DELIVERY OF PROFESSIONAL MEDICAL SERVICES

CAPACITY AND CONSENT TO CARE AND TREATMENT POLICY

A-cute medical event services limited

Contents: **Page No.**

Version	Date	Author	Rev date
2	June 2017	M. Weatherhead	June 2019
3	January 2023	M. Weatherhead	January 2025

1. **Purpose**

1.1 State the legal and ethical basis for consent to treatment and to ensure that all patients are informed and treated appropriately and with due consideration to their wishes and best interest.

2. Scope

2.1 This instruction applies to all personnel working for A-cute Medical Event Services Ltd.

3. Responsibility

3.1 A-cute medical Event Services operational personnel.

3.2 Any healthcare provider who does not respect these principles may be liable to legal action from the patient and where appropriate their registering body.

3.3 A-cute Medical Event Services Director is responsible for ensuring all staff are informed and trained in the subject of this policy and that the policy is updated periodically

4. Introduction

4.1 Patients with capacity have fundamental legal and ethical right in determining what happens to them. Valid consent to treatment by a patient who has capacity is therefore absolutely central to all forms of healthcare, from providing personal care to more invasive interventions.

4.2 Seeking consent is also a matter of common courtesy between health professionals, patients and in those patients without capacity their carer, relative or the person with power of attorney. All discussion regarding proposed assessment or treatment should be documented, this must include the decision around which treatment is accepted and declined. A good level of communication will facilitate informed consent through to the management of non-consent.

4.3 It is not uncommon in pre-hospital situations for patients to refuse care or treatment. Although patients may refuse, there is still, in certain circumstances, an ongoing moral duty and legal responsibility for A-cute's clinicians to provide further intervention. This procedure provides guidance on how these situations should be managed.

4.4 The Department of Health (DH) has issued guidance documents on consent, which may be consulted for good practice and legal guidance.

5. Definitions

Valid Consent:

5.1 The voluntary and continuing permission of the patient to be given a particular examination, treatment, operation or examination. Consent is only valid where it is given by an appropriately informed person who has the capacity to consent to the intervention in question.

Informed Consent:

5.2 A patient's consent to a clinical procedure (or to participation in a research study) after being advised of all relevant facts and all risk involved (see below).

Capacity to Consent:

5.3 The ability to receive, understand and retain information long enough to be able to make a decision. An individual must be assumed to have capacity unless it has been determined that they lack capacity.

Duration of Consent:

5.4 The length of approval gained by valid consent being given. This generally remains valid unless it is withdrawn by the patient, however, new information should be given to the patient as it arises, and consent regained.

6. Seeking Consent

6.1 Before staff examine, treat or care for their patients they should obtain the patients consent. Valid consent can only be given by the patient or, where relevant, someone with power of attorney or parental responsibility for a child or young person (see Section 9) or an appropriate representative if patient does not have the capacity to consent, this includes where there is a valid Living Will or Do Not Resuscitate (DNR) in place (this will be a lilac document detailing the treatment that will be stopped and under what circumstances that these treatments will be stopped. It will be signed and dated by the patient or person responsible for the patient the Patients own Dr and the treating Dr).

6.2 Patients can change their mind 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. Consent should be continuous – if previously unexplained treatment is carried out, further consent should be gained.

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

6.3.1 ***Does the patient have capacity?*** **(See section 7 for further advice)**
Is the patient able to comprehend/understand and retain information material to the decision, and use that information material to the decision, believe it and use that information, bearing the full consequences in mind?

6.3.2 ***Is the consent given voluntarily?***
Consent is only valid if given freely, with no pressure or undue influence to accept or refuse treatment.

6.3.3 ***Has the patient received sufficient information?***
The patient should understand, in broad terms, the nature and purpose of the procedure. Failure to provide all relevant information may render the healthcare provider liable to an action for negligence.

