East of England Ambulance Service NHS Trust

Mental Capacity Act Policy

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Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of:

age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

1. Introduction

The Mental Capacity Act 2005 creates a legal framework to provide protection for people who cannot make decisions for themselves. It applies to everyone who works in health and social care and is involved in the care, treatment or support of people who are 16 years of age or more (England & Wales)

The Act contains provision for assessing whether people have the mental capacity to make decisions, and procedures for making decisions on behalf of people who lack mental capacity. It is supported by a code of practice (MCA Code 2005)

The underlying philosophy of the MCA is that any decision made, or taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests. The MCA 2005 applies irrespective of whether the decision is a day-to-day matter or relates to a serious medical treatment.

The Mental Capacity (Amendment) Act 2019 has introduced the Liberty Protection Safeguards (LPS) and will replace the Deprivation of Liberty Safeguards (DoLs). The liberty protection safeguards are planned to come into force in April 2022. We will ensure this policy reflects the changes.

2. Purpose

This policy sets out the standards and guidance for the Trust, which aim to ensure that Trust staff are able to comply with the law and Department of Health Guidance with regards to the principles of consent and mental capacity assessment.

This Policy should be read in conjunction with the Trust's Safeguarding Children and Young People, and Safeguarding Adults policies.

3. Duties

3.1 Chief Executive Officer

The Chief Executive Officer (CEO) is ultimately responsible for ensuring that the Trust is compliant with all aspects of the MCA and Code of practice. Accountability for ensuring the Trust fulfils its legal requirement rests with the Trusts CEO who may delegate to a nominated officer within the organisation. The Trust board will receive reports either directly or through the trust committee structure.

3.2 Staff, apprentices, volunteers & commissioned services (including Private Ambulance Services PAS)

All staff, Apprentices, volunteers and commissioned services have a responsibility to read, understand and take full responsibility to adhere to the requirements of this policy and its appendices

4. The Code of Practice for the Mental Capacity Act 2005

The Code of Practice provides guidance for a range of people and professionals with different functions and duties under the MCA and has statutory force.

This means that certain categories of people have a legal duty to have regard to it when working with or caring for individuals who lack the capacity to act or make decisions for themselves. In particular the Code of Practice focuses on those who have a duty of care to someone who lacks the capacity to consent to the care that is being provided and that duty of care requires the worker to act in the best interests of the person at all times.

4.1 The five guiding principles of the Mental Capacity Act

The MCA has five key principals which emphasise the fundamental concepts and core values of the MCA. These **MUST** be borne in mind when working with or providing care or treatment for people who lack capacity.

The five principals are:

1. Presumption of capacity. Every patient who is 16 or older has the right to make his or her own decisions and must be assumed to have the capacity to do so unless it is proved otherwise. This means it cannot be assumed that an individual lacks capacity just because they have a particular medical condition or disability. A lack of capacity, and therefore the need to act on the person's behalf, must be clearly decided upon and documented.

2. Individuals have the right to be supported to make their own decision. They must be given all the appropriate help they require before it is decided that they are unable to make their own decisions.

3. An individual has the right to make what others might regard as unwise decisions. This does not mean that they lack capacity. Although risk factors and the individuals understanding of these will be an aspect of any assessment of capacity.

4. Anything done for, or on behalf of, a person who lacks capacity must be done in their **best interest.** An explanation of the term "best interest" is not specifically defined in the MCA, although the principal is set out in the MCA as "An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interest". The person making the decision on behalf of the person who lacks capacity, is known as the 'decision-maker'.

5. Anything done for, or on behalf of. A person who lacks capacity must be the least restrictive option and take into account their rights and freedom of action.

Mental Capacity Act 2005 – 5 principles

1. A presumption of capacity
   - Start by thinking I **can** make a decision
2. **Individuals supported to make their own decisions**
   - Do all you can to **help** me make a decision
3. **Unwise decisions**
   - You must **not** say I lack capacity just because my decision seems unwise
4. **Best interests**
   - Use a **best interest checklist** for me if I can't make a decision
5. **Less restrictive option**
   - Check the decision made **does not** stop my freedom more than needed

4.2 What happens in emergency situations? (chapters 3,5,6,9 & 10 of the code of practice)

In emergency medical situations (for example, where a person collapses or is unconscious & requires urgent medical care) immediate actions may need to be taken to preserve life the persons best interests. In these situations, it may not be practical or appropriate to delay treatment while trying to help the person make their own decisions, or to consult with any known attorneys or deputies.

