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YAS Patient Consent Policy

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Associated Documentation:

CQC Essential Standards of Quality and Safety – Regulation 18,

CQC Outcome 2 - Consent to Care and Treatment

YAS EOC Language Line Procedure

YAS Policy for the conveyance and Non-conveyance of Patients

YAS Domestic Abuse Policy & Guidance for the management of Domestic Abuse

YAS Research Governance Policy

YAS Safeguarding Children, Young People and Adults Policy

YAS Managing Complaints and Concerns Policy

Staff Summary

Clinicians have an ethical obligation to respect a patient's right to be involved in decisions that affect them. It is a general legal and ethical principle that valid consent must be obtained before undertaking any examination or investigation, providing treatment, providing personal care, or involving patients in teaching or research

Before a clinician examines, treats or cares for patients they should obtain the patients consent. In an emergency situation where consent cannot be obtained ambulance clinicians should provide treatment that is in the patient's best interest and is immediately necessary to prevent harm or avoid significant deterioration in the health of the patient.

A presumption should be made that every adult patient has the capacity to make decisions about their care, and to decide whether to agree to, refuse, an examination, investigation or treatment. A patient must not be assumed to lack capacity to make a decision solely because of their age, disability, appearance, behaviours, medical condition, their beliefs, their apparent inability to communicate or the fact that they make a decision that the clinician disagrees with.

Adult patients with capacity are entitled to refuse treatment, even where the treatment would clearly benefit their health. The only exceptions to this are patients, who have had an ambulance response to a hypoglycaemic episode or a seizure who should be automatically be referred for follow up, even if they refuse consent to do so.

Treatment involving patients with mental disorders are covered by the Mental Health Act 1983 (revised 2007), provided that the patient is formally detained under that Act. Exceptions under the Act only relate to treatment for the mental disorder itself, and not for other illnesses or conditions

The legal position regarding consent and refusal of treatment by those under the age of eighteen is different for that of adults, in particular when treatment is being refused. A young person's ability to make decisions depends more on their ability to understand and weigh up options, than on their age. Children and young people should be involved as much as possible in discussions about their care, even if they are not able to make decisions on their own.

An advance refusal of treatment, which is made voluntarily, by an appropriately informed person with capacity, and applicable to subsequent circumstances in which the patient lacks capacity, is legally binding. Ambulance clinicians should respect the wishes stated in such a document, often termed a 'living will' or 'advance directive', drawn up to cater for medical situations arising in the case of future incapacity.

Restraint covers a wide range of actions including the use, or threat of force to do something that the person concerned resists, for example by using ambulance stretcher sides or confining people's movements. The Mental Capacity Act (2005) identifies two conditions which must be satisfied in order for protection from liability for restraint to be available:

- You must with good reason believe that it is necessary to restrain the person who lacks capacity in order to prevent them from harm
- Any restraint must be reasonable and in proportion to the potential harm.

1.0 Introduction

1.1 Person-centred care moves away from professionals deciding what is best for a patient or service user, and places the person at the centre, as an expert of their own experience. The person and their family where appropriate, becomes an equal partner in the planning of their care and support, ensuring it needs their needs, goals, and outcomes.

1.2 Clinicians have an ethical obligation to respect a patient's right to be involved in decisions that affect them. It is a general legal and ethical principle that valid consent must be obtained before undertaking any examination or investigation, providing treatment, providing personal care, or involving patients in teaching or research. Consent is only valid if adequate information is supplied and the patient has the capacity to understand it and make a balanced decision, free from coercion.

1.3 Clinicians must ensure that patients are aware of any material risks involved in a proposed treatment, and of any reasonable alternatives. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the clinician is or should reasonably be aware that the particular patient would be likely to attach significance to it.

1.4 It is not uncommon in out of hospital situations for patients to refuse care or treatment. Although patients may refuse, there is still, in certain circumstances an on-going moral duty and legal responsibility for clinicians to provide further intervention particularly if life-threatening risk/s are involved.

2.0 Purpose/Scope

2.1 This policy sets out the standards and guidance for the organisation, which aim to ensure that Yorkshire Ambulance Service (YAS) staff and volunteers are able to comply with the law and Department of Health (DoH) guidance with regards to the principles of consent. This also includes identifying, recording and acting upon patient mental capacity assessments complying with the Mental Capacity Act (2005).

3.0 Process for obtaining patient consent

3.1 Before a clinician examines, treats or cares for patients they should obtain the patients consent. Appendix 1 provides the process to be followed when obtaining consent.

3.2 For consent to be valid:

The patient must be competent

Mental capacity is decision-specific. Assessment of a person's capacity should be based on his/her ability to understand, retain and weigh in the balance the information relevant to a particular decision. The person must also be able to communicate the decision. A patient who is unable to make a decision about a complex proposal is not necessarily incapable of making any decisions at all, and may be perfectly able to consent where the issues are simpler. The starting

point in the case of adults is always to presume that the patient has capacity until it is shown otherwise.

