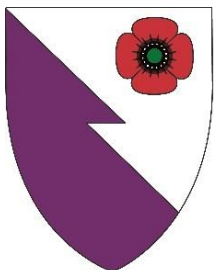


The Royal College of Emergency Medicine

Best Practice Guideline

**The Mental
Capacity Act in
Emergency
Medicine
Practice**



February 2017

Summary of recommendations

- All Emergency Department (ED) doctors should understand the Mental Capacity Act (MCA) and be trained to be comfortable assessing a patient's capacity.
- ED nurses should be trained to make a brief assessment of a patient's capacity to decide to leave the ED as part of their initial assessment of a patient.
- Difficult decisions about a patient's capacity should be shared with a senior doctor.
- If a patient is prevented from leaving the ED because they do not have the capacity to decide to leave, the means used to keep them must be proportionate to the risk to the patient.
- If a patient has a mental health problem that is diminishing their capacity, then they should be assessed under the Mental Health Act (MHA). In these circumstances, the MHA is more appropriate than the MCA.
- Common law powers can be used in areas not covered by MHA or MCA or when there is no opportunity to form a judgement about patient's mental capacity or mental state in situations where urgent intervention is needed to avert serious consequences. This power is short and lasts only until crisis subsides.

Scope

The application of the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DOLS) to Emergency Medicine, and the interplay between the Mental Health Act (MHA), MCA, and Common Law.

Reason for development

A review of the MCA by a House of Lords committee in 2014 reported widespread lack of understanding among professionals of the principles and applications of the MCA and DOLS. The application of the principles of the MCA is now a focus for Care Quality Commission (CQC) inspections, in order to identify hospitals that need to improve their care in this respect.

This guideline aims to improve understanding and promote good care of patients who lack capacity.

Introduction to the Mental Capacity Act 2005

A sound understanding and application of the Mental Capacity Act (MCA) ⁽¹⁾, the Deprivation of Liberty Safeguards (DoLS), common law, and professional responsibilities relating to consent, is essential for ED clinicians. We have a legal responsibility to fulfil, and our role is to safeguard our patients' rights under the European Convention on Human Rights (ECHR).

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations and enables people to plan ahead for a time when they may lose capacity.

The Act is intended to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions.

When might the principles of the MCA apply in the Emergency Department?

- Patients who refuse treatment.
- Patients who abscond.
- Patients suffering from long term conditions that impair their ability to make decisions such as dementia.
- Patients suffering from temporary lack of capacity due to intoxication, delirium, or reduced level of consciousness.
- Some patients at end of life.
- Patients whose mental health condition impairs their ability to make decisions

What situations are not covered by the MCA?

- The Act does not generally apply to children under 16. Decisions about competence to make a decision in an under 16-year-old are covered by the Children's Act 1989. It does apply to young people aged 16 and 17, exceptions to this are that only people aged 18 or over can make an advanced decision to refuse treatment or appoint a lasting power of attorney.
- Mental Health Act matters are excluded (see cases 2, 3 & 4 below)

What are the key principles of the MCA?

1. **A presumption of capacity** - Every adult (aged 16 or over) has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. **The right for individuals to be supported to make their own decisions** - A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. **The right to make what might be seen as eccentric or unwise decisions**- A person is not to be treated as unable to make a decision merely because he makes an unwise decision. It is important to acknowledge the difference between unwise decisions, which a person has the right to make and decisions based on a lack of understanding of risks or inability to weigh up the information about a decision.
4. **Best interests** – A decision made, under this Act on behalf of a person who lacks capacity must be made, in their best interests.
5. **Less restrictive intervention** -Before the act is done, or the decision is made, it should be considered if the outcome is less restrictive of the person's rights and future freedom of action.

When we assess a patient's capacity, we make an assessment based on the patient's ability to make a specific decision at a specific time. Capacity to make this decision may fluctuate, and a patient may be able to make that decision e.g. to consent to examination, but not to be able to make other decisions e.g. to decide to leave the ED.

How to use this guideline

The principles above and application of various aspects of the Act and relationship to the MHA and common law will be explained using a series of cases. Appendix 2 contains a flowchart summary of the legal powers to detain/restrain in the Emergency Department.

