



London Ambulance Service **NHS**
NHS Trust

Policy for Consent to Examination or Treatment

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To set out and explain the requirements for seeking consent for the examination and treatment of a patient.

Sponsor Department: Medical Directorate

Author/Reviewer: Clinical Adviser for Mental Health. To be reviewed by December 2017.

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Links to Related documents or references providing additional information		
Ref. No.	Title	Version
TP/024	LAS Managing Patient Confidentiality When dealing with the Media	
LA4	PRF LAS Trust Assignment Record and Clinical Record	
LA5	Capacity to consent to treatment and/ or course of action	
OP14	Managing the Conveyance of patients policy and procedure	
OP072	Operational procedure for the use of restraint on patients	

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1. Introduction

The Department of Health has issued a range of guidance documents on consent, and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in the LAS which aim to ensure that health professionals are able to comply with the guidance.

This policy is for all staff who provide care to patients, irrespective of the route by which they came into contact with them.

2. Scope

- 2.1 This policy sets out the guidance for all staff employed or otherwise working for the London Ambulance Service (LAS) NHS Trust who provide care for patients and is in accordance with the requirements of the Department of Health in respect of consent for examination and treatment.

3. Objectives

- 3.1 To provide guidance on obtaining consent for examination and treatment of a patient for adults and children
- 3.2 To provide guidance on assessing capacity
- 3.3 To provide guidance on refusal and withdrawal of consent
- 3.4 To provide guidance on advance and delegated decision-making
- 3.5 To provide guidance on recording

4.0 Responsibilities

- 4.1 **Clinicians** are required to maintain awareness of the law in respect of consent and capacity. The individual HCP carrying out the procedure (or supervising a student carrying out a procedure or examination) is responsible for obtaining and recording informed consent where required by law, and for assessing mental capacity if required.
- 4.2 **Operational Managers**, including **Clinical Team Leaders** are responsible for ensuring that this guideline is adhered to in practice
- 4.3 **All staff** who may have contact with people who lack capacity have an obligation to have regard to the [Mental Capacity Act Code of Practice](#).

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5.0 Background

- 5.1 Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment and to transportation for the purposes of receiving treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. It should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind.
- 5.2 As well as being a well-established ethical principle, the law in England and Wales demands that suitably informed consent must be given in most cases before a treatment can be given, or examination undertaken. This guideline aims to outline the basic legal position for obtaining consent in adults (18 years and over), and children (0 to 17 years), and provide guidance on what do to if a person lacks the capacity to provide consent.
- 5.3 For consent to be valid, it must be 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, 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. Acquiescence where the person does not know what the intervention entails is not 'consent.

6.0 Guidance

Consent

- 6.1 Consent is a patient's agreement for a clinician to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must have capacity to take the particular decision, have received sufficient information to take it and not be acting under duress. Advice on assessing mental capacity can be found within this policy document at section 3.37 onwards. Advice on obtaining consent in relation to children can be found at 3.24 onwards with advice on assessing *Gillick* competence at 3.29.
- 6.2 Before you examine, treat or care for patients you must obtain their consent unless they lack the capacity to consent to the proposed course of action or the nature of the emergency precludes this. The context of consent can take

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many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

6.3 Gaining the consent of a patient to examination and treatment will most often happen as a natural progression of the interaction of staff with the patient. However, staff must never assume that the patient will consent to examination and treatment, even if they have called for our assistance. Staff must ensure a full discussion takes place with the patient, a course of action is agreed and that these decisions and actions are fully documented. The staff must respect the patient's wishes and needs throughout this process and always bear in mind that the patient is entitled to withdraw consent at any time.

6.4 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 patient's decision and the discussions that have taken place.

6.5 In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient and gaining their consent. If the patient is willing for the treatment to be provided, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

6.6 If a proposed procedure carries significant risks, it may be appropriate to seek written consent, and health professionals must consider whether the patient has had sufficient opportunity to absorb the information necessary for them to make their decision. As long as it is clear that the patient had

capacity and consents, the health professional may then proceed. This simple process will be most applicable in the ambulance setting.