The patient must have sufficient information to make a choice
Without adequate information, patients are unable to make decisions about their treatment. The information provided should, for example, include: an explanation of the investigation, diagnosis or treatment; an explanation of the probabilities of success, or the risk of failure; or harm associated with options for treatment. The patient should be given time to ask questions. The GMC and the courts expect patients to be given all information material to their decision, with the proviso that it would not cause the patient serious harm. (Appendix 3 for further information)

The patient must be able to give their consent freely
Pressuring patients into consenting to treatment invalidates the consent. To ensure that consent is freely given, patients should, where possible, be given time to consider their options before deciding to proceed with a proposed treatment. Be aware, too, that patients' friends and relatives may also try to exert their influence and that this can be subtle but nevertheless powerful.

3.3 In an emergency situation where consent cannot be obtained, clinicians should provide treatment that is in the patient's best interest and is immediately necessary to prevent harm or avoid significant deterioration in the health of the patient.

3.4 Adults are presumed to have capacity but where any doubt exists, the clinician should assess the capacity of the patient to take the decision in question. This assessment and any conclusions drawn from it should be recorded.

3.5 Patients may have cognitive, emotional, social, or economic factors which impact on the patient making informed decisions. It is the duty of clinicians to act in a patient's best interest by assisting to overcome such difficulties so that the patient has a clear, unbiased and informed view of the care that is being proposed.

3.6 In practice, patients need to be able to communicate their decision. Care should be taken not to underestimate the ability of a patient to communicate whatever their condition. Clinicians should take all steps that are reasonable in these circumstances to facilitate communication with the patient, using interpreters or communication aids as appropriate, while allowing for the urgency of the situation.

3.6.1 Patients with Sensory Impairment

Clinicians should ensure that when seeking consent from patients who have a sensory impairment that they consider available resources or assistive technology to help with communication, for example type talk or British Sign Language interpreters

3.6.2 Patients whose first language is not English

YAS is committed to ensuring that all patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not best practice to use family members

to interpret for the patient who does not speak English, however, it is recognised this may be the only option available. If language is still a barrier to effective communication then staff should consider translation services such as 'The Big Word'. Multi-lingual communication booklets are also available on every front-line vehicle to aid communication.

3.6.3 Other patients who may have difficulties in communicating

A person identified as having a learning disability may require empowerment to consent through a variety of means. Alternative communication methods should be considered when possible e.g. Books, beyond words, visual aids. The YAS Staff Communication Guide for People with Learning Disabilities is available as a resource when assisting patients with learning disabilities which includes some Makaton signage. Copies are available on YAS Intranet.

3.7 Refusal of Consent

3.7.1 Adult patients with capacity are entitled to refuse treatment, even where the treatment would clearly benefit their health. All relevant information about the management options and associated risks must be provided to allow the patient to make an informed decision. Without adequate information, patients are unable to make decisions about their treatment. The information provided should, for example, include: an explanation of the investigation, diagnosis or treatment; an explanation of the probabilities of success, or the risk of failure; or harm associated with options for treatment. The patient should be given time to ask questions. The GMC and the courts expect patients to be given all information material to their decision, with the proviso that it would not cause the patient serious harm. Refusal should be a rare situation and cannot be used as a proxy for a non-conveyance and efforts must be made to explore all potential options including appropriate safety netting.

3.8 Withdrawal of Consent

3.8.1 A patient with capacity is entitled to withdraw consent at any time, including during a procedure. Where a patient does object during treatment, it is good practice for the clinician, if at all possible, to stop the procedure, establish the patient's concerns and explain the consequences of not completing the procedure, and should ensure this is documented.

3.9 Capacity to Consent (Appendix 2)

3.9.1 Making decisions about treatment and care for patients who lack capacity is governed by the Mental Capacity Act 2005. The legislation sets out the criteria and procedure to be followed in making decisions when these patients lack the capacity to make decisions themselves.

3.9.2 A presumption should be made that every adult patient has the capacity to make decisions about their care, and to decide whether to agree to, refuse, an examination, investigation or treatment. A patient must not be assumed to lack capacity to make a decision solely because of their age, disability, appearance, behaviours, medical condition, their beliefs, their apparent inability to communicate or the fact that they make a decision that the clinician disagrees with.

3.9.3 A person lacks capacity in relation to a decision or proposed intervention if, at the material time he or she is unable to make a decision for him or herself in relation to the matter or proposed intervention because of an impairment of, or a disturbance in the functioning of the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary.