CASE 1

You are asked to see a 24 year old female who has taken an overdose of 8 ibuprofen 2 hours before attending the ED. The triage nurse has noted the timing of the overdose and that the patient was cooperative and happy to wait to see a doctor. When you call the patient's name, there is no reply and it appears she has left before being seen.

A. How would you manage this situation?

The Presumption of Capacity

The Mental Capacity Act's starting point is that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make decision at the time the decision needs to be made.

A. There are no grounds for bringing this patient back by force as there is no reason to believe she lacks capacity due to her mental state or from what she has taken. However, it would be prudent to review her notes looking for previous mental health issues or domestic violence. It is recommended that attempts are made to contact the patient by phone and to consider contacting the patient's GP.

If it was felt that this patient did **not** have the capacity to decide to leave, for example because the triage nurse thought she was intoxicated or very distressed, then a local search should be initiated. At times ED staff may have to make a capacity decision based on what little information they know and act accordingly. If found, she could be brought back using persuasion or if this fails, using means that are proportionate to the situation. When she returns, a full assessment of her capacity to decide to leave and her risks should be carried out. If she is not found, it is recommended the police are called and asked to do a welfare check.

Patients presenting with mental health problems should have a Mental Health Triage on arrival. Nursing Staff should be trained to triage patients with mental health problems and to make an initial assessment of the capacity of a patient who may decide to leave.

Wherever restraint or force is used for a patient who does not have capacity to decide to leave or refuse treatment:

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

Guidance on managing the patient who has absconded can be [here](#), and includes a mental health triage tool.

CASE 2

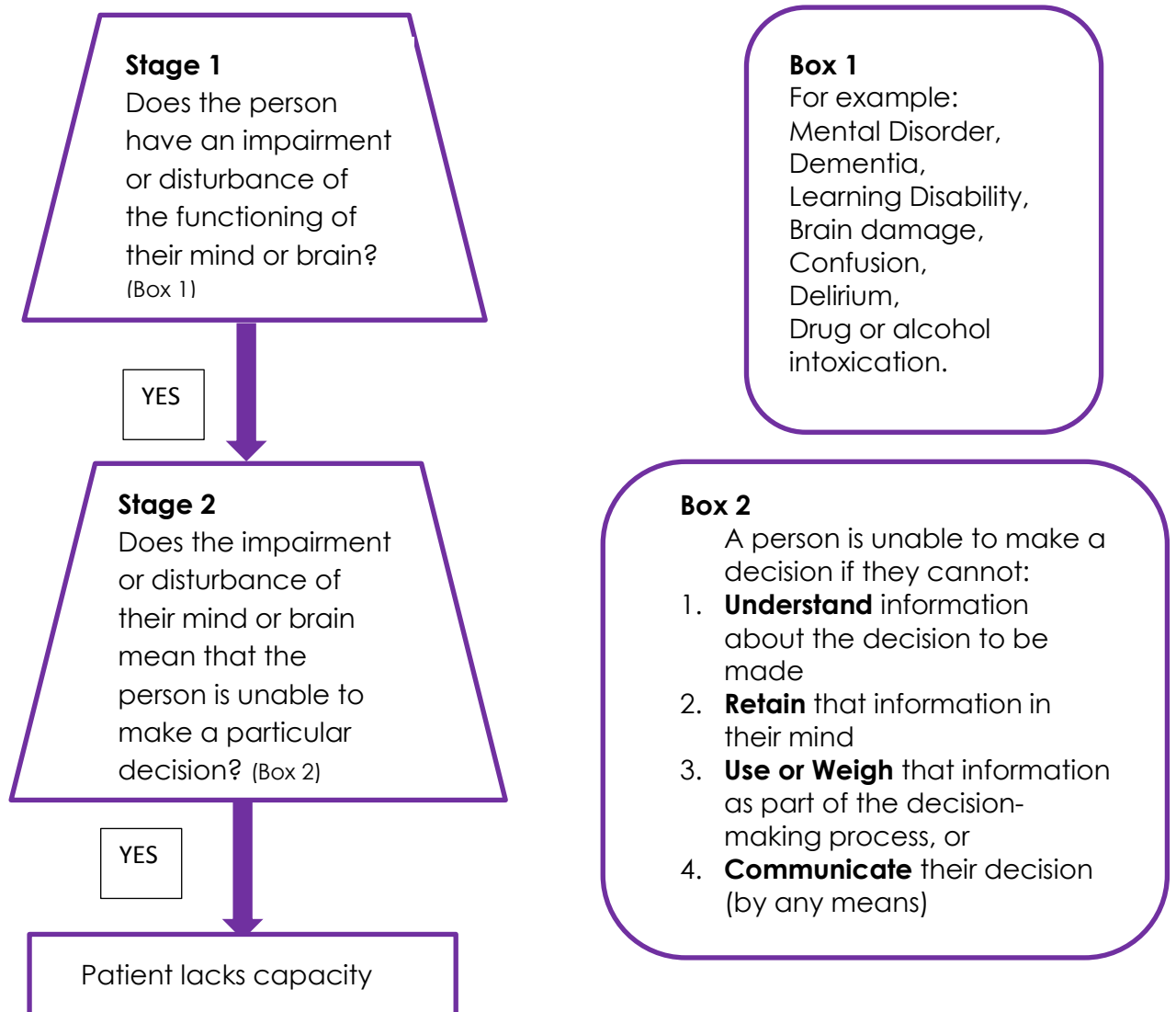
A 27 year old lady with a known diagnosis of bipolar disorder is brought to the ED by friends concerned about her erratic behaviour over the last few weeks (playing loud music in the early hours of the morning, giving away significant amounts of money to strangers, not sleeping). The ED nurse has seen the patient and is concerned that she is highly distractible, speaking very loudly and quickly but currently cooperative with the help of her friends; however, she has had to be placed in a quiet room because she was disturbing everyone else in the waiting room and asking why they were there and could she help them.

