

CLINICALEDU

C3

Communication, accessibility and supported decision-making

Detailed learner reading material

Consent: Shared Decision-Making, Risk, Refusal and Valid Authority

Source review: 19 September 2026

Official and authentic sources only. This educational material is not a substitute for current local policy, specialist legal advice or case-specific clinical judgment.

How to use this reading

This downloadable reading expands the browser module. It is intended for reflection, portfolio evidence and later reference. The browser module remains the interactive learning route; this PDF provides deeper explanation, practical tables, worked scenarios and the full official reference list.

Learning outcomes

- Identify communication barriers that can undermine a consent process.
- Use interpreters, accessible information, communication aids and teach-back appropriately.
- Separate communication difficulty from incapacity.
- Plan staged or repeated discussion when one consultation is insufficient.

The communication-first principle

Before asking whether a person lacks capacity, ask whether the service has given them a fair opportunity to understand and communicate. Communication impairment, sensory loss, limited English and learning disability are not diagnoses of incapacity. A poor consultation can manufacture the appearance of incapacity when the real problem is inaccessible information.

The foundation for supported decision-making is practical: reduce distractions, treat pain where possible, choose a good time, use the person's preferred communication method, arrange interpreting or advocacy, simplify without patronising, and check understanding.

Practice point

Treat teach-back as feedback on your explanation, not as a test the patient must pass.

Interpreters and supporters

Professional interpreting is especially important when the decision is complex, sensitive or high stakes. Relatives may be valuable supporters, but using them as interpreters can alter meaning, filter information, create confidentiality problems or conceal pressure. If the patient chooses family involvement, clarify roles: who is interpreting, who is supporting, and who is making the decision.

For BSL users and people with other communication needs, plan support early. Waiting until the consent appointment to discover that no suitable interpreter is available creates avoidable risk and can delay care.

Jurisdiction point

The Accessible Information Standard is England-specific; the Equality Act 2010 applies in Great Britain, not Northern Ireland.

Accessible information in England and across the UK

The NHS England Accessible Information Standard is a concrete implementation framework: identify needs, record them, flag them, share them appropriately and meet them. It applies in England, so ClinicalEdu should not label it a UK-wide statutory standard. Wales and Scotland operate under their own service arrangements, while the Equality Act 2010 provides a Great Britain equality framework. Northern Ireland has separate equality legislation.

The educational lesson transcends these legal differences: the healthcare system should adapt information to the person rather than treating communication access as the patient's problem.

Chunk-and-check, teach-back and decision aids

Chunk-and-check reduces cognitive load by presenting information in small, meaningful units and checking comprehension before proceeding. Teach-back asks the patient to explain the decision in their own words so that misunderstanding can be detected. The tone should be collaborative: "I want to make sure I explained that clearly" rather than "prove that you understood me".

Decision aids can help people compare options, particularly where trade-offs are preference-sensitive. They should supplement a conversation and should be accessible to the patient using them.

Supported decision-making and capacity

NICE NG108 emphasises practical support before substitute decision-making. Scotland's AWI principles similarly require encouragement of residual capacity. Northern Ireland's 2016 Act is only partially commenced, so the exact statutory route must be checked at publication. Across all jurisdictions, the safe clinical principle is to distinguish a communication problem from an inability to decide.

If capacity assessment is still required after support, document what was done to optimise the person's participation. This makes the later assessment more defensible and more respectful.

Documentation

Record the communication need, the adjustment or support used, the identity and role of any interpreter, whether the patient wanted family involvement, and how understanding was checked. Avoid labels such as "poor historian" when the record could instead describe the specific communication barrier and what helped.

Good documentation also makes future care safer: the next clinician can arrange the right support rather than repeating the same communication failure.

Planning accessible consent rather than repairing failure

Good accessibility is often a system design issue. Referral, booking and pre-assessment processes should capture communication needs early enough to arrange interpreters, accessible information or additional appointment time. If teams wait until the patient reaches the procedure room, they may create avoidable delay, inequity and pressure to proceed with inadequate communication.

The patient is the best starting source for what works. Ask how they prefer to receive information and communicate. Previous records or communication passports may help but should not replace asking the person directly. Support should be proportionate to the decision: a high-stakes discussion may require a professional interpreter and more time even if family support is adequate for ordinary conversation.

Documentation and continuity of communication support

Recording communication needs is not merely administrative. It allows the next clinician to reproduce effective support and prevents the patient repeatedly having to explain the same barriers. In England, the Accessible Information Standard provides a structured model of identifying, recording, flagging, sharing and meeting needs. Elsewhere, local systems should achieve the same practical objective even where the national standard differs.

Avoid writing that the patient "failed to understand" without documenting how information was presented. A more useful record is: "Complex information initially difficult to follow verbally. BSL interpreter present; diagrams used; information given in short sections; patient accurately described the purpose, main alternatives and key risks using teach-back." This shows what support was used and what the patient demonstrated.