However, even in emergency situations, healthcare staff should try to communication with the person and keep them informed of what is happening. Advance decisions to refuse treatment may be applicable in these circumstances, but there should not be a delay with emergency treatment whilst trying to locate this if there is no evidence that such a directive exists.

4.3 Helping people make decisions (chapter 3 of the Code of Practice)

People should be helped to make their own decisions, even when circumstances mean that this is more difficult for, for example: when a person is suffering from a mental health problem, or has a

learning disability which may compromise their ability to make some decisions.

When working with a person who needs to make a decision, the law defines that all staff must start from the presumption that the presumption that the person has capacity to make their own decisions. Where staff are unsure an MCA 2 stage assessment must be undertaken.

4.4 Assessing capacity (chapter 4 of the MCA Code of practice)

The presumption that all adults have capacity is central to the MCA. Where a person has the capacity to make a particular decision, then they should ensure others know what their decision is. If a person has capacity, they are allowed to make a decision which appears unwise, or unsafe, this still needs to be respected. Those making a decision, in that person's best interest, on behalf of another person, must first determine that the person on whose behalf they are acting lacks the capacity to make the particular decision.

Where there are grounds to doubt a person's capacity to make a particular decision, an assessment of capacity must be done in accordance with the MCA and its related Code of Practice (particularly Chapter 4). Any deviance from the guidance contained in the Code of Practice must be logical, rational, reasonable and defensible, and clearly documented.

It is important to recognise that people who lack capacity can still be very articulate and provide a rationale in their reasons for making or not making a particular decision. This needs to be considered when assessing whether or not the person has the capacity to make the decision in question. An example of this may be a person with a personality disorder, where they may articulate very well their reasoning behind a particular decision but their disorder may prevent them from appreciating the consequences of their decision.

A person may lack capacity for a number of reasons: capacity is not dependent on any condition alone, but the effects a condition may have on the ability to make decisions. Lack of capacity can be

profound, fleeting or fluctuating. Also, distress can be a possible element to the lack of capacity (fleeting/temporary).

A non-exhaustive list of some of the conditions which may lead to a lack of capacity to make a particular decision is as follows:

- Acquired brain injury.
- Stroke.
- Toxic confusional states.
- Learning disability.
- Dementia.
- The effects of an illness or a treatment, such as pain, distress, confusion, drowsiness, unconsciousness.
- The effects of drugs (prescribed or illegal) or alcohol.
- Mental health problems including: psychoses, anxiety, phobias, depressive illness, other mood problems, Personality disorders and Diogenes syndrome.

It is important to remember that capacity is decision and time specific. This is important: people are not assumed to be incapable of making decisions because of a diagnosis. A person should be considered to have capacity for each and every decision, and a person may have the capacity to make one decision, but not another, more complex decision, for example: the decision to decide how to spend their money every week, but not how to invest their savings. If a person has been assessed as not having capacity to make a particular decision one can, then make a decision on their behalf and act in their best interest.

It is a fundamental principle that people live with elements of risk in their personal life. Where a person is assessed as lacking capacity to make a decision, consideration of what action is in their best interests will need to take into account a balance of risks and needs/benefits. It is important that when assessing capacity, a person is able to understand the risks associated with either making, or not making a decision, and this understanding is considered as part of assessment. Does the person understand the risks involved? Understanding and accepting risks is an important part of decision making. If the person is unable to understand the risks, it is likely that they lack capacity to make that decision. For example, a person

with fluctuating capacity, who is unable to understand or accept that their capacity fluctuates, and the risks associated with this.

Planning ahead for the future (Chapter 7 of the Code of Practice)

People can plan ahead for a time when they may lack capacity. The MCA introduces three ways of doing this:

- Advance decisions to refuse treatment.
- Statement of wishes, feelings and beliefs.
- Lasting Powers of Attorney

Advance decisions to refuse treatment (previously commonly known as living wills) existed prior to the MCA. People can make an advance decision to refuse specified treatment in the future which may include refusal of life sustaining treatment. Advance decisions to refuse treatment can only be made by a person aged 18 or over who has mental capacity at the time the advance decision is made.

Advance decisions may set out the circumstances in which the refusal will apply. Advance decision to refuse treatment (not life sustaining treatment) need not be in writing.