- A. How would you assess if she had capacity to decide to leave?
- B. How should a capacity assessment be documented?
- C. If she attempted to abscond, on what grounds could you keep her?
- D. If the patient needed urgent treatment for her bipolar disease and she refused treatment, on what grounds could she be treated?

- A. Talk to her and determine if she can understand why she should stay in hospital and what her risks are of leaving before she is assessed and treated. Assess her understanding and retention of information. Decide if you think she can weigh her options and communicate her decision to you clearly. She almost certainly does not have capacity to decide to leave.

A clinician should not assume that a person lacks capacity simply because they have a particular diagnosis or condition. You should be sure that the diagnosed illness or condition affects their ability to make a decision when it needs to be made. The more serious the decision, the more formal the assessment of capacity is likely to be, and, where appropriate, referral to a psychiatrist for a second opinion may be needed.

How to assess capacity using the two stage capacity test:



- B. Record in the notes the specific decision for which capacity was assessed, how capacity was assessed, why you think the patient lacks capacity. This should also include the nature of the impairment, what steps were taken to promote ability to make decision. An assessment of capacity is often worded "I believe looking at the balance of probabilities that *this person has / lacks* capacity to make this decision because..." Record what the outcome of the decision is (e.g. the patient may need continuous observation).

Grounds for detaining a patient for assessment or treatment in the ED or ward (See appendix 2).

- C. This patient does not have the capacity to decide to leave the ED as she is not able to understand that she is unwell and unable to weigh the consequences of not being assessed and treated for her condition. Her lack of capacity is due to her mental health. She can be stopped from leaving under the MCA, but will need a mental health act assessment if she is to be detained for any length of time.

If she were on a ward as an inpatient trying to leave, then she could be detained using a section 5.2 of the MHA. This allows general hospital staff to keep her for up to 72 hours to enable a full Mental Health Act assessment to be done.

In either case she could be prevented from leaving using means that are proportionate to the situation.

Grounds for detaining a patient for treatment in the ED.

- D. For this patient to be treated without her consent for her mental health condition, she would need to be under a section of the Mental Health Act, the MCA is not sufficient to allow long term psychiatric treatment to be commenced. The patient has to be assessed by two registered medical practitioners one of whom is section 12 approved and an AMHP (approved mental health professional). A section 2 of the MHA is most commonly applied in the ED, which is primarily for assessment but also for commencing treatment. Treatment for mental disorder can be given in this circumstance under MCA if it is possible to give the treatment needed without carrying out an action that might deprive them of their liberty (see sections 13. 26 to 13.33 of the MCA Code of practice 2014).⁽²⁾

Emergency medical treatment e.g. sedatives can be given to a patient who has a mental disorder who is deemed not to have capacity. This treatment should be in their best interests i.e. the option that is least restrictive of their freedom and future choices and can be performed before or after formal 'sectioning'.