6.7 Clearly in emergencies, discussion of options and confirmation that the patient wishes to go ahead will follow straight on from each other, and it is appropriate to use the LA4 to document any discussion and the patient's consent. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality. If someone lacks capacity to consent to treatment or transport in order to save their life or prevent serious harm it will almost always be in the person's best interests to receive urgent treatment without delay. In such situations treatment should not be delayed to assess capacity. Where immediate medical treatment is required the only practical and appropriate step may be to keep the person informed of what is happening to them (and why) whilst you provide urgent treatment to prevent their death or a serious deterioration in their condition.

6.8 Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Informed consent

6.9 Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent will not be valid.

6.10 Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. The presumption must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented. The case of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 established what the law requires with regards to how much information must be shared with patients in order for consent to be valid in law and holds that "...reasonable care

[must be taken] to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternatives or variant treatments.” A material risk is one which a reasonable person in the patient’s position would be likely to attach significance to. In other words, health professionals should seek to identify the issues that the patient considers are important in the time available to them. Health professionals should bear in mind that further to points made above (to include at 3.7 above) that time may be of the essence in which case prolonged discussions will not be practicable, desirable.

6.11 The London Ambulance Service NHS Trust is committed where possible, practicable and safe to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff.. All staff have access to interpreting services and multi-lingual phrasebooks. Other specific advice can be sought from the Equality and Inclusion Manager.

6.12 It is not normally appropriate to use children to interpret for family members who do not speak English, or for an adult family member to interpret for a child who does not speak English. If the clinical acuity of the patient dictates that a child needs to be used as a translator, or a parent to translate for a child then further translation services need to be explored at the earliest possible moment, and the reasons documented on the PRF.

Voluntariness

6.13 Consent must be given voluntarily: not under any form of duress or undue influence from clinicians, family or friends.

Refusal

6.14 Adult patients with capacity are entitled to refuse treatment, even where the treatment would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. For example a pregnant woman may refuse any treatment, even if this would be detrimental to her or to the foetus, if the woman has capacity to refuse such treatment.

6.15 If the process of seeking consent is to be a meaningful one, refusal must be one of the patient’s options. An adult patient, who has capacity, is

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entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983*. The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults.

- 6.16 If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented on the LA4 and/ or LA5. If the patient has already signed a consent form, but then changes their mind, you (and, where possible, the patient) should note this on the form.
- 6.17 Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.
- 6.18 If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient's care to that health professional.
- 6.19 Adults are always assumed to have capacity unless proved, on the balance of probabilities, otherwise. If you have doubts about their capacity, the question to ask is: "can this patient understand and weigh up the information needed to make this specific decision?" Further details on the assessment of capacity can be found at section 3.37. Unconventional decisions, or decisions that may appear unwise to others, do not prove that the patient lacks capacity, but may indicate a need for further information or explanation. Capacitated patients are entitled to make unwise and irrational decisions. The fact that a clinician may not agree with the decision made by a patient does not mean that the patient lacks capacity to make that decision.

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6.20 If a patient **with capacity** is refusing treatment, the crew may be acting unlawfully if they treat them against their wishes. In these circumstances they must document carefully both on the LA5 and LA4, all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative or friend, the Clinical Support Desk, or their Clinical Team Leader/ manager. Staff should notify the Emergency Operations Centre (EOC) of their actions so that this can be entered onto the call log.

6.21 Where a patient who **does not have capacity** is refusing treatment, the crew must consider the consequences of the patient not receiving treatment and must consider the least restrictive approach to meeting the assessed need. If the crew believes that the patient needs urgent or lifesaving treatment, they should act in the patient's best interests. Crew and patient safety must be paramount in this decision. Occasionally the police may be of assistance.

6.22 In these circumstances they must document fully and carefully both on the LA5 and LA4, all relevant discussions, decisions and actions. Staff may need to seek further advice, from the patient's GP, a relative or friend, Clinical Support desk or Clinical Team Leader. Unless the patient has appointed a lasting power of attorney for health and welfare, or the Court has appointed a personal welfare deputy who has the authority to consent to the specific treatment proposed, no-one else can give consent on behalf of such a patient. They may only be treated if that treatment is believed to be in their 'best interests'. For more information on best interests see paragraph 3.42 onwards.