Those making a best interest decision on a person's behalf have a legal duty to have regard to such a statement in considering that person's best interests. Not complying with the statement must be for reasonable and rational reasons. Statements of wishes, feelings and beliefs need not be in writing, but those that are written down and given to family, friends, health, and social care professionals are more likely to be followed.

4.5 Best Interests (Chapter 5 of the Code of Practice)

It is important to remember that when a person lacks capacity to make a particular decision, it follows that they do not have the capacity to either consent or object to the proposal. Any person acting on behalf of a person who lacks capacity **MUST** act in that person's best interests. The ability to articulate a decision, consent or refusal is not the single determining factor in determining capacity or best interests. Some conditions may enable a person to be very articulate, but they may still lack the ability to make an informed decision and therefore lack capacity.

It is important to consider the following factors when determining best interests:

- What is the decision about?
- Is there a Nominated Person?
- Is there a Lasting Power of Attorney?
- Is there an Enduring Power of Attorney?
- Is there a Deputy appointed by the Court of Protection?
- Is there an advocate already involved?
- Is there a duty or power to consult an Independent Mental Capacity Advocate?
- Who needs to be involved in making the decision?
- Who needs to be consulted?
- Who is the decision maker?
- How should the decision be made?
- What is known about the person's previous wishes, feelings and beliefs?
- What are the person's current wishes feelings and beliefs even though lacking capacity?
- What are the practical implications of making decisions in a person's best interest?
- What are the risks involved?

4.6 Lasting Power of Attorney

The MCA introduced a new form of Power of Attorney which will allow people over the age of 18 to formally appoint one or more people to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. The person making an LPA will be called the Donor. The power which is given to someone else is called a Lasting Power of Attorney (LPA) and the person(s) appointed will be known as an Attorney(s). The LPA will give the Attorney the authority to make decisions on behalf of the Donor. The attorney will have a duty to act or make decisions in the best interests (Principle 4 of the MCA) of the person who has made the LPA.

The Office of Public Guardian (OPG) are the registering authority for LPAs and deputies. They supervise deputies appointed by the Court of Protection and provide information to the Court to help make decisions. They also work together

with other agencies such as the police and social care, to respond to any concerns raised about the way in which an attorney or deputy is operating

There are two different types of LPA:

- A health and welfare LPA
- A property and financial affairs LPA

a. When a person makes an LPA, they must have the mental capacity to make that decision (in accordance with the MCA)
b. Before an LPA can be applied, it must be registered with the Office of the Public Guardian. Without registration, an LPA cannot be applied.
c. An Attorney for health and welfare has no power to consent to, or refuse treatment, at any time or about any matter when the person has the capacity to make the decision themselves.
d. If the person in your care lacks capacity and has created a health and welfare LPA, the Attorney will be the decision-maker on all matters relating to the person's care and treatment. Unless the LPA specifies limits to the Attorney's authority, the Attorney will have the authority to make health and welfare decisions and consent to or refuse treatment (*except life-sustaining treatment*) on the Donor's behalf. The Attorney must make these decisions in the best interests of the person lacking capacity (Principle 4).
e. If the decision is about life-sustaining treatment, the Attorney will only have the authority to make the decision if the LPA specifies this.
f. **In an emergency situation staff will always act to preserve life (the precautionary principle) and in the best interest of the person, unless the Attorney is present, an LPA is immediately available and clearly specifies that the Attorney can make an appropriate decision as part of that LPA**.
g. It is important to read the LPA if it is available to understand the extent of the Attorney's powers.
h. If an Attorney is not acting in accordance with the LPA or is not acting in the person's best interests, this should be immediately raised with the Safeguarding team or the Clinical

Advice Line (CAL). Valid concerns about Attorney's will be raised with the Office of Public Guardian.

i. All LPAs are filed with the Office of Public Guardian.

4.7 SPOC Referrals

Most adult and children (see relevant safeguarding policies) referrals require consent for the referral to be made to the trust Single Point of Contact. This means they must have capacity to consent to that referral. Best practice will always be to engage the individual in discussions, decision making and agreement to next steps.

However, where the individual or a member of their household is deemed to be at significant risk from neglect, self-neglect, coercion and control, significant harm, or any other type of abuse, their consent is not necessary to continue making a welfare or safeguarding referral.