3.9.4 The responsibility for deciding to test capacity rests with the professional who needs to make a decision on behalf of someone who lacks capacity and is based on the following principles;

- Always in the best interests of the patient
- Less restrictive care provision option
- Encourage individual to make their own decision
- Eccentric decisions are okay

3.9.5 Adults who usually have capacity may, especially in emergency situations, become temporarily incapable of having their capacity assessed. In such circumstances it is permitted for clinicians to apply treatments that are necessary and no more than is reasonably required in the patient's best interests pending the recovery of capacity. This includes any action taken to preserve the life, health or well-being of the patient, and can include wider social, psychological or welfare considerations. Where possible a general practitioner (GP) or professional carer should be fully consulted if there is any doubt concerning the patient's capacity.

3.10 Children and Young People

3.9.1 The legal position regarding consent and refusal of treatment by those under the age of eighteen is different for that of adults, in particular when treatment is being refused. A young person's ability to make decisions depends more on their ability to understand and weigh up options, than on their age. Children and young people should be involved as much as possible in discussions about their care, even if they are not able to make decisions on their own.

3.9.2 In time critical situations involving children and young people, when managing a life threatening emergency, and consultation with either a person with parental responsibility is impossible, or the persons with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of the child, the preservation of life takes precedence and it will be acceptable for all clinicians to undertake treatment to preserve life or prevent harm without consent

3.9.3 The YAS policy on the assessment and conveyance of patients states "There may be occasions where the child or parent/carer does not wish the child to travel despite a recommendation to do so by the attending staff. There may also be occasions where there is refusal to travel by the child or the parent/carer. For any child that refuses treatment and transport the clinician MUST make an immediate referral to another healthcare professional who can assume responsibility for their on-going care. In any case of refusal, full documentation should be completed to this effect." If the child is believed to be at risk of significant harm, then the attending staff should contact the Police.

3.9.4 Young People aged 16 – 17

3.9.5 Under the Children's Act 1989 a young person (anyone aged 16-17) is presumed to be capable of consenting to their own medical treatment. Consent will only be valid if it is given voluntarily by a young person who has received and understood the appropriate information. As with adults, a young person has the right to refuse to consent to treatment.

3.9.6 Under Sixteen

3.9.7 Patients under the age of 16, those who have sufficient understanding and intelligence to understand fully what is proposed also have the capacity to consent to the intervention. This is known as being Fraser competent. Additional consent by a person with parental responsibility is not required, and a parent cannot override that consent.

3.9.8 This means that the level of capacity of children varies with the complexity of the treatment/refusal and its consequences. There is no particular age when a child becomes Fraser competent. In emergency care, consequences of non-treatment are usually evident, but it must be fully explained to ensure that a refusal to give consent is fully informed.

3.9.9 In cases where a child refuses to consent to treatment that is deemed life sustaining then a parent can consent for that treatment. Such cases are likely to be rare but an example is a child under 16 who has taken a clinically significant overdose.

3.9.10 Where a child under the age of 16 lacks the capacity to consent, consent can be given on their behalf by any one person with parental responsibility or by the court.

3.9.11 Where possible, the child or young person should be given the opportunity to express their wishes. If this is not possible or feasible, ambulance clinicians should obtain consent from a person with parental responsibility for that child. As in the case where patients are giving consent for themselves , those giving consent on behalf of children must have the capacity to consent to the intervention in question, be acting voluntarily, be appropriately informed and be acting in the best interests of the child. In the absence of a person with parental responsibility and a child without capacity, ambulance clinicians must act in the child's best interests.

3.9.12 Where a child refuses treatment the following guide should be used by staff:

<u>Accept refusal</u>

For example if a child refuses to be cannulated in order to receive morphine. The refusal can be accepted and pain controlled with Entonox

<u>Persuade</u>

A child may be frightened or anxious about attending hospital and in a non-life threatening situation the attending clinician can attempt to persuade the child to attend

Treat on the basis of parental consent

Where a child refuses what is considered life sustaining treatment the child can be treated with parental consent. If the parents are absent the clinician can act in the child's best interests. Occasionally a child under the age of 16 may physically refuse to be conveyed and in these situations assistance should be sought from the police.

3.9.13 **Looked After Children**

A Looked After Child (sometimes referred to as 'LAC') is a child who is Accommodated by the local authority; a child who is the subject of an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation. In addition where a child is placed for Adoption or the local authority is authorised to place a child for adoption - either through the making of a Placement Order or the giving of Parental Consent to Adoptive Placement - the child is a Looked After child. Looked After Children may be placed with parents, foster carers (including relatives and friends), in Children's Homes, in Secure Accommodation or with prospective adopters.

3.9.14 Other than in exceptional circumstances, all reasonable steps should be taken to inform the parent(s) or others with Parental Responsibility before medical advice or treatment is sought for a child Looked After. If this is not achieved, they should be informed as soon as practicable thereafter.

3.9.15 For Looked After Children under 16 years, Social Services should be contacted to give consent if the parent is unable or unwilling to do so.