CASE 3

An 18 year old man has been found wandering semi-naked on a busy road having tried to cut his arm. The police have brought him to the ED because they are concerned about his wound and his welfare. He is clearly highly agitated and the triage nurse has requested that a doctor assess him immediately. He is generally uncooperative and inattentive and he has not allowed the nurse to obtain any baseline observations and is not responding to direct questioning. A quick search of the ED computer system has shown that he has a past history of schizophrenia and a few attendances related to drug ingestion.

- A. What would you ask the police officers?
- B. When can the police officers leave?
- C. If he tries to leave, on what grounds can you restrain him?
- D. In terms of the restraint, what options are open to you?
- E. What if a patient like this had tried to leave saying he planned to hurt someone?
- F. What if a patient like this had tried to leave before you had a chance to assess his capacity or mental state?

Use of section 136 in the ED.

- A. Ask the police if they have brought the patient to the ED under a section 136. It is important to understand the nature of the police presence – are they merely escorting the patient, have they arrested the patient or have they used their s136 powers? The proper use of a section 136 is to remove a patient with a suspected mental health disorder from a public place to a place where they can be assessed under the mental health act. An ED is usually not defined as a place of safety but a patient will need to come to the ED if they have physical health problems such as overdose, self-harm or severe intoxication. It is also important to ascertain whether the patient has been formally searched by the police to ensure staff safety. There is RCEM guidance on the care of patients in custody, see [here](#).
- B. The police should stay with the patient until a risk assessment has taken place. Technically this should be until a formal mental health act assessment has taken place if the patient was brought under section 136. The patient requires a full Mental Health Assessment as a result of being on a section 136. If not on a section 136, then senior ED staff should do a brief risk assessment with the police and discuss the need for police presence. Local agreements may exist regarding the continued presence of the police; these should be designed with ensuring the safety of the patient.

- C. If the patient is under a section 136 and decides to leave, he may be restrained and prevented from leaving under these grounds, by police or security staff trained to restrain. He cannot be treated under a section 136. If he is not under a 136 for some reason, then a capacity assessment, in this case, is likely to conclude he does not have capacity, so he could be restrained under MCA. He may have an 'excited delirium' or Acute Behavioural Disturbance (see RCEM guidance [here](#)), these patients may well have additional significant medical requirements.
- D. Options include physical and chemical restraint (rapid tranquilisation). It is recommended that departments have a well-rehearsed protocol for administering rapid tranquilisation.

Use of Force

Wherever restraint or force is used for a patient who does not have capacity to decide to leave or refuse treatment:

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

Use of common law in the ED (see appendix 1)

- E. If a patient presents to the ED and then immediately tries to leave the department saying they plan to hurt someone, and it was unsafe or impractical to assess capacity or mental state, then they can be restrained under common law. Common law allows anyone to take reasonable and proportionate action to prevent immediate significant harm to others. This applies whether or not he has capacity ⁽⁶⁾ (see R {on the application of Munjaz} v Mersey Care NHS Trust [2003] EWCA CIV 1036).
If a patient leaves the ED brandishing a weapon and is obviously intending to cause significant harm to themselves, then again common law can be used to prevent them causing significant harm.
- F. This patient's behaviour suggests that he lacks capacity and staff should act in his best interests, to keep him safe by preventing him from leaving using restraint if necessary. If he has already absconded, then every effort should be made to have him brought back to the department for a formal assessment.

CASE 4

A 60 year old man is brought in by relatives after taking a beta blocker OD. His mood seems flat, but he appears to be able to understand and retain information. He refuses treatment. He understands what may happen to him and the consequences of this. He calmly says he wants to go to be with his wife who died a year ago.

- A. Do you think this man has capacity to decide to refuse treatment?
- B. On what grounds could you treat him for the OD?

How do the MCA and MHA interact?

- A. This patient may initially seem to have the capacity to decide to refuse treatment, in that he is able to understand the consequences, retain the information, weigh the decision, and communicate his wish. These decisions are difficult and should be shared with a senior colleague. A capacity decision is at best an opinion and may vary amongst individuals.