If a person refuses to give consent but a referral is needed then it must be made If their capacity is in question, it must be assessed and if recorded as lacking in capacity - a Best Interest (BI) decision can be made to refer the person.

A child in law, section 2 (7) Children's Act,1989 (updated 2004), cannot refuse care and treatment and this trumps the Mental Capacity Act should a 16- or 17-year-old refuse care and treatment or referral to SPOC.

4.8 Assessing Capacity

It **MUST** always be assumed the person has capacity to make the decision in question. In cases where capacity is in question an assessment of capacity will need to be undertaken **BEFORE** carrying out any care, treatment or making a referral to another service or agency

3. **Emergency situations (Doctrine of Emergency)**

a. Clearly in emergency medical situations, urgent decisions will have to be made and immediate action taken in a person's best interest. In these situations, it may not be practicable or appropriate to delay treatment or care while trying to help

the person make their own decisions. Emergency Doctrine a principle that allows individuals to take action in the face of a sudden or urgent need for aid, without being subject to normal standards of reasonable care.

b. What is doctrine of necessity?
   In an emergency, the patient may be treated without consent under the doctrine of necessity, as long as there is a necessity to act when it is not practicable to communicate with the patient and that the action taken is no more than is immediately necessary in the best interests of the patient

4. Who should assess capacity

a. The Health Professional who assesses an individual's capacity to make a decision will be the Health Professional who is directly concerned with the individual at the time the decision needs to be made. This means different Health Professionals will be involved in assessing someone's capacity to make different decisions at different times.

Where a crew are attending the person, the crew member who is in a position of treating or caring for the person will undertake the capacity assessment. **Where a paramedic is available it will be their responsibility to carry out the capacity assessment. However, the legal duty falls to all staff who are undertaking treatment and / or transport of any individual either in an emergency setting or non-emergency setting.**

Principle 3 of the Mental Capacity Act Code of Practice states that a person is not to be treated as unable to make a decision merely because they make an unwise decision.

Everybody has their own values, beliefs, preferences and attitudes. A person should not be assumed to lack the capacity to make a decision just because other people think their decision is unwise. This applies even if family members, friends or healthcare or social care staff are unhappy with that decision. It is important to be conscious of your own bias & opinions and respecting a person's wishes even when you do not agree.

Every adult has the right to make their own decisions if they have the capacity to do so. Family carers and healthcare or social care

staff must assume that a person has the capacity to make decisions, unless it can be established that the person does not have capacity.

People should receive support to help them make their own decisions. Before concluding that individuals lack capacity to make a particular decision, it is important to take all possible steps to try to help them reach a decision themselves.

People have the right to make decisions that others might think are unwise. A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision.

Any act done for, or any decision made on behalf of, someone who lacks capacity must be in their best interests.

Any act done for, or any decision made on behalf of, someone who lacks capacity should be an option that is less restrictive of their basic rights and freedoms – as long as it is still in their best interests.

The Health Professional undertaking a capacity assessment does not need to be an expert in assessing capacity. They must however have a 'reasonable belief' that the person lacks capacity to make the decision or consent to an act at the time that the decision or consent is needed and be able to demonstrate clearly how that the decision of a lack of capacity has been reached. The Trust has documentation (Capacity to Consent Assessment Form) for all staff to follow when undertaking a capacity assessment. The documentation will guide any member of staff through an appropriate assessment.

The only time a specific professional who is trained and qualified to undertake specialist capacity assessments is required, is when a formal "Best Interest" assessment is being made under Deprivation of Liberty safeguards. In such cases the assessment will be undertaken by either an Approved Mental Health Practitioner (AMHP), Best Interest Assessor/Social Worker or Psychiatrist who has received the appropriate training.

An exception to this will be when the healthcare professional giving treatment is satisfied that an Advance Decision to refuse medical treatment exists.

5. Who should keep a record of capacity assessments?

The Trust requires all staff to undertake an appropriate assessment of a person's capacity to make particular decisions and to record the findings

Written records should clearly indicate what decision or consent to an act the person was assessed for and how the decision was made that the person lacked capacity. This should include the steps taken to establish 'reasonable belief'.

6. Protection from liability

The MCA provides protection for actions carried out in connection with care or treatment, when those actions are carried out on behalf of someone who is believed to lack capacity to give permission for the action, so long as it is in the person's best interest. The MCA does not define 'care and treatment' but within the MCA, treatment includes diagnostic or other procedures.