3.9.15 In an emergency, when urgent medical treatment is required and every effort has been made to locate parents or a person with Parental Responsibility, the following may apply:

- A child who has reached his/her sixteenth birthday may give consent;
- A responsible adult acting in loco parent is, may give consent on the parents' behalf so long as all reasonable steps have been taken to consult the parent(s) or those with Parental Responsibility and such action is not against their expressed wishes. In the case of a child who is looked after, this will involve the relevant social worker having a discussion with the clinician involved before considering whether it is appropriate to give consent;
- Dependent on his/her age and level of understanding, a child who has not reached the age of sixteen may be regarded by a clinician as capable of giving consent (Fraser Competent);
- In a 'life or limb' situation, a clinician may decide to proceed without any consent;

3.10 Advanced Decision to Refuse Treatment (ADRT)

3.10.1 An advance decision to refuse treatment, which is made voluntarily, by an appropriately informed person with capacity, and applicable to subsequent circumstances in which the patient lacks capacity, is legally binding. Ambulance clinicians should respect the wishes stated in such a document, often termed a

'living will' or 'advance directive', drawn up to cater for medical situations arising in the case of future incapacity.

3.10.2 Advance decisions to refuse treatment do have a legal basis and should be binding where they exist and are valid. Clinicians should take steps to check the validity of any such document in line with current guidelines (JRCALC). Where there is doubt surrounding the validity of any advance decision document, care should be provided in the best interest of the patient.

3.11 Self-Harm

3.11.1 Cases of self-harm often present particular difficulties for clinicians. Where the patient is able to communicate verbally or with available assistive devices, an assessment of their mental capacity should be made as a matter of urgency. If the patient is judged not to have capacity, they may be treated on the basis of temporary incapacity, similarly, patients who have attempted suicide and are unconscious must be given emergency treatment in all circumstances.

3.12 Consent for Clinical Photography and Video recording/streaming

3.12.1 Clinical photographs and video recording must only be taken when they are necessary for treating or assessing a patient. Each image and image content which provides patient-identifiable information must be justifiable, and must not be used for any purpose other than the patients care. Patients must be informed about the intended use of any images and staff must seek a verbal consent. Where consent is given this should be recorded in the ePR, CAD or Adastra record.

3.12.2 Although it is best practice to inform the patient at the time of the image being taken, this may not be possible. In this case the patient should be informed at the earliest opportunity that an image has been taken.

3.12.3 Recording of video-assisted triage/assessment in the Emergency Operations Centre or Integrated Urgent Care centre is forbidden. For audit purposes all calls are recorded and stored as per Caldicott principles and it is good practice to gain the patients consent before commencing a clinical assessment.

3.12.4 All other photography and motion pictures for purposes such as media promotion require express patient and staff consent in writing.

3.13 Exceptions to the Principle of Consent

3.13.1 A competent pregnant woman can refuse treatment even if that refusal may result in harm to her or her unborn child (St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S [1998] 3 All ER 673)

3.13.2 The Public Health Act 1984 (Control of Disease) provides that, on an order made by a magistrate or sheriff, persons with certain notifiable infectious diseases can be medically examined, removed to, and detained in a hospital without their consent. Similarly, Section 47 of the National Assistance Act 1948 provides for the removal to suitable premises of persons in need of care and attention without their consent. Such persons must either have grave chronic disease or be physically incapacitated due to age or significant physical impairment or other ill health and living in unsanitary conditions.

3.13.3 These situations are, however, extremely rare. If a patient refuses decontamination treatment, following a chemical, biological radiological or nuclear (CBRN) incident, responsibility lies with the ambulance manager in charge of the incident, in liaison with the Police, Health Protection Agency and Public Health Laboratories to decide on an appropriate course of action. Powers lie within these groups to take action for the public good.

3.13.4 Treatment involving patients with mental disorders are covered by the Mental Health Act 1983 (revised 2007), provided that the patient is formally detained under that Act. Exceptions under the Act only relate to treatment for the mental disorder itself, and not for other illnesses or conditions. Part IV of the Mental Health Act 1983 sets out circumstances in which patients detained under the Act may be treated without consent for their mental disorder. It has no application to treatment for physical disorders unrelated to the mental disorder, which remains subject to the common law principles. Neither the existence of mental disorder nor the fact of detention under the 1983 Act should give rise to an assumption of incapacity. The patient's capacity must be assessed in every case in relation to the particular decision being made. The capacity of a person with mental disorder may fluctuate and must therefore be re-evaluated on a frequent basis.

3.13.5 All patients, of all ages, who have had an ambulance response to a hypoglycaemic episode or a seizure should automatically be referred for follow up. This has been approved by the UK Council of Caldicott Guardians due to the wider public interest on the safety of continued driving. The referral should be made to either the patient's GP or other appropriate service such as diabetes or epilepsy specialist teams according to the local ambulance service agreed pathways. The service should then follow up the patient and address any issues of concern, which may include driving or operating machinery. The patient should be informed of the referral, and even if the patient objects, the referral should still be made.