The requirement in the MCA that a patient must be able to use or weigh information to make a decision is not easy to assess as illustrated by the case of JB Vs Heart of England NHS Foundation Trust ⁽⁵⁾. This subjective element in capacity assessment makes it possible for clinicians to conclude that patients lack capacity.

Inability to weigh in the balance could be due to a seriously distorted perception of reality, in other words, they may base much of their reasoning on false premises and the rationale given is so extraordinary that no "reasonable man" would hold that view. For example, severe phobia can dominate one's thinking and make them unable to consider anything else. Other examples are:

- Profound grief
- Severe depression
- Severe delusional state
- Undue (external) influence
- Illusion
- Hallucination
- Lack of ability to appreciate in a deeper or sufficient extent

In this scenario, the patients' strong desire to join his wife may be dominating his mind, making him unable to consider anything else. The clinician would be justified in questioning in greater detail, the patient's capacity to make a valid refusal in order to eliminate the possibility that capacity may be impaired as a result of his depressive illness. A specialist psychiatric opinion may be required. If there is doubt and a decision cannot be deferred due to

the necessity of administering treatment within a specific timeframe, it is better to take action to preserve life.

There is evidence from case law ⁽⁵⁾ that chronic schizophrenia can impact on decision making and other cognitive functions. One might be able to understand, retain and communicate but their ability to weigh in the balance might be compromised. Additionally, some psychiatrists assert that in cases of presumed lethality, treatment refusal by a patient with personality disorder may represent a manifestation of (their) tendency to adopt a contrary and self-destructive stance in response to clinical advice.

In summary, if he is significantly depressed, you may conclude that he cannot weigh the information given to him about his risks. It may also be that the overwhelming desire to "join his wife" dominates his thinking so much that it distorts his perception of reality, also affecting his ability to weigh the decision.

In reality capacity decisions in cases such as these are difficult and clinicians may come to different conclusions. When making a capacity decision, it is one "on the balance of probabilities" not one which is "beyond all reasonable doubt."

- B. Whilst a patient can be treated under MCA for the overdose, it would be preferable for this patient, if he seems depressed, to have a MHA assessment which may allow him to be treated for the overdose, if the overdose is felt to be the consequence of a mental disorder.

The MCA applies to people subject to the MHA in the same way as it applies to anyone else, for example if a patient under a section of the MHA refuses treatment for a physical illness, the clinician should assess the capacity of a patient to make this decision.

However for a mental health issue, the MHA takes precedence over the MCA. E.g.

1. If someone is detained under the MHA, decision-makers cannot use the MCA to give treatment for their mental disorder or make decisions about treatments on that person's behalf (MCA COP 13.27) ⁽²⁾.
2. If somebody can be treated for their mental disorder without their consent because they are detained under the MHA, healthcare staff can treat them even if it goes against an advance decision to refuse that treatment under the MCA.

The MHA (section 63) can be used to treat physical disorders where they are believed to contribute towards or be symptomatic of a mental health problem, for example an overdose or if a patient stops their treatment for a physical disorder as a form of self-harm.

CASE 5

79 year old lady has been sent into the ED by her nursing home following a fall and an obvious head wound (parietal scalp laceration). She is known to have vascular dementia and is on warfarin for atrial fibrillation. She has no family. She is currently confused and uncooperative and does not look like she will lie still for a CT head scan. She is GCS 13, E4V4M5.

The junior doctor managing the case, who has just finished a 4 months' care of the elderly job, wants know if it is alright for him to contact an Independent Mental Capacity Advocate (IMCA) and start completing the Deprivation of Liberty Safeguards (DoLS) paperwork prior to her sedation for the CT head scan.

- A. What is an IMCA, do you need one for this patient and in what situations might you consider involving one?
- B. How do you determine this patient's best interests? How would you manage her?
- C. What is DoLS and in what circumstances is it applicable to the emergency department setting? Is it relevant here?

Use of an Independent Mental Capacity Advocate

Independent Mental Capacity Advocate

- A. IMCAs do not necessarily need to be involved in the decisions regarding emergency treatment; the expectation is that the clinicians will act in the patient's best interests, so an IMCA is not needed here.

Independent Mental Capacity Advocates (IMCAs) are instructed by local authorities or NHS organisations to help particularly vulnerable people who lack the capacity to make important decisions and who have no family or friends to consult. An IMCA may be needed in this case for on-going clinical decisions after the emergency diagnosis and treatment stage is over.