6.4 The type of information that needs to be given to the patient or their representative by the ambulance 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:

6.4.1 Treatment options; including the option not to treat and the likely consequences.

6.4.2 Description and method of treatment, removal and ongoing care.

6.4.3 Purpose and reason for treatment, removal and ongoing care.

6.4.4 Possible complications and side effects of treatment

6.4.5 Explanation of likely benefits of treatment.

6.4.6 A reminder that the patients can change their mind about consent at any time.

6.5 In practice, patients also need to be able to communicate their decision. Care should be taken not to under-estimate the ability of a patient to communicate, whatever their condition. Many people with learning disabilities have the capacity to consent if time is taken explaining to the individual the issues in simple language, using visual aids. Ambulance clinicians should take all steps that are reasonable in the circumstances to facilitate communication with the patient, using interpreters or communication aids as appropriate, whilst allowing for the urgency of the situation.

6.6 Most adults are presumed to have capacity, but where any doubt exists, the clinician should assess the capacity of the patient and make an informed decision on how to progress with the most appropriate care pathway for that patient (see section 7). This assessment and the conclusions drawn from it should be recorded in the patient's clinical record (PRF).

6.7 In an emergency/time critical situation where consent cannot be obtained, emergency clinicians should provide treatment that is in the patient's best interests and is immediately necessary to save life or avoid significant deterioration in the patient's health.

7. Mental Capacity Act 2005 – Assessing Capacity

7.1 The Mental Capacity Act 2005 defines how to assess the capacity of anyone aged over 18 years of age: it uses a 2 stage test of capacity. 1) Does the person have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use? 2) Does the impairment mean the person is unable to make a specific decision when they need to?

7.2 A person must be assumed to have capacity unless it has been established that they lack capacity.

7.3 To determine that a person lacks capacity they must have failed at least one of the following:

- understand the information given to them that is relevant to the decision making process;
- retain that information long enough to be able to make the decision;
- use or weigh up the information as part of the decision making process;
- communicate their decision – this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

7.4 Adults who usually have capacity may, especially in emergency situations; become temporarily incapable this should be recorded on the Patient Report Form. In such circumstances it is permitted to apply treatments that are necessary and no more than is reasonably required in the patient's best interest 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 welfare considerations. Where possible, a GP or professional carer should be fully involved if there is doubt concerning the patient's capacity.

8. Refusal and Withdrawal of Consent

8.1 If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment, or decides to withdraw their consent at any time, their decision should be respected.

Exceptions exist for children and some patients under various sections of the Mental Health Act. If a child makes a decision to refuse or withdraw consent, this can be over-ridden provided the consequences of refusal are so grave that the child could not possibly fully understand the implications of their decision.

8.2 A patient with capacity is entitled to withdraw consent at any time. The clinician should stop the procedure, establish the patient's concerns, and explain the consequences of withdrawal. If, however, stopping a procedure at that point may reasonably be seen to put the patient's life at risk, then the ambulance clinician may continue until such risk no longer applies. If this is not possible and/or treatment is stopped this must be documented fully with the patient's reasons and any advice given to the patient by the clinician relating to the withdrawal of treatment on the PRF.

8.3 Withholding or withdrawing treatment is not an option for A-cute's clinicians unless consent is withdrawn. To do so would be seen as a breach of duty of care and a breach of the patient's human rights.

8.4 Patients can refuse treatment and remain at the location, as is their right. There is, however, a responsibility to provide treatment against a patient's wishes in specific circumstances (see sections 8 & 9).

9. Documentation of Non Transportation

9.1 If a patient declines transportation to a treatment centre a report form must be completed, detailing advice and guidance given to the patient, or any referral to specialist staff, ideally signed by the patient (although this simply confirms their presence) and witnessed by a third party.

10. Children and Young People

10.1 The legal position concerning consent and refusal of treatment by those under the age of 18 is different from the position for adults, in particular where treatment is being refused

10.2 Young people aged 16 and 17 years are presumed to have sufficient understanding and intelligence to be able to consent to their own medical treatment. As with adults, clinicians should ensure that consent is valid. That consent is given voluntarily by an appropriately informed patient, who is capable of understanding and consenting to the treatment or care pathway being offered by the clinician.
It is, however, good practice to involve (if they are available) the young person's family in the decision-making process. If the young person specifically wishes to exclude them from the decision making process this needs to be documented with the young person's reasons if they are willing to divulge this information on the PRF.