Healthcare and treatment actions covered by the MCA include:

- Giving medication
- Taking someone to hospital for assessment or treatment
- Providing care in an emergency

7. Limits on Protection from Liability

The key areas where acts might not be protected from liability under the MCA are where there is inappropriate use of restraint or where a person who lacks capacity is deprived of their liberty in the absence of formal authorisation issued by the designated supervisory body.

8. Use of restraint

The Trust has a policy of **no restraint** being used when attending to persons except in exceptional circumstances under common law. Whilst restraint may be used under the MCA, it can only be used when it is considered to be in the Best Interests of a person who lacks capacity, and **ONLY** then when it is proportionate and reasonable to do so.

Under the MCA, a person is defined as using restraint if they:

- Use force – or threaten to use force – to make someone do something that they are resisting, or
- Restrict a person's freedom of movement, whether they are resisting or not, in law this can be identified as a physical or verbal act.

Any action intended to restrain a person who lacks capacity must meet the following two recommendations:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it takes, must be a proportionate response to the likelihood and seriousness of harm

In addition, common law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent has challenging behaviours, or is in the acute stages of an illness causing them to act in a way that may cause harm to others, staff may under common law, take appropriate and necessary action to restrain or remove the person in order to prevent harm both to the person concerned and anyone else. Acts under common law would not provide sufficient grounds to deprive someone of their liberty.

Any use of restraint should be reported through DATIX and reviewed by the Safeguarding team.

9. Deprivation of Liberty Safeguards under the Mental Capacity Act

Deprivation of Liberty Safeguards (DoLS) was introduced as legislation within the MCA, when it was updated in 2007. The MCA and DoLS came about following a ruling by the European Court of Human Rights (ECHR) The ECHR declared that it was illegal to deprive a person, who lacked capacity, of their liberty, without the specific authorisation of a supervisory body - a DoLS. A DoLS is a detailed best interest assessment, undertaken by a specially trained and qualified professional.

DoLS are most likely to apply to people within hospital or nursing/care homes and it is unlikely that the ambulance crew will have any direct involvement, unless a person subject to a DoLS is transferred from one establishment to another. In such cases, staff should ensure that they adhere to the DoLS, and satisfy themselves that any action taken by them complies with it. A written copy of the DoLS should be kept with the person records. A Datix & SPOC referral should be raised if there is no DoLs within a care home where a patient clearly lacks capacity or the DoLs is out of date.

10. Wilful Neglect or ill treatment of a person who lacks capacity (Chapter 14 of the Code of Practice)

The MCA created an offence of ill-treatment or wilful neglect by any person who has the care of another person, who lacks or is reasonably believed, to lack capacity. This also applies to any person with Lasting Powers of Attorney or Court of Protection under the MCA. The offence is now included in the new Criminal Justice and Court Act 2015.

The Code of Practice states that the offence of ill-treatment and wilful neglect are separate.

Ill treatment - involves deliberate acts or recklessness whether the behaviour was likely to cause, or actually caused, harm or damage to the person's health.

Wilful neglect - in general means that a person had deliberately failed to do something he or she knows as their duty.

In situations where ambulance staff have assessed a person as lacking capacity, they then must act in the persons best interest. For example, a person assessed as lacking capacity refuses to transfer to hospital for further investigation and treatment which the staff believe would be in the person's best interests. If the ambulance staff elect not to take the person to hospital even though such action is considered to be in the person's best interests, then the ambulance staff could be held liable to wilful neglect if any harm came to the incapacitated person as a result.

11. Other aspects of the Mental Capacity Act

The MCA introduced revisions for the following:

Court of Protection (chapter 8 of the Code of Practice)

The Court of Protection has been given new powers under the MCA and extended their role in cases relevant to protecting and safeguarding adults at risk of neglect or harm. The Court of Protection has the power to make declarations about a person's capacity and the lawfulness of any act done, or proposed to be done, in relation to the person. They also have the power to appoint deputies to act on behalf of the person (for health and welfare and/or property and affairs) or make decisions (orders) about the best interest for the person.

12. Sharing information

People making decisions on behalf of people who lack capacity will often need to share personal information about the person lacking capacity. This information is required to ensure that decision makers are acting in the best interests of the person lacking capacity.

When releasing information, the following questions must be considered:

- Is the person asking for the information acting on behalf of the person who lacks capacity?
- Is disclosure in the best interests of the person who lacks capacity?
- What kind of information is being requested?