6.23 If a patient who lacks capacity has clearly indicated in the past, while they had capacity, that they would refuse treatment in certain circumstances (an 'advance decision'), and those circumstances arise, you must abide by that refusal if it meets the procedural requirements of the Mental Capacity Act. Further advice on Advanced Decisions can be found at paragraph 3.49 of this policy.

Consenting children and young persons

6.24 Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed in law to have the capacity to give consent for themselves. Younger children who understand

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fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency.

- 6.25 If a child with capacity consents to treatment, a parent cannot override that consent. Legally, a parent, or a court, can provide consent if a competent child (if 15 or under) or capacitated young person (16 or 17) refuses, but it is likely that taking such a serious step will be rare. However, in the event there is a dispute as to whether or not treatment should take place between a child or young person who may have competence or capacity and the parent then the Clinical Hub and Legal Services should be contacted if time permits (See 3.28 below).
- 6.26 Only people with 'parental responsibility' are entitled to give consent on behalf of their children, when the child lacks the competence or the young person lacks capacity to make that decision. You must be aware that not all parents have parental responsibility for their children. If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check. If the child or young person does have competence or capacity to make the decision to accept treatment themselves then they can do so.
- 6.27 When babies or young children are being cared for, it will not usually seem practicable to seek their parents' consent for every routine intervention. However, you should remember that, in law, such consent is required. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.
- 6.28 Critical situations involving children and young persons involving a life threatening emergency may arise when it is impossible to consult a person with parental responsibility, or if they refuse consent. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable for all carers to undertake treatment to preserve life or prevent serious damage to health. In emergency medical situations urgent decisions will have to be made and immediate action taken in the patient's best interests. In circumstances when it is not possible to properly determine whether or not the child or young person has the competence or capacity to consent, or when it is not possible to find an adult with parental responsibility to make the decision on their behalf then you can proceed to treat the patient in their best interests.

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6.29 Children under the age of 16, who when tested can fully understand what is proposed, also can be considered to have the “competence” to consent to, or refuse, an intervention. This is known as Gillick Competence. Where practicable children under 16 should be assessed to establish whether they have competence to make the decision on the basis they have sufficient maturity and understanding to consent to the proposed treatment. A child may have the competence to consent to some interventions but not others. The level of capacity of children varies with the complexity of the treatment/refusal and its consequences. That means that if the decision involves complexity and higher, or more serious risk, the child must demonstrate a proportionate level of competence (i.e. the greater the risk, the more competent the child will need to be). In some situations, although the consequences of non-treatment may be evident, these must be fully explained to ensure that the child fully understands the consequences of refusal.

6.30 There is no particular age when a child gains competence to consent or refusal. At the age of 16 the child becomes a young person under the Mental Capacity Act and is assumed capacity to consent to therapeutic treatment. They should be treated as an adult unless they lack capacity in which case someone with parental responsibility can consent (see 3.37 below). For clarity, in the case of children under the age of 16, the law presumes incapacity unless proved otherwise by the clinician proposing the treatment. When considering whether a child has the competence to decide about proposed intervention health professionals may find it helpful to consider the following questions:

- Does the child understand the information that is relevant to the decision that needs to be made?
- Can the child hold the information in their mind long enough so that they can use it to make the decision?
- Is the child able to weigh up that information and use it to arrive at a decision?
- Is the child able to communicate their decision by talking, using sign language or any other means?

6.31 A child may lack competence to make the decision in question because they do not have the necessary maturity or understanding of their particular situation. As is 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, and be appropriately informed and be acting in the best interests of the child. If neither the child nor the person with parental responsibility has capacity, clinician must act in the child's best interests.

Recording consent

6.32 Staff must ensure that decisions regarding consent are documented using the appropriate form.

6.33 It cannot be stressed enough that where consent to treatment is withheld or subsequently withdrawn, having been previously given, that this must be documented on the LA4, and the LA5 if appropriate.

6.34 All staff must ensure that they have access whilst on duty to the requisite forms to document consent decisions.

6.35 Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has signed the form, but is not *proof* of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal or implied consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract. It is vital, therefore that the process leading to the patient's consent or refusal should be carefully and fully recorded, including any advice given.