10.3 Critical situations involving children and young people suffering a life threatening emergency may arise during a consultation with a person with parental responsibility who refuses consent, despite such emergency treatment appearing to be in the best interests of the child to prevent grave and irreversible mental or physical harm. **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 health care providers to undertake treatment to preserve life or prevent serious damage to health.**

10.4 With patients under the age of 16, those who have sufficient understanding and intelligence to fully comprehend what is proposed also have the capacity to consent to the intervention. 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 gains capacity to consent. In emergency care, consequences of non-treatment are usually evident – but should be fully explained to ensure that a refusal to give consent is fully informed.

10.5 Where possible, the child or young person should be given the opportunity to express their wishes. If this is not possible or feasible, A-cute clinicians should seek to obtain consent from a person with parental responsibility.

10.6 As is the case where patients are giving consent for themselves, those giving consent on behalf of young patients should 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. In the absence of a person with parental responsibility and a child without capacity, ambulance clinicians should act in the child's best interest.

11. Duty of Care, Consent and Human Rights

11.1 There is a professional, legal and moral consensus about the clinical duty to obtain informed consent. Patients may, however, have cognitive and emotional limitations in understanding clinical information. Social and economic variations are also important variables in understanding the practical difficulties in obtaining informed consent. It is the duty of clinicians to act in a patient's best interest by overcoming such difficulties so that the patient has a clear, unbiased and informed view of the care that is being proposed.

11.2 **'**Duty of care' may be defined as 'The absolute responsibility of a healthcare professional to treat and care for a patient with a reasonable degree of skill and care'.

11.3 Negligence arises when that duty is breeched and 'reasonably foreseeable harm' arises as a result. A lack of valid consent does not automatically absolve the carer of their duty of care, or risk of negligence.

11.4 The European Court of Human Rights has ruled that –*'Treatment without consent, invasive treatment contrary to a patient's best interest, and withholding medical care'* can all be deemed *'inhumane or degrading treatment'* in extreme cases.

11.5 Any healthcare provider who does not treat a needy patient because valid consent was not gained, could be deemed to be negligent if a genuine effort was not made to gain such consent.

12. Advance Refusals of Treatment

12.1 Patients may have in place a living will ("advance directive") or DNR specifying how and what treatment they want in the case of future incapacity. *Case law is now clear that refusal of treatment under a living will or advance directive that 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, when the crew are aware of its existence.*

12.2 In a pre-hospital emergency environment, there may be situations where there is doubt about the validity of a living will or advance directive or DNR. If A-cute's clinicians are not satisfied or can identify proof that the patient had made a prior and specific request to refuse treatment, they should continue to provide all clinical care in the normal way until the validity of the documentation is confirmed e.g. initially where a copy of the document does not appear to be valid but then the original document is handed to you.

13. Self-Harm

13.1 Cases of self-harm present particular difficulties for health professionals. Where the patient is able to communicate, 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 under the basis of temporary incapacity, as outlined above. Similarly, patients who have attempted suicide and are unconscious should be given emergency treatment in all circumstances.

13.2 In a pre-hospital setting, an instance of self-harm may require urgent intervention, such as in the case of a toxic drug overdose. If the patient refuses treatment, and the delay caused to clinical intervention is tolerable, the patient's GP should be urgently requested to attend the patient and fully assess their level of capacity. If the incident is more critical and there is insufficient time to arrange additional health care professionals, crews currently overcome most situations with commendable determination to act in the best interests of the patient. These practices should continue, but strict determination of the patient's capacity should be made.

13.3 Staff usually act intuitively to assess whether they perceive a patient is at risk of suicide. Where possible a formal risk assessment must be completed using the **SAD PERSONS** deliberate self-harm assessment tool. *Appendix 1*

14. Consent for Patients whose First Language is not English

14.1 A-cute Medical Event Services Limited is committed to ensuring that patients whose first language is not English receive the best care and information they need to be able to communicate appropriately with healthcare staff. Although in some circumstances it is not best practice to use family members to interpret for a patient who does not speak English, it is recognised that this may be the only option available. Staff should use any means available to overcome the language barrier including translate apps or bystanders who speak both languages.