Communication support matrix

Barrier	Possible support	Do not assume
Hearing loss / Deaf BSL user	Appropriate interpreter, hearing support, visual information, quieter environment	That nodding or lip-reading proves understanding
Aphasia	Communication board, pictures, yes/no verification, speech and language support where available	That impaired speech means impaired decision-making
Limited English	Professional interpreter, translated/accessible written material	That a relative should automatically translate a high-stakes discussion
Learning disability / cognitive difficulty	Easy-read information, extra time, repetition, familiar supporter, decision aid	That diagnosis alone establishes incapacity
Remote consultation	Check privacy, who is present, technical quality and whether in-person review is needed	That remote communication is always equivalent to face-to-face

Before assessing capacity

Step	Question
1	Is pain, anxiety, delirium, medication, fatigue or the environment affecting communication?
2	Does the person need an interpreter, sensory aid, easy-read material or another communication method?
3	Can information be simplified, chunked, demonstrated or repeated without changing its meaning?
4	Would a different time, setting or supporter improve participation?
5	After these supports, is there still a decision-specific reason to assess capacity?

Worked scenarios

Scenario 1

A profoundly deaf patient is described as "unable to consent" before a BSL interpreter is arranged. Correct the communication barrier first.

Application: Arrange appropriate communication support and avoid treating lack of access as incapacity.

Scenario 2

A patient with aphasia reliably indicates choices using a communication board. The ability to speak fluently is not the test of capacity.

Application: Use the communication board and other supports; speech impairment is not the same as inability to decide.

Scenario 3

A daughter offers to translate a sensitive cancer discussion. Clarify the patient's preference and consider a professional interpreter because accuracy, privacy and voluntariness matter.

Application: Clarify the patient's wishes about family involvement and use professional interpreting for sensitive/high-stakes decisions where needed.

Practice checklist

- Identify communication needs before the consent discussion begins.
- Use professional interpreting or specialist communication support when the decision is complex or sensitive.
- Present information in manageable chunks and check understanding.
- Use teach-back collaboratively.
- Record the adjustment/support used and whether it was effective.
- Do not label a person as lacking capacity merely because communication is difficult.

Official references

S001 - GMC: Decision making and consent. Scope: UK.

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent>

S004 - GMC: The dialogue leading to a decision - part 3. Scope: UK.

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision-continued-2>

S018 - NICE: NG197 Shared decision making - recommendations. Scope: England; clinically useful more widely with jurisdiction label. <https://www.nice.org.uk/guidance/ng197/chapter/recommendations>

S019 - NICE: NG108 Decision-making and mental capacity - recommendations. Scope: England; clinically useful more widely with jurisdiction label.

<https://www.nice.org.uk/guidance/ng108/chapter/recommendations>

S020 - NICE: CG138 Patient experience in adult NHS services - recommendations. Scope: England; clinically useful more widely with jurisdiction label.

<https://www.nice.org.uk/guidance/cg138/chapter/recommendations>

S033 - UK legislation: Equality Act 2010. Scope: Great Britain.

<https://www.legislation.gov.uk/ukpga/2010/15/contents>

S034 - NHS England: Accessible Information Standard. Scope: England.

<https://www.england.nhs.uk/accessible-information-standard/>

S028 - Scottish legislation: Adults with Incapacity (Scotland) Act 2000. Scope: Scotland.

<https://www.legislation.gov.uk/asp/2000/4/contents>

S029 - Scottish Government: Adults with incapacity: code of practice for medical practitioners.

Scope: Scotland. <https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorised-carry-out-medical-treatment-research-under-part-5-act/>

S030 - Department of Health NI: Mental Capacity Act (Northern Ireland) 2016 - topic hub. Scope: Northern Ireland. <https://www.health-ni.gov.uk/topics/mental-capacity-act>

Reference status: Links were verified in the Stage 2 dossier on 18 September 2026. Core high-risk pages were rechecked during Pass 2 on 19 September 2026. Recheck high/very-high update-risk sources immediately before publication.

Key takeaways

- Communication difficulty is not incapacity.
- Support access before drawing conclusions about decision-making ability.
- Use interpreting and accessible information proportionately to the decision.
- Record the support used and whether it enabled understanding.

ClinicalEdu - Authoritative Stage 2 source map

C3: Communication, accessibility and supported decision-making

This appendix is the controlling source map for this module. Source IDs follow the Stage 2 Research Dossier v1.0 (evidence reviewed through 18 September 2026). Any legacy shorthand labelled SUPP is supplementary and is not a Stage 2 source ID.

S001 - GMC: Decision making and consent

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent>

S004 - GMC: The dialogue leading to a decision - part 3

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision-continued-2>

S018 - NICE: NG197 Shared decision making - recommendations

<https://www.nice.org.uk/guidance/ng197/chapter/recommendations>

S019 - NICE: NG108 Decision-making and mental capacity - recommendations

<https://www.nice.org.uk/guidance/ng108/chapter/recommendations>

S020 - NICE: CG138 Patient experience in adult NHS services - recommendations

<https://www.nice.org.uk/guidance/cg138/chapter/recommendations>

S033 - UK legislation: Equality Act 2010

<https://www.legislation.gov.uk/ukpga/2010/15/contents>

S034 - NHS England: Accessible Information Standard

<https://www.england.nhs.uk/accessible-information-standard/>

S028 - Scottish legislation: Adults with Incapacity (Scotland) Act 2000

<https://www.legislation.gov.uk/asp/2000/4/contents>

S029 - Scottish Government: Adults with incapacity: code of practice for medical practitioners

<https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorised-carry-out-medical-treatment-research-under-part-5-act/>

S030 - Department of Health NI: Mental Capacity Act (Northern Ireland) 2016 - topic hub

<https://www.health-ni.gov.uk/topics/mental-capacity-act>

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