IMCAs will work with and support people who lack capacity, and represent their views to those who are working out their best interests. In adult protection cases, an IMCA may be appointed even where family members, friends or others are available to be consulted.

How should a best interest decision be made?

- B. Most clinicians would choose to do a CT head at least to establish if there is a bleed, and then they would make a best interest decision about reversing warfarin and ongoing care, whether that should be in hospital or at home. In this patient's case the clinician will have to determine what the patient might have wanted by talking to family and staff at her home.

In general:

- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision.
- The person's past and present wishes and feelings, beliefs and values should be taken into account.
- Assess whether the person may regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?
- Consult others if it is practical and appropriate to do so, for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values.
- Avoid discrimination- do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.

The hierarchy of decision makers is:

1. Welfare LPA or court appointed deputy if no valid and applicable advanced decision and decision is not urgent
2. Healthcare staff in charge of care, using the best interests' principles, if LPA not available and/or situation is urgent.

Exceptions to the best interest's principle:

- Where someone has previously made an advance decision to refuse specific medical treatment while they had capacity.
- The enrolment of incapacitated adults in certain forms of research.

What is DoLS and when does it apply in the ED?

Deprivation of Liberty Safeguards (DoLS) is the framework of safeguards under the Mental Capacity Act 2005 (MCA), for people who need to be deprived of their liberty in their best interests for care or treatment for which they lack the capacity to consent.

A DoLS authorisation does not in itself authorise care or treatment, only the deprivation of liberty that results from the implementation of the proposed care plan. Any necessary care or treatment should be provided in accordance with the MCA.

There is a deprivation of liberty in circumstances where a person:

- is under continuous control and supervision,
- is not free to leave and lacks capacity to consent to these arrangements.

The MCA DoLS applies to anyone aged 18 and over, who has a mental disorder and lacks capacity to consent to the arrangements made for their care or treatment in either a hospital or a care home (registered under the Care Standards Act 2000). A deprivation of liberty is felt to be necessary in their best interests to protect them from harm and detention under the Mental Health Act 1983 is not appropriate at that time.

C. MCA DoLS generally applies to admitted patients within the hospital in the non-emergency setting therefore it is unlikely to be applicable in the ED. It could in certain circumstances be applicable in a Clinical Decisions Unit or Observation Ward. In ED, patients are restrained and treated under the MCA. It is likely that the provision of life sustaining treatment to an incapacitated patient in a true emergency will not be considered a deprivation of liberty. As the patient transitions from emergency to ongoing care the risk of deprivation increases. The DoL Safeguards Code of Practice (section 6.4) ⁽⁷⁾ states that an urgent deprivation of liberty authorisation should not be granted if a person is in an ED and "it is anticipated that within a matter of a few hours or a few days the person will not be in that environment". For further discussion see the documents produced by the Law Society. ⁽⁸⁾

CASE 6

A 73 year old resident of a nursing home is brought into the ED peri-arrest. She has been unwell for some time with heart failure. The paramedics have brought in an unsigned and unwitnessed DNACPR form which the patient was going to discuss with their GP at the end of the week. The accompanying relatives know nothing about the DNACPR form, it hasn't been discussed with them and they feel that their relative would want "everything possible" to be done to save her life.

- A. What is an Advanced Decision / Direction?
- B. Does the form which the paramedics present represent a valid advanced direction? What weight would you place on it?
- C. What weight would you place on the relative's wishes when making the decision whether or not to stop CPR? How would this situation alter if one of the relatives was able to provide evidence that they have Lasting Power of Attorney?
- D. How would you make the decision whether the patient should be for cardiopulmonary resuscitation?

What is an Advanced Decision and when is it valid?

An Advanced Decision

- A. An advance decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment when they may have lost the capacity to consent to or refuse that treatment. People can only make advance decisions to refuse treatment. Nobody has the legal right to demand specific treatment or insist on being given treatments that healthcare professionals consider to be clinically unnecessary, futile or inappropriate.

An advance decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity. Healthcare professionals must follow a valid and applicable advance decision, even if they think it goes against a person's best interests.