15. Clinical Photography and Conventional or Digital Photography

15.1 Photography intended to benefit the patient's treatment is seen as 'treatment' in itself, and requires valid consent. Photographs should be retained in the patient's hospital file and no other copies are permissible. No photographs are to be taken using personal media devices.

15.2 All other photography and motion pictures for purposes such as media promotion require patient and staff consent, which needs to be sought in writing.

16. Exceptions to the Principle of Consent

16.1 An unborn foetus has no rights under consent law. A pregnant mother has every right to refuse treatment for her or her foetus, irrespective of the potential harm that may arise to the foetus however the requirements of Safeguarding the unborn child under the Children's Act come into play and a safeguarding referral must be instigated without delay and a request made for support from a duty manager. A-cute has a Bronze Rota to support its staff.

16.2 The Public Health (Control of Disease) Act 1984 provides that, on an order made by the magistrate or sheriff, persons suffering from certain notifiable infectious diseases can be medically examined, removed to, and detained in 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 should either be suffering from grave chronic disease or be aged, infirm or physically incapacitated and living in unsanitary conditions. These situations are extremely rare and A-cute clinicians should request guidance from the duty manager who should be available to attend such incidents.

16.3 It a patient refuses decontamination treatment, for example following a chemical, biological, radiological or nuclear (CBRN) incident, clinicians should liaise with the Police, Fire Service, 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.

16.4 Treatment involving mentally ill patients is covered by the Mental Health Act 1983, 2005 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. This means that any patient detained under the Mental Health Act has every right to impart and deny consent for treatment for physical disorders not directly related to his/her mental illness. It is very likely that specialist nursing advice will be available in such circumstances.

17. Consent and Research

17.1 Whilst A-cute Medical Event Services Limited currently does not take part in formal research projects, it is recognised that individual staff may be involved in research as part of their ongoing development. Involvement in a research project requires that valid consent is obtained beforehand with certain exceptions.

17.2 **Key Points – Consent**

17.2.1 Gaining valid consent is central to all forms of healthcare.

17.2.2 Consent is only valid if it is given freely by a person who has all the relevant facts, is able to assimilate them, and can fully understand the implications of their decision. (i.e. has capacity)

17.2.3 Patients can change their minds and withdraw consent at any time.

17.2.4 Young persons who have the intelligence to fully understand the proposed treatment also have the capacity to consent to such treatment.

17.2.5 The rules of consent do not absolve clinicians of their duty of care, nor do they affect the human rights of patients.

18. Further Reading

18.1 Further information is available on the Department of Health website: http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Consent/index.htm

18.2 Mental Capacity Act, 2005

18.3 Reference guide to consent for examination or treatment, Second edition 2009

18.4 CQC – Health and social care act 2008 (regulated activity) Regulations 2014 Regulation 11

18.5 JRCALC

19. Related Policies and Guidance

Safeguarding Policy

Appendix 1

SAD PERSONS scale

S – Sex: 1 if male; 0 if female; (more females attempt, more males succeed)

A – Age: 1 if < 20 or > 44

D – Depression: 1 if depression is present

P – Previous attempt: 1 if present

E –Ethanol abuse: 1 if present

R – Rational thinking loss: 1 if present

S – Social Supports Lacking: 1 if present

O – Organized Plan: 1 if plan is made and lethal

N – No Spouse: 1 if divorced, widowed, separated, or single

S – Sickness: 1 if chronic, debilitating, and severe

Guidelines for action with the SAD PERSONS scale	
Total points	Proposed clinical action
0 to 2	Send home with follow-up
3 to 4	Close follow-up; consider hospitalization
5 to 6	Strongly consider hospitalization, depending on confidence in the follow-up arrangement
7 to 10	Hospitalize or commit