3.14 Consent and Research

3.14.1 Research Governance procedures are in place within YAS, and these include the requirement that all research is ethically reviewed. All research involving NHS patients must be ethically reviewed using standard national processes put in place by the Health Research Authority. For studies only involving staff or data, ethical review will be put in place by the organisation managing the research. Ethical review ensures that appropriate arrangements are in place to obtain consent, including ensuring that the requirements of the Mental Capacity Act 2005 and the Human Tissue Act 2004 are met. Research studies taking place within the YAS remit will be assessed and must comply with the appropriate laws and policies relating to consent prior to gaining organisational approval to proceed.

3.14.2 Exceptionally, the Secretary of State for Health can give permission for the NHS to pass on data which identifies patients without patient consent, but only after consideration by ethics experts, where there is a need to include patient data, and where there are data security arrangements in place.

3.15 Restraint/Safer Holding

3.15.1 Restraint covers a wide range of actions including the use, or threat of force to do something that the person concerned resists, for example by using ambulance stretcher sides or confining people's movements. The Trust position is still one of advocating **no restraint** being used when attending to persons except under exceptional circumstances under common law. However, under the Mental Capacity Act restraint may be used by staff when it is considered to be in the Best Interests of a person who lacks capacity in a genuine life threatening or life changing emergency but then **ONLY** restraint that is proportionate and reasonable may be used. The Mental Capacity Act (2005) identifies two conditions which must be satisfied in order for protection from liability for restraint to be available:

- You must with good reason believe that it is necessary to restrain the person who lacks capacity in order to prevent them from harm
- Any restraint must be reasonable and in proportion to the potential harm

3.15.2 The Mental Capacity Act cannot be used to provide restraint to transport a patient under the Mental Health Act into hospital

3.15.2 Types of Restraint

- Physical Use of physical force, however small/low
- Mechanical The use of any device or implement intended to restrict movement
- Environmental The use of buildings, doors etc. to manage freedom of movement (i.e. locking someone in a room, locking them in an ambulance)
- Chemical The use of a drug either illicit or prescribed
- Psychological Instructing someone they can't do something. The very nature of wearing uniform and being present may amount to this.

3.15.3 For any use of force to be considered reasonable, it must follow the JAPAN principles:

- Justified Why did you do it, what were you trying to achieve?
- Auditable Documented clearly the rationale for example in ePR
- Proportionate The Force used must be no greater than the perceived risk
- Authority There must be a defence to the force being used prescribed in law
- Necessary There must be no other option other than to use force based on your honestly held belief.

3.15.4 If any restraint is used the type of restraint, length of restraint and reasons for using restraint must be recorded on the ePR. Clinicians should not hesitate to contact and seek assistance from the Police, GP or the Mental Health Nurses in the EOC if they are concerned.

3.16 Deprivation of Liberty

3.16.1 The Mental Capacity Act allows restraint and restrictions to be used, but only if they are in the person's best interests. Extra safeguards are required if the restraints or restrictions used will deprive a person of their liberty. These safeguards include authorisation to deprive a person of their liberty, and representation by someone with the legal powers to represent them. Currently

these safeguards will only be used if the person is in a care home or hospital and do not apply during transfer of the patient.

3.17 Documentation

3.17.1 The assessment and the conclusions drawn from any assessment regarding capacity or consent should be recorded on the ePR. Clinicians should record an assessment of capacity and use of best interests (where relevant) when any serious decisions are being considered on behalf of someone who may lack capacity in relation to the decision.

3.17.2 The key issue is not whether the patient signed a form or not, but whether they were given all the information they needed to make a considered decision. It is, therefore, crucial that the essential elements of discussions with the patient are documented in the ePR. The notes do not need to be exhaustive, but should state the nature of the proposed procedure or treatment and itemise the risks, benefits and alternatives brought to the attention of the patient. Any particular fears or concerns raised by the patient should also be noted.

- Document does the person have an impairment/disturbance of the brain and or mind?
- Document does the impairment/disturbance mean the person is unable to make a decision at this time
- Document how you know the person is unable to understand, retain, use and weigh up information and communicate their decision. Documenting the person is intoxicated or has dementia is not adequate.

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Definitions

Valid Consent

The voluntary, and continuing permission, of the patient to be given a particular examination, course of treatment, or intervention. Consent is only valid when it is given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. This will be the patient or someone with parental responsibility for a patient under the age of 18, and someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy. To give consent a person must:

- be competent to take the particular decision
- have received sufficient information to take it
- not be acting under duress.

Informed Consent

A patient's consent to a clinical procedure (or to participation in a clinical study) after being advised of all relevant facts and the risks involved.