6.36 Whilst written consent will rarely be an absolute legal requirement it is good practice to do so especially if the treatment is part of a project or programme of research approved by the London Ambulance Service.

Mental Capacity

6.37 In order to be able to provide consent, an adult must have the mental capacity to make decisions for themselves. The starting point in law is that adults are assumed to have mental capacity; thus the burden of proof is on

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the clinician to establish, on balance of probabilities, that the person lacks capacity to make the required decision, at the necessary time.

6.38 Patients may have capacity to make some health care decisions, even if they lack it to make others.

6.39 This policy provides summary guidance; the main source of guidance is contained within the Code of Practice to the Mental Capacity Act.

6.40 Considerations about a patient's capacity must be guided by the five basic principles contained in the Mental Capacity Act 2005:

- i. A person must be assumed to have capacity unless it is established that they lack capacity.
- ii. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- iii. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- iv. An act done, or a decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- v. Before an act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

6.41 The Mental Capacity Act provides a **two stage test of capacity**, which provides the framework for all assessments:

Stage 1 The Diagnostic Test

Is there any evidence that the patient has; ‘an impairment of, or a disturbance in the functioning of, the mind or brain ‘?

Examples of impairments include alcohol intoxication, traumatic brain injury (TBI), dementia, infection and depression.

If so, move onto stage 2. If not, this indicates that the patient has capacity and is able to consent to, or refuse, the proposed treatment or course of action.

Stage 2 The Functional Test

The presence of a mental disorder alone is not sufficient for the patient to lack capacity. The presumption is that all patients have capacity whether or not they have got a mental disorder. In order to lack capacity the patient must be unable to carry out one of the following four activities as a result of the mental disorder, rendering them unable to make a decision about the care and treatment in question. A person will lack capacity if their mental disorder means they cannot:

- Understand relevant information about the decision to be made
- Retain that information in their mind
- Use or weigh that information as part of the decision making process or
- Communicate that decision by talking or using sign language or any other means.

If the patient can carry out all those activities regardless of the presence of a mental disorder then the patient has capacity and is able to consent to or refuse the proposed treatment. If the patient is unable to carry out any single one of those activities then the patient lacks capacity to make the relevant decision and the clinician must make a best interests decision unless it is possible to delay providing the treatment until such time as the patient can regain capacity. When urgent medical treatment is needed it may not be possible to wait

Best interests

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6.42 Where an adult patient lacks the mental capacity to give or withhold consent for themselves at the time of contact with the LAS, unless the patient has appointed a Lasting Power of Attorney (LPA) for Health and Welfare, or the Court has appointed a personal welfare deputy who has the authority to consent to the specific treatment proposed, **no-one else can give consent on their behalf**. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance decision.

6.43 'Best interests' are wider than best medical interests and includes factors such as their past and present wishes and beliefs, their general wellbeing and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has an enduring condition that may have prevented them from expressing their own wishes and feelings relatives, carers and friends may be best placed to advise on the patient's needs and preferences and should be consulted, if practical and appropriate.

6.44 Any intervention must also depend on a physical assessment, which considers the likelihood of the imminent risk to the person of loss of life or limb. If it is felt that, without immediate treatment, there would be a significant or irreversible deterioration in health, the LAS has a duty to intervene safely and provide care in the person's best interests. If the incident is less serious and patient care can be provided on scene by alternative measures, forced removal is inappropriate.

6.45 The law recognises that every case of mental incapacity is different and provides a checklist of factors to be taken into consideration when making a best interests decision.

6.46 Best interests should not be based on assumptions about the person's age, appearance, condition or behaviour.

6.47 All relevant circumstances should be considered

6.48 Every effort should be made to encourage and enable the person who lacks capacity to participate in the decision making process.

- 6.49 If there is a chance that the person will regain the capacity to make a particular decision then it should be considered if it appropriate to put the decision off until that time, if the decision is not urgent.
- 6.50 The person's past and present wishes and feelings, beliefs and values should be taken into account.
- 6.51 The views of relevant others should be taken into consideration, as well as the views of an attorney or deputy.
- 6.52 If the decision relates to life-sustaining treatment, the decision should not be motivated by a desire to bring about death.
- 6.53 When assessing best interests, staff are advised to consider completing form LA066 and submitting this to management information along with their LA4 and LA5.
- 6.54 Occasionally, there will not be a consensus on whether a particular treatment is in the best interests of an adult lacking capacity. Where the consequences of having, or not having, the treatment are potentially serious, a court declaration may be sought. The Head of Legal Services will obtain advice/ assistance from the LAS solicitors on seeking directions from the Court.

