Standard operating procedure (SOP) · PRO-SOP-002 · Version 1.0 · Approved by the ASF Expert Committee

Supports: 11.4

At a glance

- Consent is informed and recorded on PRO-FRM-003 before each procedure.
- It covers the expected outcome, the risks, the complications that can occur and their treatment, and the alternatives.
- For elective procedures the patient has time to reconsider, and the time given is recorded.
- Results are given realistically, not as guarantees.
- Stop and get help straight away if: a procedure starts without consent that covers the risks and complications, or an elective patient is pushed to decide without time to reconsider.

1. Purpose

To give each patient realistic information and time to decide (11.4).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of the facility
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions

Term	Meaning
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background

Consent for a procedure must cover what can go wrong, not only what is expected. A patient who did not hear about the risks cannot make a real decision.

5. Responsibilities

Role	Responsibility	Competence
Responsible practitioner	Gives the information and records consent	Clinician
Nurse	Confirms the reconsideration time is recorded	Nurse

6. Materials and equipment

Item	Requirement	Condition
Records and forms named in this document	Current version	Checked before use

7. Safety

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Step 1. Inform.

- Explain the expected outcome, risks, complications and their treatment, and alternatives, using PRO-FRM-003.

Key point: Realistic, complete.

Step 2. Give time.

- For elective procedures, give a defined time to reconsider, and record the date and time given.

Key point: Time to decide.

Step 3. Record.

- Record the consent, the questions asked and the answers.

Key point: Recorded before the procedure.

10. Decision points

- No decision points in this procedure.

11. Special situations

Situation	Action
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

12. Escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

13. Monitoring

Measure	Target	Frequency	Owner	If not met
Consent records covering risks and complications	100%	Monthly	Medical director	Escalate to chief executive

14. Records

Record	Kept in	Retention

Record named in this document	Patient record or the area file	the period set by the facility’s records policy years

15. Training

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

16. Related documents

ID	Title	Use
PRO-FRM-003	Procedure consent and reconsideration record	Record
CON-SOP-001	Informed consent before significant care (existing, reused)	Procedure

17. Evidence

Reference	Note
E-009	Based on the ASF Expert Committee consensus and the WHO Guidelines for Safe Surgical Care and Safe Procedures (2009).
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

18. Change history

Version	Date	What changed	Approval
1.0	the date of approval	First version	set Expert Committee approval

E-learning for this document

- **Patient Identification, Informed Consent and Patient Rights** (T-07)
- Healthcare Ethics for ASF Accreditation (A-07)

References

- Accréditation Sans Frontières (2026). ASF Policy Framework v1.2. (E-006)
- Accréditation Sans Frontières (2026). ASF Expert Committee consensus on Standard 1. (E-009)

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