Implied Consent

Consent is often implied by the patient's compliance, an obvious example being when a patient rolls up a sleeve so that a blood sample can be taken. Nevertheless, patients should be told about the nature and purpose of any examination, investigation or procedure beforehand**,** and documented appropriately.

Capacity to Consent

A person's capacity to consent must not be judged simply on the basis of age, appearance, condition or an aspect of their behaviour (MCA, Code of Practice 2007: P.40) The Act applies to all adults aged 16 years or over (with some exceptions).

The functional test of capacity;

1. Does the person have an impairment or disturbance in the functioning of his or her mind?
2. Does the impairment or disturbance make the person unable to;
    - Understand the information relevant to that decision
    - Retain that information long enough to reach a decision
    - Use or weigh that information as part of the process of making the decision
    - Communicate his or her decision.

A person lacks capacity in relation to a decision or proposed intervention if, at the material time he or she is unable to make a decision for him or herself in relation to the matter or proposed intervention because of an impairment of, or a disturbance in the functioning of the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary.

Assumed Capacity

A person must be assumed to have capacity unless it is established that they lack capacity. Gaining and obtaining consent is usually a process, not a one off-event. Patients can change their minds and withdraw their consent at any time.

Verbal or Written

Consent can be written, oral or non-verbal. A signature itself does not prove the consent is valid. The most important point is to record the patients decision and the subsequent discussions that have taken place.

Duration of Consent
The length of approval gained by valid consent being given may differ. This generally remains valid unless it is withdrawn by the patient, or there is a change in their circumstances and they no longer have the capacity to give consent. New information must be given to patients as it arises and consent regained.

Best Interests

An act done or decision made under the Mental Capacity Act (2005) for or on behalf of a person who lacks capacity. This act or decision must be made with the persons best interests in mind.

Mental Capacity Act (2005)

The Mental Capacity Act (MCA-2005) is specifically designed to cover situations where someone is unable to make a decision because the way their mind or brain works is affected, for instance, by illness, impairment or disability, or by the effects of drugs or alcohol.

The MCA applies in England and Wales to anyone who works in health and social care and is involved in the care, treatment or support of people over 16 years of age who may lack capacity to make decisions for themselves.

Parental Responsibility

Parental Responsibility means all the duties, powers, responsibilities and authority which a parent has by law in relation to a child. Parental Responsibility diminishes as the child acquires sufficient understanding to make his or her own decisions.

A child's mother always holds Parental Responsibility, as does the father if married to the mother.

Unmarried fathers who are registered on the child's birth certificate as the child's father on or after 1 December 2003 also automatically acquire Parental Responsibility. Otherwise, they can acquire Parental Responsibility through a formal agreement with the child's mother or through obtaining a Parental Responsibility Order under Section 4 of the Children Act 1989.

Parental responsibility can be acquired by any person through a Court Order, for example a Residence Order or Special Guardianship Order. As well as an unmarried father, a step parent or a parent's civil partner can apply for a Parental Responsibility Order under section 4 of the Children Act 1989.

The local authority acquires Parental Responsibility through an Emergency Protection Order, an Interim Care Order and Care Order. In these circumstances the local authority shares Parental Responsibility with the parents and those with Parental Responsibility, including special guardians. Parents do not lose their Parental Responsibility unless an Adoption Order is made.

Where a child is placed with prospective adopters, the prospective adopters acquire Parental Responsibility as soon as the placement is made. This will be shared with the birth parents and with the adoption agency making the placement.

Roles & Responsibilities

Assurance Processes:

The Trust Board has overall responsibility for the implementation and management of this policy.

The Quality Committee (QC) is responsible for seeking assurance through the Clinical Governance Group (CGG) that the policy has been implemented and appropriate monitoring arrangements and infrastructures are in place.

The CGG will receive reports from the Deputy Medical Director identifying any incidents actual or potential in relation to the implementation and management of this policy.

Clinical Business Unit Locality Boards will receive assurance from Clinical Managers that the policy is being implemented and monitored accordingly within local Clinical Business Units (CBU).

Management Processes

The Trust Management Group will ratify the policy and will ensure the policy is implemented through managing any identified overall risks, and ensuring consistency in relation to any allocation of resources.

The A&E Heads of Operations will be responsible for the management of this policy within their specific CBU.

The Medical Director is the lead director for this policy and will provide regular updates to the relevant group/committees highlighting any risks and issues of concern.

The Clinical Pathways Advisers will ensure patient consent and mental capacity are key factors for consideration when developing clinical pathways. Reports will be provided to the CGG identifying both compliance and non-compliance.

All staff have a responsibility to read, apply and adhere to the requirements of this policy and maintain an up to date knowledge of current practice in relation to assessment of a person’s capacity to give consent.

The Clinician examining, or treating the patient, is ultimately responsible for ensuring the patient is genuinely consenting to what is being done: it is they who will be responsible in law if consent is challenged later.