Documentation

- 6.55 Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented on form LA5 - Capacity to Consent to Examination or Treatment. This will include an assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient. The form should also be used to guide the assessment of capacity, and to document any intervention that is taken in the patient's best interests if they are deemed to lack capacity. It is also recommended that the form is completed for patients who have capacity but are refusing treatment against advice with the potential outcome having a detrimental effect of their health.

6.56 The form LA5 has been devised to assist staff in both the reasoning process and the need to document decisions and actions in these difficult circumstances. It is understood that staff may not be able to complete the form as the process develops, but, it must be completed as soon as is practically possible.

6.57 A completed copy of the form LA5 is to be retained and submitted to management information along with the LA4.

6.58 A copy of form LA4, appropriately completed at section 11, must be given / offered to the patient, if they are not conveyed to a treatment centre. If the patient is conveyed to a treatment centre, a copy of the LA5 is to be left with a copy of the LA4 at the treatment centre.

Advance Decisions

6.59 An Advance Decision enables a person aged 18 or older, whilst they still have capacity to refuse a specified medical treatment for a future time when they may lack the capacity to consent to or refuse that treatment.

6.60 If an advanced decision is valid and applicable to the circumstances it must be followed.

6.61 In order to ascertain the validity of an advance decision, clarification may need to be sought from either the patient's GP, the clinician involved in that aspect of the patient's care, or any person (if any) named in the decision, which may include the patient's solicitor. Where there is real doubt over the validity of an advance decision and any delay in treating and/or transferring the patient is likely to lead to a significant or irreversible deterioration on health, then staff should do what is practicable in order to treat/ transfer the patient having consulted with EOC.

6.62 [An advanced decision which relates to life sustaining treatment is valid only if it meets the following procedural requirements:

- i. It must be in writing (including written in healthcare notes)
- ii. It must be signed and witnessed

- iii. It must state clearly that the decision applies even if life if at risk.

Furthermore, if the clinician is concerned that any of the following factors may be present they should contact the Clinical Hub and investigate further if time permits.

- iv. The person has done anything clearly inconsistent with the decision remaining a fixed decision.
- v. The person has subsequently withdrawn the decision.
- vi. The person has subsequently conferred the power to make that decision to an attorney, or
- vii. Would have changed their decision if they had known more about the current circumstances.

Where the circumstances in iv to vii arise, the advance decision is not valid and the clinician should act in the patient's best interests. Where doubt exists as to the validity of an advance decision, treatment must be continued until the patient is able to discuss their current treatment wishes. However, only that treatment, which is immediately necessary and in the patient's best interests should be provided.

6.63 When assessing the validity of an advance decision, staff should consider completing form LA067 and submitting the form to management information along with the LA4 and LA5.

6.64 Refer to Appendix 1 for further guidance and frequently asked questions.

Lasting powers of attorney

6.65 Where a person who lacks capacity nominated a lasting power of attorney (LPA) for health and welfare, prior to losing capacity, this attorney would normally be consulted when making health and welfare decisions for the patient.

6.66 The LPA form itself will specifically describe how the attorney(s) may act, and what powers they have. When presented with a LPA form, staff must

review the form to ensure it is valid, and that they understand what powers the attorney(s) have.

6.67 Staff are strongly advised to use the checklist contained in form LA068, and to complete the form and submit it to management information along with their LA4 and LA5.

6.68 LPAs for 'Property and Financial Affairs' give no power to the attorney(s) to make health and welfare decisions.

6.69 Note that attorneys are bound to act in the best interests of the person who lacks capacity.

6.70 Refer to appendix 2 for further guidance and frequently asked questions.

Deprivation of liberty

6.71 The statutory DoLS scheme can only be used where a person will be deprived of their liberty in a care home or hospital. All other settings, including deprivation in an ambulance would require authorisation from the Court of Protection (CtOP), which may be granted if it is satisfied that it is in the person's best interests¹.