Access to personal information must be in accordance with the law. For example, the NHS Code of Practice on Confidentiality provides the following guidance:

"Where the person is incapacitated and unable to consent, information should only be disclosed in the person's best interests, and then only as much information as is needed to support their care."

Disclosure of, and access to, information is regulated by:

- the Data Protection Act 2018
- General Data Protection Regulation (GDPR) 2018
- the common law duty of confidentiality
- professional codes of conduct
- the Human Rights Act 1998.

Attorneys with a Lasting Power of Attorney (LPA) are entitled to as much information as if they were the person lacking capacity. Court of Protection Deputies may have access to a person's records if the Court gives them that power. Independent Mental Capacity Advocates (IMCA's) have a right of access to the part of a person's record relevant to the decision in question.

Appendix A

East of England Ambulance Service NHS
NHS Trust

Capacity to Consent Form

Date ☐☐/☐☐/☐☐☐☐ Time ☐☐:☐☐ CAD number ☐☐☐☐

Patient Name

Age ☐☐☐ NHS Number ☐☐☐/☐☐☐/☐☐☐☐

Address

All Trust staff must undertake a capacity assessment if the patient refuses reasonable treatment and/or transport to an acute unit.

The MCA dictates that all people over the age of 16 must be assumed to have capacity unless their decision making/behaviour is felt to be questionable. The following 2 stage assessment must be undertaken, both aspects must be covered by law to complete a full capacity assessment.

Stage 1
Does the person have an impairment of brain or brain function?

Is the person orientated to time, place and person?

Stage 2
The impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made meaning they cannot:

- understand information about the decision to be made
- retain that information
- weigh that information as part of a decision making process; or
- communicate that decision

Ensure the person is clear of all the details relevant to the decision you want them to make.
Outline your conversation below:

If the patient demonstrates a capacity to understand, retain, weigh up and communicate their decision making then by law they have capacity.
Even if the decision is not one you agree with

If the patient cannot understand, retain, weigh up, and communicate their decision making, (this can be done in writing), then they have no capacity

You MUST remove them to the hospital for treatment, record the means of the removal below and also log who helped you to undertake the removal of the patient

Clinician Signature_____ Print Name_____

Top copy return to Medical Records - 2nd copy as required

Appendix B

Guidance for Staff Assessing Capacity

When should you complete a form?

A form must be completed for the following patient groups: Patients who have **refused** recommended treatment/conveyance and you doubt a person's ability to make that decision at the time, Patients who have had to be restrained by ambulance staff for their own safety (in their best interests) and other patients who lack capacity at the time of recommended assessment/treatment.

After completing a form, the top copy should be submitted to Medical Records as part of the patient care record. The second copy can be used for onward referral, left with the patient or returned to Medical records as appropriate.

Step 1: Clinical Presentation

Is the patient suffering from an impairment or disturbance in the functioning of the mind or brain? This may include: Conditions associated with some forms of mental illness; Dementia, significant learning disabilities, the long-term effects of brain damage, physical or medical conditions that cause confusion, drowsiness or loss of consciousness, Delirium, confusion following a head injury, symptoms of alcohol or drug abuse

Then check:

Q1. Is the person orientated for time, place and person?

Q2. Is the patient able to identify or locate familiar objects? Example – location of medicines in the home, identification of a personal item such as wallet, purse, keys

Q3. Is the patient able to follow simple commands? Example – lifting arm to allow BP to be taken, standing or sitting when asked (if appropriate)

Step 2: Cognitive functioning

Q4. Does the patient have a general understanding of what decision they need to make and why they need to make it?

Example - does the patient recognise their current health situation and what actions are required to provide further assessment or treatment?

Q5. Does the patient understand the consequences of making, or not making, the decision, or of deciding one way or another?

Example – can the patient state what will happen if they elect not to follow recommended course of action?

Q6. Is the patient able to understand and weigh up the importance of the information relevant to the decision?

Example – can the patient state what factors they are taking into account when making the decision?

Q7. Is the patient able to retain the information as part of the decision-making process? **Example** – can the patient demonstrate recall of what has been discussed?

Q8. Can the patient communicate their decision, using any means available to them?

Appendix C

Use of restraint (EEAST Capacity to Consent Policy) or (EEAST Safer Holding (in the clinical environment) Policy).