It is the clinicians own responsibility to ensure, when seeking the assistance of colleagues, that:

- The colleagues are both competent to assist and work within their competence without performing tasks which exceed their skill levels
- Their actions are fully documented.

Training expectations for staff

Training is delivered as specified within the Trust Training Needs Analysis. Mental Capacity Act training tier 1 for all staff groups and tier 2 for all patient facing groups with be mandatory, and compliance monitored via non-clinical PGB.

Implementation Plan

The latest approved version of this Policy will be posted on the Trust Intranet site for all members of staff to view. The training plan is detailed above, and the ePR capacity function will be reviewed in-line with the policy. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

Patient Transport Service (PTS)

Communication will occur via published Team Briefs and staff meetings. PTS Locality Managers and Team Leaders will play an active part in ensuring implementation and monitoring compliance with the policy.

Emergency Operations Centre (EOC) and NHS 111

A process exists within the EOC and NHS 111 to ensure staff are aware and updated in relation to policies and this process will be followed for the dissemination and implementation of the policy. The policy will also be stored electronically on the respective 'I' drive folder to enable EOC staff to have ready access.

A&E Operational Staff

Clinical Development Managers will be responsible for the dissemination and implementation of the policy within the individual Clinical Business Units. They will be assisted at a frontline level by Clinical Supervisors. Communication will occur via team briefs and incorporated into clinician training and supervised practice programmes.

Monitoring compliance with this Policy

The Clinical Governance Group (CGG) will be responsible for monitoring compliance with the policy. The CGG will receive quarterly reports from the Deputy Medical Director in relation to policy compliance and any emerging issues regarding consent and/or mental capacity. In addition;

- A random review of completed ePR's will be undertaken on a quarterly basis by the Clinical Managers as a Clinical Audit process. The review will identify the percentage of completed forms having consent and mental capacity recorded.

- Any identified patient/stakeholder concerns regarding consent will be monitored by the Clinical Managers along with clinical case reviews (where patient consent/capacity has been identified as a causal factor), risk management processes (incident reporting) where consent/capacity is identified as an issue.

- The percentage of staff completing the online training(as set out within the Key Performance Indicators) will also be used as a method of monitoring compliance.

- It is the duty of all Operational Managers from Clinical Supervisors upwards to ensure that this policy is adhered to by staff under their management.

Appendix 1

Process to be followed when obtaining consent

- Before a clinician examines, treats or cares for patients they should obtain patient consent

- In an emergency situation where consent cannot be obtained clinicians should provide treatment that is in the patient's best interest and is immediately necessary to save life or avoid significant deterioration in the health of the patient.

- Adults are presumed to have capacity but where any doubt exists, the clinician should assess the capacity of the patient to take the decision in question. This assessment and any conclusions drawn from it should be recorded.

- Patients can change their mind and withdraw consent at any time. If there is any doubt clinicians should always check that the patient still consents to care or treatment. Consent should be obtained based on an explained overview of the envisaged treatment offered up to arrival at a care centre or hospital.

- In practice, patients need to be able to communicate their decision. Care should be taken not to underestimate the ability of a patient to communicate whatever their condition. Clinicians should take all steps that are reasonable in these circumstances to facilitate communication with the patient, using interpreters or communication aids as appropriate, while allowing for the urgency of the situation.

Three basic tests are used to ensure that consent is valid:

- **Does the patient have capacity?**

  Is the patient able to comprehend and retain information material to the decision, and weigh that information in making a decision while bearing the full consequences in mind?

- **Is the consent given voluntarily?**

  Consent is only valid if given freely, with no pressure or undue influence to accept or refuse treatment.

- **Has the patient received sufficient information?**

  The patient must understand, in broad terms, the nature and purpose of the procedure as well as the potential consequences of consenting to it or refusing to consent. The type of information that needs to be given by the clinician will vary depending on circumstance and urgency, but the following is a useful guide to the type of information the patient should receive prior to treatment:

- Description and method of treatment, transport and ongoing care
- Purpose and reason for treatment, transport and ongoing care
- Possible complications and side-effects of treatment
- Treatment options, including the option not to treat and the likely consequences
- Explanation of likely benefits of treatment
- A reminder that the patient can change their mind about consent at any time

Appendix 2

Mental Capacity Act 2005 Overview

What is Mental Capacity?

Having mental capacity means that a person is able to make their own decisions. A person is unable to make a particular decision if they cannot do one or more of the following four things:

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand

The Mental Capacity Act (2005)

The Mental Capacity Act 2005 (MCA) is specifically designed to cover situations where someone is unable to make a decision because the way their mind or brain works is affected, for instance, by illness or disability, or the effects of drugs or alcohol.