6.72 A person may be deprived of their liberty by the London Ambulance Service NHS Trust in circumstances where they:

a) Lack capacity to make a decision to be transported for more than a "negligible period" by patient-facing staff.

b) Are under continuous supervision and control; and

c) Are not free to leave the ambulance or the care of the patient-facing staff..

The Deprivation of Liberty Safeguards supplement to the Mental Capacity Act Code of Practice is expressly clear that transporting a person who lacks capacity from their home, or another location, to a hospital or care home will not usually amount to a deprivation of liberty.

¹ MCA Code of Practice, 6.51. P109.

6.73 Health professionals should consider whether the person has the capacity to consent to or to transportation for the purposes of receiving care and treatment in accordance with section 3.37 onwards. If they can consent then there will be no deprivation of liberty.

6.74 In the event that the person does not have capacity (or if there is insufficient time to properly assess capacity then in an emergency) it will be lawful to provide treatment and transportation on an urgent basis in a patient's best interests in order to provide life sustaining treatment and/or to prevent serious deterioration in the patient's condition (see section 3.42 onwards). Healthcare staff can restrain patients in their best interests in order to bring them to hospital in circumstances where they lack capacity to make such decisions for themselves. This will not normally amount to a deprivation of liberty.

6.75 The vast majority of cases in which a person who lacks capacity requires care and control during an ambulance transfer constitute restraint or a restriction of liberty rather than a deprivation of liberty in legal terms, and occur in the emergency situation.

6.76 It would be a rare event for an ambulance journey to require an authorisation of a deprivation of liberty however it is important to obtain advice via Legal Services in the following circumstances:

- Where the assistance of the police and/ or statutory services to gain entry and assist in the removal of the person from their home and into the ambulance, and the situation is not covered by the Mental Health Act and it is not an emergency.
- Where it may be necessary to do more than persuade or provide transient forcible physical restraint of the person during the transportation, and the situation is not covered by the Mental Health Act and it is not an emergency.
- Where the journey is exceptionally long; for example expected to last longer than 60 minutes or is otherwise deemed unusually long for the circumstances.

- Where the person may have to be sedated for the purposes of transportation and the situation is not covered by the Mental Health Act and it is not an emergency.

6.77 It must be emphasised that emergency life-sustaining interventions and the provision of emergency care to patients who lack capacity must not be delayed for the purposes of obtaining authorisation to deprive a person of their liberty.

6.78 In exceptional circumstances it may be that the level of restraint required or the duration of the journey require prior authorisation for a deprivation of liberty to be granted by the Court of Protection. However, such applications will only be possible where health professionals have advance notice that a deprivation of liberty is going to be required and is in the best interests of the patient to delay transportation to enable that authorisation to be obtained.

7.0 Clinical Photography and Conventional or Digital Video Recordings

7.1 Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, staff should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

7.2 Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient.

7.3 Photographic and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient, as long as this policy is well publicised. However, express consent must be sought for any form of publication – see also LAS Managing Patient Confidentiality when dealing with the Media – TP/024.

7.4 If you wish to make a photographic or video recording of a patient specifically for education, publication or research purposes, you must first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to

use it (see TP/024). Patients must know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

7.5 The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

7.6 If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of someone close to the patient. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

8.0 References and further reading

8.1 Information on consent and capacity is available on [the Pulse](#), including a good practice documentation guide.

8.2 The Department of Health has issued a [reference guide](#) to consent for examination or treatment. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies, (such as the Health Professions Council's Code of Conduct, Performance and Ethics).

8.3 The BMA provide a comprehensive toolkit for assessing and managing patients who lack capacity which can be accessed here: <http://bma.org.uk/practical-support-at-work/ethics/mental-capacity/mental-capacity-tool-kit>

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8.4 The Social Care Institute of Excellence have developed a rich source of multi-professional guidance which can be accessed here: <http://www.scie.org.uk/mca-directory/>

8.5 The Mental Capacity Act [Code of Practice](#) is the most accurate source for information on the assessment and management of adults who lack capacity and is available online.

