decision will not be reached, despite all reasonable attempts by the Panel members to find a way out of the impasse, a majority decision will prevail. The Chair of the ScoutMed Executive Committee will be informed of this when the Panel makes its decision notification.

3.2.17. Panel decisions will be based on the evidence presented working on the balance of probability rather than on beyond reasonable doubt.

4. Sanctions.

4.1. *Written warning*. This will stay on the member's record for one year and will then be removed.

4.2. *Final Written Warning:* This may be given;

4.2.1. As a first sanction in cases where the conduct of the member gives serious cause for concern.

4.2.2. If the member concerned is already the subject of a written warning and a further breach of discipline has occurred.

4.2.3. A Final Written Warning will remain on record for between one and three years. Provided there are no further breaches of discipline in this time it will then be removed.

4.3. *Dismissal:* Dismissal should be reserved for the most serious offences or for repeated breaches of discipline, namely:

4.3.1. Theft or fraud, whether or not arising during the course of ScoutMed duties.

4.3.2. Indecency or sexual offences, whether or not arising during the course of ScoutMed duties.

4.3.3. Violence or assault upon a member of the public or patient arising during the course of ScoutMed duties.

4.3.4. A breach of discipline by a member already on a Final Written Warning would normally result in dismissal unless there were mitigating circumstances.

4.4. Where an investigation leads to the suspension of a member of ScoutMed, or a Disciplinary Panel decides to dismiss a member, where appropriate a written report of the circumstances should be forwarded without delay by the Chair of the ScoutMed Executive Committee, or nominated deputy, to the National Commissioner (Adult Support) at Association Headquarters. The Scout Association may wish to take any further action that it deems appropriate.

4.4.1. When a member has been suspended and no further action is taken after investigation, or the member is exonerated following a Panel Hearing, where appropriate these details must also be so forwarded in writing to the National Commissioner (Adult Support) at Association Headquarters.

4.5. Whilst complying with the requirements of Section 7, paragraphs 4.4 and 4.4.1, the Chair of the ScoutMed Executive Committee, or nominated deputy, must be mindful of the requirements concerning patient confidentiality.

5. Appeals.

5.1. The decisions made by the Panel as to whether the case is proved or not are final and binding on all parties.

5.2. Where a member feels that the sanction awarded by the Panel is unduly harsh and/or disproportionate they may, within seven working days of the Panels decision, lodge an appeal in writing with the Chair of the ScoutMed Executive Committee. The appeal will need to state the reasons why the appellant feels that the sanction awarded was unduly harsh and/or disproportionate.

5.3. The Chair of the ScoutMed Executive Committee may substitute the Panels sanction for a lesser one. The Chair cannot impose a stricter sanction or overturn the Panels verdict.

5.4. In the event of further good evidence coming to light in the future that is sufficient to cast doubt on the Panels original verdict, the Chair of the ScoutMed Executive Committee may ask the Panel to reconvene to consider the new evidence. The Panel having regard to all the evidence may either uphold the original decision or quash any proven verdicts.

Bibliography:

Advanced Life Support Group. (2005) *Pre Hospital Paediatric Life Support. The Practical Approach.* Second Edition. Oxford. Blackwell Publishing Ltd.

Access to Records Act 1990

Children's Act 1989.

Children's Act 2004.

Data Protection Act 1998.

Department of Health., Home Office., Department for Education and Employment. (1999). *Working Together to Safeguard Children.* London. Stationary Office.

Department of Health. (2001a). *Seeking Consent: working with children.* London. Department of Health.

Department of Health. (2001b). *Seeking Consent: working with older people*. London. Department of Health.

Department of Health. (2001c). *Reference Guide to Consent for Examination or Treatment.* London. Department of Health.

Department of Health. (2003a). *Consent: A guide for children and young people.* London. Department of Health

Department of Health. (2003b). *What To Do If You're Worried A Child Is Being Abused.* London. Department of Health.

Department of Health. (2003c). *Guidance for Access to Health Records Requests under the Data Protection Act 1998*. London. Department of Health.

Joint Royal Colleges Ambulance Liaison Committee. (2004). *Clinical Practice Guidelines.* JRCALC. London.

Laming. Lord., Adjaye. N., Fox. J., Kinnair. D., Richardson. N. (2003). *The Victoria Climbie Inquiry.* London. Stationary Office.

Montgomery J. (2003) *Health Care Law.* Second Edition. Oxford. Oxford University Press.