EEAST has a policy of **no restraint** being used when attending to patients except in 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 patient who lacks capacity but then **ONLY** that which is proportionate and reasonable may be used.

Under the Mental Capacity Act, a person is defined as using restraint if they:

Use force – or threaten to use force – to make someone do something that they are resisting, or

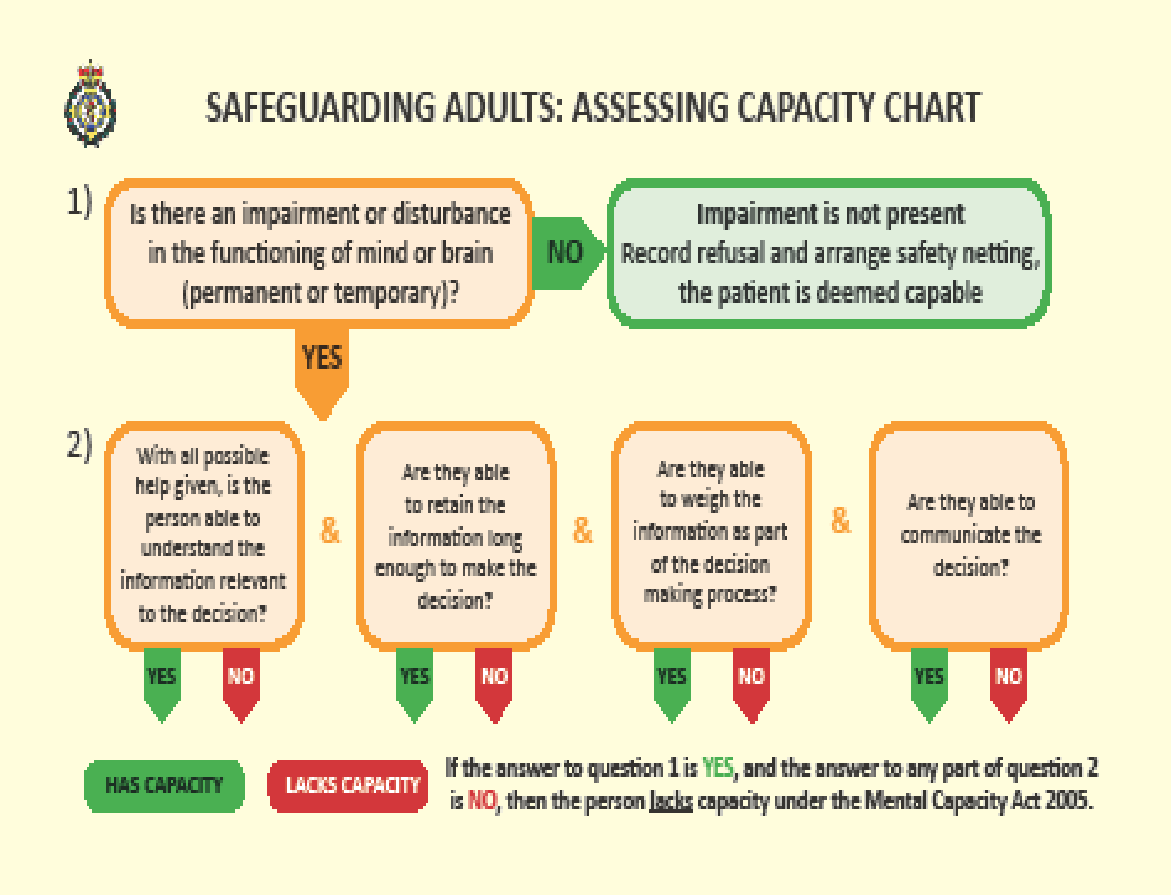
Restrict a person's freedom of movement, whether they are resisting or not.

Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two recommendations are met:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person, who lacks capacity,
- and the amount or type of restraint used and the amount of time it takes must be a proportionate response to the likelihood and seriousness of harm.

In addition, Common Law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent has challenging behaviours, or is in the acute stages of an illness causing them to act in a way that may cause harm to others, staff may under

Common Law, take appropriate and necessary action to restrain or remove the person in order to prevent harm both to the person concerned and anyone else. Acts under Common Law would not provide sufficient grounds to deprive someone of their liberty. It should always be the less restrictive method and last only as long as necessary.