A lack of mental capacity could be due to:

- a stroke or brain injury
- a mental health problem
- dementia
- a learning disability
- confusion, drowsiness or unconsciousness because of an illness or the treatment for it
- substance misuse (alcohol or drugs)

The type of decisions that are covered by the MCA range from day-to-day decisions such as what to wear or eat, through to more serious decisions about where to live, having an operation or what to do with a person's finances and property.

Assessment of capacity should be time and decision specific.

The MCA applies in England and Wales to everyone who works in health and social care and is involved in the care, treatment or support of people over 16 years of age who may lack capacity to make decisions for themselves. It is based on existing best practice and creates a single, coherent framework for dealing with mental capacity issues and an improved system for settling disputes, dealing with personal welfare issues and the property and affairs of people who lack capacity. It puts the individual who lacks capacity at the heart of decision making and places a strong emphasis on supporting and enabling the individual to make his/her own decisions. If they are unable to do this it emphasises that they should be involved in the decision making process as far as possible.

It provides new safeguards for people who lack capacity and the people who work with, support or care for them. It is underpinned by five key principles which must inform everything you do when providing care or treatment for a person who lacks capacity. There is a Code of Practice which explains how the MCA works on a day to day basis – available to download at: www.dca.gov.uk/menincap/legis.htm or available to view via the MCA page on the YAS intranet site.

Key Provisions of the MCA

- There must always be the presumption that people you provide care or treatment for have capacity to make decisions for themselves.
- A single clear test for assessment whether a person lacks capacity to make a decision
- A check list of key factors which provides a starting point to help you determine what is in the 'best interests' of a person lacking capacity
- Several ways that people can influence what happens to them if they are unable to make particular decisions in the future, include advance decisions to refuse medical treatment, statements of wishes and feelings, and creating a Lasting Power of Attorney (LPA).
- Clarification about the actions you can take if someone does lack capacity, and the legal safeguards that will govern this.
- An obligation for you to consult, where practical and appropriate, people who are involved in caring for the person who lacks capacity and anyone interested in their welfare (for example family members, friends, partners, carers and advocates) about decisions affecting that person.
- A new advocacy service called the Independent Mental Capacity Advocate (IMCA) service.
- A new criminal offence of ill-treatment or wilful neglect of people who lack capacity.

The Five Principles of the MCA

The MCA has five key principles which emphasise the fundamental concepts and core values of the MCA. These must be considered and applied when you are working with, or providing care or treatment for people who lack capacity. The five principles are:

1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition impairment or disability.

2. People must be supported as much as possible to make a decision before anyone concludes that they cannot make their own decision. This means that you should make every effort to encourage and support the person to make the decision for themselves. If a lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

3. People have the right to make what others might regard an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat people as lacking capacity for that reason.

4. Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

5. Anything done for, or on behalf of, people without capacity should be the least restrictive of their basic rights and freedoms. This means that when you do anything to or for a person who lacks capacity you must choose the option that is in their best interests and you must consider whether you could do this in a way that interferes less with their rights and freedom of action.

Appendix 3 – Montgomery Principles

The Montgomery vs Lanarkshire Health board (2015) ruling underlines the need for informed decision making. Principally, without adequate information a patient is unable to make an informed to decision to consent (or not) to assessment or treatment.

The context of the case involved a pregnant woman with diabetes who was at increased risk of complications during labour as babies of diabetic mothers are often larger than average. The risk of complications (shoulder dystocia) during normal vaginal delivery was around ten percent. The doctor did not disclose the risk to the mother and as a result of complications the baby was born with a hypoxic brain injury. Had the mother known the risk she would have elected for a caesarean section and the baby would have been born in good health. The ruling by the Supreme Court found that it is not acceptable to withhold information from patients during the decision making process.

In order that consent is valid it must be informed. Patients must be provided with information regarding the recommended care and alternatives to the recommendations. The foreseeable risks of decisions must in all cases be fully explained to the patient and recorded. Where risks are unknown (for instance where a working impression is non-specific such as *generally unwell*) this must also be disclosed to the patient: an unclear diagnosis or working impression is in itself a risk.

The record must reflect the following information:

- Capacity to consent or best interest decision
- Working impression
- Recommended care plan
- The risks associated with the plan and any alternatives
- Patient choice (where they have capacity)
    - Refusal against advice – a refusal must only be documented where the choice made by the patient is against the advice of the attending clinicians. A refusal against advice indicates the patient has made an informed choice to consent or refuse treatment where there are disproportionate or unmitigated clinical risks. This can also include refusal for care to be referred.
    - Where there are a range of options with equal risk and neither is preferable to another the options should be explained to the patient, documented and their choice supported and documented.
    - Discharge – where the recommendation by the attending clinicians is that the patient's care can be definitively provided on scene and there is no

requirement for referral to another healthcare provider, their care is discharged. Where a referral is recommended but refused this is should be recorded as a refusal.