For an advanced decision to refuse life sustaining treatment to be valid:

- Patient has to be 18 or over and have capacity when the decision is made.
- The decision should be in writing, signed and witnessed.
- It should include a statement that advance decision is to apply "even if the person's life is at risk."
- The person has not, since the advance decision was made appointed a welfare attorney to make decisions on their behalf.
- The person has not done anything clearly inconsistent with its terms.
- The circumstances that have arisen match those envisaged in the advance decision.

- B. For an advanced directive to refuse life sustaining treatment to be valid; it must be in writing, be signed and clearly witnessed and state clearly that the decision applies even if life is at risk.

Without knowing exactly the circumstances (from an impartial witness) that the unsigned form brought in by the paramedics arose from it is difficult to attribute any weight to the document. It could be treated as an “Advanced Statement,” which is not legally binding but should be considered by the healthcare professional when working out the person’s best interests. The document seems to be at odds with what the relatives understood about this patient’s wishes.

When can a relative make decision on behalf of a patient who lacks capacity?

- C. A relative has no legal power to make decisions on behalf of a person unless they have been appointed as a Lasting Power of Attorney (LPA) by the person under the MCA. The relatives can only give an opinion as to what they think the person would have wanted.

Lasting Power of Attorney

If a relative has been appointed as LPA, they can only act if the patient lacks capacity to make that particular decision and with certain safeguards.

An LPA can only be appointed by a person over 18, who has the capacity to decide to do so. An LPA must always follow the Act’s principles and make decisions in the patient’s best interests. An LPA must be registered with the Office of the Public Guardian (OPG).

There are two sorts of LPA, some are appointed for property and affairs, the other for health and welfare decisions. An LPA has no power to consent to or refuse life-sustaining treatment, unless the LPA document expressly authorises this.

An LPA cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983. The Court of Protection has the power to remove an LPA if they do not appear to act in the best interests of the patient.

- D. The decision to resuscitate or not is primarily a clinical one based on the best interests of the patient and likely prognosis. Clinicians must however respect a valid advanced decision of the patient or of an LPA not to resuscitate. If CPR is ongoing, the decision to stop will be that of the clinical team based on the best interests of the patient and likely prognosis and should not be influenced by the relatives. A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the cardiorespiratory arrest that does not match the circumstances envisage when that decision was made and recorded, examples could include choking, displaced tracheal tube or a blocked tracheostomy tube.

See [RCEM end of life care guideline](#) and joint guidance issued by the [Resuscitation Council](#) for more detail.

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Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None declared.

Disclaimers

RCEM recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Audit standards

- Where an assessment of capacity has been performed it should be documented clearly in the notes. It should include the decision for which capacity is assessed. It should be documented how the decision was made and if capacity is lacking, what reason medical staff believe capacity is lacking.
- All ED nurses should have training in mental capacity and how to perform a brief assessment at triage.
- All ED clinicians should have training in how to assess capacity.

Key words for search

Mental Capacity Act. Best interests. Mental Health Act.