Appendix D Equality Impact Assessment

EIA Cover Sheet	
Name of process/policy	**Capacity to Consent Policy**
Is the process new or existing? If existing, state policy reference number	**POL018**
Person responsible for process/policy	**Safeguarding Adults Specialists**
Directorate and department/section	**Clinical Quality, Safeguarding**
Name of assessment lead or EIA assessment team members	**Safeguarding team**
Has consultation taken place? **Was consultation internal or external? (please state below):**	**The policy has been previously ratified by external critical friends from the CCG.** **CQSG acting Chair has taken chairs action to forward to MAG for an extension due to the upcoming legislative changes due in the next 12 months that are indicated in the MCA (Amendment) bill and associated MCA and LPs Codes of Practice due in Summer 2020.**
Internal	**Safeguarding Group**
.	**CRG**

The assessment is being made on: **Please tick whether the area being assessed is new or existing.**	

Guidelines	
Written policy involving staff and patients	√
Strategy	
Changes in practice	
Department changes	
Project plan	
Action plan	
Other (please state)	

Equality Analysis

What is the aim of the policy/procedure/practice/event?

This policy outlines the Trust duties around the Mental Capacity Act and how it inter-relates to the new trust policy when safer holding or restrictive practices (these terms will be used interchangeably within this policy) as an intervention may be carried out in order to maintain the balance between independence and safety.

It also outlines the procedure to follow when considering the use of safer holding/ restrictive practice for patients receiving care and treatment and the procedure for raising concerns regarding possible abuse of restraint.

As the changes to the MCA (Amendment) Bill are not truly to be enforced until the Summer of 2020, an extension of the current policy has been requested with minor changes until September 2020 and an opportunity was taken to update the EQIA that was last completed in 2017.

East of England Ambulance Service Trust is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is always being followed and the safety of everyone is paramount.

Who does the policy/procedure/practice/event impact on?

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Who is responsible for monitoring the policy/procedure/practice/event?

Safeguarding Lead and nominated specialist team

What information is currently available on the impact of this policy/procedure/practice/event?

The requirement of this policy is to support the ongoing conflict resolution and managing challenging behaviour training programme procured through MAYBO on behalf of the Trust.

Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event?

No, this has been through several forums internally and externally to ensure it is fit for purpose.

Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics?

No

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics?

No

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

Appendix E Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Any changes in Legislation which may have an impact on the requirements of capacity to consent & Mental Capacity which may have an impact on patients	Safeguarding Lead and Safeguarding Adult Specialist, Bi-monthly Safeguarding Meeting. ACL who has Mental Capacity in their portfolio	Reviews on cases which have an impact on the Act.	The Policy will be monitored yearly.	Changes in Legislation or recommendation's from Learnings	Bi-monthly Safeguarding Meeting. This will be reflected in the minutes taken at the meeting.	This will be led by EEAST safeguarding Lead and monitored through the bi-monthly safeguarding meeting	There are a number of ways this can be implemented. This will be led through the Safeguarding Lead, this can be disseminated through policy, training, clinical app, comms bulletins, mandatory updates

Depravation of Liberty Safeguards	Safeguarding Lead and Safeguarding Adult Specialist, Bi-monthly Safeguarding Meeting. ACL who has Mental Capacity in their portfolio	Reviews on cases which have an impact on the Act.	The Policy will be monitored yearly.	Changes in Legislation or recommendation's from Learnings	Bi-monthly Safeguarding Meeting. This will be reflected in the minutes taken at the meeting.	This will be led by EEAST safeguarding Lead and monitored through the bi-monthly safeguarding meeting	There are a number of ways this can be implemented. This will be led through the Safeguarding Lead, this can be disseminated through policy, training, clinical app, comms bulletins, mandatory updates
Safer Holding (use of restraint)	Safeguarding Lead and Safeguarding Adult Specialist, Bi-monthly	Any adverse incidents reported on Datix, any legislation	The Policy will be monitored yearly.	Changes in Legislation or recommendation's from Learnings	Bi-monthly Safeguarding Meeting. This will be reflected in the minutes	This will be led by EEAST safeguarding Lead and monitored through the bi-monthly	There are a number of ways this can be implemented. This will be led through

	Safeguarding Meeting. ACL who has Mental Capacity in their portfolio	reviews or changes to the way EEAST operate within the scope of safer holding			taken at the meeting.	safeguarding meeting	the Safeguarding Lead, this can be disseminated through policy, training, clinical app, comms bulletins, mandatory updates