IMPLEMENTATION PLAN				
Intended Audience	For all LAS staff			
Dissemination	Formal education during clinical training and CPD courses. RIB and availability to all staff on the Pulse.			
Communications	Revised Procedure to be announced in the RIB and a link provided to the document.			
Training	Training in consent is provided by the Clinical Education and Standards Department through both new-entrant courses and the Core Skills Refresher programme.			
Monitoring:				
Aspect to be monitored	Frequency of monitoring AND Tool used	Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported	Committee/ group responsible for monitoring outcomes/ recommendations	How learning will take place
Application of the policy in respect of consent and patient treatment documentation	Clinical Performance Indicator checks (CPIs)	Clinical Team Leaders Clinical Safety and Standards Committee	Clinical Safety and Standards Committee	Individual staff will be monitored via CPI checks and Group Station Management

MENTAL CAPACITY ACT 2005

Checklist for assessing “Advance Decisions” for patients aged 18 or above

Patient’s Name:	Incident Date:
Date of Birth:	CAD:

An advance decision (AD) is an oral or written decision made by an adult (18 and +) with capacity to do so, that if:

- (i) At a later time (in specified circumstances, if they are specified) a specified treatment is proposed by a health professional; and
- (ii) The patient lacks capacity to consent to the carrying out of that treatment

Then the treatment is not carried out or continued. Where the AD relates to life sustaining treatment the specific criteria stated overleaf must be met. The decision may be expressed in layman’s terms.

Please document clearly in the patient’s records or overleaf your reason for answering “**Yes**” or “**No**” for any of the questions below. This form must be placed in the patient’s records.

1. Does the patient have capacity or may he/she have it at some time in the future when he/she could take the decision to consent to or refuse treatment for him/ herself?

YES/NO

If “**Yes**” then the AD is not applicable and the patient’s views should be obtained.

If “**No**” proceed to question 2.

2. Has the AD been revoked or altered? This need not be in writing, unless it includes a provision about life-sustaining treatment. (NB - a previous AD refusing life-sustaining treatment may be revoked orally).

YES/NO

If “**Yes**” the revocation or alteration should be followed, but see question 6 and the checklist to consider for life-sustaining treatment.

If “**No**” proceed to question 3.

3. If possible has the patient been asked whether they now wish to revoke or alter their previous AD?

YES/NO

If **“Yes”** and they have not changed their view proceed to question 4.

If **“No”** ask the patient if possible and if they wish to change their view legal advice should be sought. If there is no change in their view proceed to question 4.

4. Is the AD valid?

In answering this question please consider each of the following;

- Has the patient withdrawn the advance decision when he/she had capacity to do so?
- Has the patient done anything which is clearly inconsistent with the AD?
- Is there a person (donee) with a Lasting Power of Attorney, created after the AD was made, giving the donee authority to give or refuse consent to the treatment to which the AD relates?

If the answer to any question is **“Yes”** then the AD is not valid and is not binding.

5. Is the AD applicable to the treatment in question?

- Does the treatment in question fall outside of what is specified in the AD?
- Are any particular circumstances specified in the AD now absent?
- Are there reasonable grounds for believing that circumstances exist which the patient did not anticipate at the time of the AD and which would have altered his decision had he anticipated them?

If the answer to any question is **“Yes”** then the AD is not applicable and is not binding.

Life-sustaining treatment

6. Have the following conditions been satisfied for any AD which relates to life-sustaining treatment?

The AD is:

- Verified by a statement by the patient to the effect that it is to apply to that treatment even if life is at risk.
- In writing

- Signed by the patient or another person in the patient’s presence and at the patient’s direction

and

the signature is made or acknowledged by the patient in the presence of a witness

and

the witness signs or acknowledges his signature in the patient’s presence.

If **all** the answers are “**Yes**” then the AD will apply to life-sustaining treatment but you **must** also follow the remainder of this checklist. (An AD refusing life-sustaining treatment may be revoked orally)

I confirm I have understood and reviewed this checklist in respect of the above-named patient.

_____	_____	_____
Signature of Health Professional	Date	Name and position of Health Professional

This checklist is only intended to provide guidance and a framework when considering an advance decision. Where there are any doubts concerning the validity or applicability of an advance decision further medical and/or legal advice should be sought.

Notes:



MENTAL CAPACITY ACT 2005

Checklist for assessing “Lasting Powers of Attorney” for patients aged 18 or above

Patient’s Name:	Incident Date:
Date of Birth:	CAD:

Under a Lasting Power of Attorney (LPA) the donor (the patient) confers upon individuals named in the document known as the “donee”, or “donees” if more than one, authority to make decisions about the donor’s personal welfare, or specified matters concerning those.

This includes authority to make decisions when the donor no longer has capacity. However the following conditions must be satisfied for a valid LPA to be created:

- The donor must be 18 years old or above and have capacity when executing an LPA
- The donee must be at least 18 years old
- The instrument conferring authority (LPA) must be in specific terms and have been registered with the Office of the Public Guardian

Where the LPA allows decisions to be made and these decisions concern life-sustaining treatment a donee cannot refuse life-sustaining treatment unless the LPA expressly allows for this.

Where there is any doubt as to the validity of a LPA, or whether a donee under a LPA is acting in the best interests of the donor, legal advice should be sought and an application can be made to the Court of Protection if necessary.

Any decision in relation to powers conferred on a donee of a Lasting Power of Attorney should be considered with reference to the principles in section 1 of the Act and section 4 “best interests” provisions in the Act.

Please document clearly in the patient’s records or on this form your reasons for answering “Yes” or “No” for any of the questions below. This form must be placed in the patient’s records.

1. Have you seen the LPA and is it registered at the Office of the Public Guardian?

YES/NO

If “Yes” proceed to question 2

If “No” the LPA is not valid and the views and wishes of the donee do not have to be followed.

2. Does the donor / patient have capacity?

YES/NO

If “Yes” the patient can make the decision. If “No” proceed to question 3.



3. Has the patient made any subsequent advance decision that is valid and applicable to this decision?

YES/NO

If **“Yes”** follow the advance decision.

If **“No”** proceed to question

4. Does the LPA cover the patient’s property and affairs only?

YES/NO

If **“Yes”** the donee does not have power to make decisions regarding the patient’s welfare.

If **“No”** and it is clear that it covers welfare issues also proceed to question 5.

5. Does the Lasting Power of Attorney allow for a second donee and if so have they been consulted?

YES/NO

If **“Yes”** and the document states that the donees have “joint and several” responsibility then either donee may give the necessary authority. If it is only “joint” then both must agree to the proposed management.

If **“No”** then proceed with the relevant authority from the single donee.

6. Has the donee been fully informed of the nature, risks and consequences of the treatment being proposed as well as the consequences of accepting or refusing the treatment on behalf of the patient?

YES/NO

If **“Yes”** proceed to question 7.

If **“No”** you must do so before the donee or donees take any decision.

Does the decision of the donee conflict with the views of health professionals looking after the patient or do you believe that the patient’s best interests have not been properly considered (see the Best Interests checklist)?

YES/NO

If **“Yes”** consideration should be given to referring the matter to the Court of Protection and the case should be reported to senior staff in order to obtain legal advice in the first instance.

If **“No”** then proceed in accordance with the wishes of the “donee”.

Life-sustaining treatment

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8. Does the Lasting Power of Attorney contain express provision authorising the donee to give or to refuse consent to the carrying out or continuation of life sustaining-treatment?

YES/NO

If **“Yes”** then this is valid but consider question 9 also. If **“No”** and life-sustaining treatment is necessary then it must be given.

Where there is any dispute with the health professional about the assessment of the patient’s capacity which remains unresolved legal advice should be sought in order that the matter can be referred to the Court of Protection.

9. Do all relatives and carers agree with the proposed management and the wishes of the donee?

YES/NO

If **“Yes”** then proceed as planned. If **“No”** then this presents a potential risk and further advice should be sought.

I confirm I have understood and reviewed this checklist in respect of the above-named patient.

Signature of Health Professional

Date

Name and position of Health Professional

This checklist is only intended to provide guidance and a framework when considering a lasting power of attorney. Where there are any doubts concerning the validity or applicability of a lasting power of attorney further medical and/or legal advice should be sought.