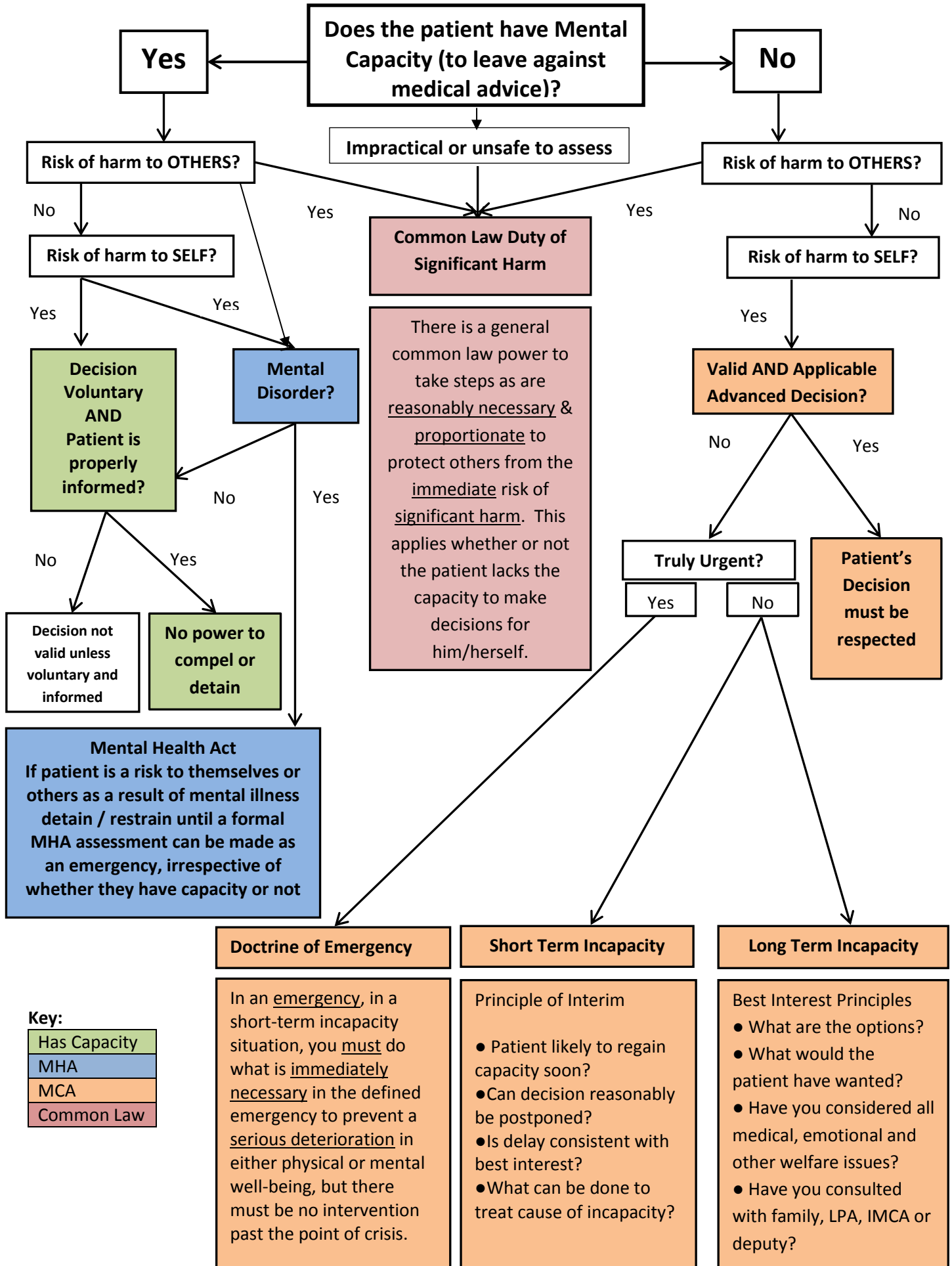
Appendix 1: Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Appendix 2: Summary of Legal Powers to Detain or Restrain in the Emergency Department

See following page.

Summary of Legal Powers to Detain or Restrain in the Emergency Department



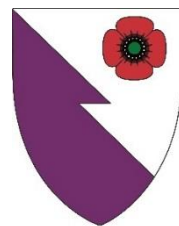
Key:

- Has Capacity
- MHA
- MCA
- Common Law

ULTIMATE DECISION MUST BE PROPORTIONATE

References

1. Mental Capacity Act 2005 <http://www.legislation.gov.uk/ukpga/2005/9/contents>
2. Mental Capacity Act 2005. Code of Practise 2007. The Stationary Office.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf
3. Making Decisions. A guide for people who work in health and social care.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/348440/OPG603-Health-care-workers-MCA-decisions.pdf
4. RCEM Guidelines on End of Life Care, The Absconded patient, Consent, and Restraint.
Available at:
http://www.rcem.ac.uk/RCEM/Quality_Policy/Clinical_Standards_Guidance/RCEM_Guidance/RCEM/Quality-Policy/Clinical_Standards_Guidance/RCEM_Guidance.aspx?hkey=862bd964-0363-4f7f-bdab-89e4a68c9de4
5. Heart of England NHS Foundation Trust v JB (2014) EWHC 342 (COP), (2014) MHLO 9
6. R {on the application of Munjaz} v Mersey Care NHS Trust [2003] EWCA CIV 1036
7. The Ministry of Justice. The Mental Capacity Act 2005: Deprivation of Liberty Safeguards. The Stationary Office; 2008. ISBN 9780011328155
8. The Law Society. Identifying Deprivation of Liberty: a practical guide. 2015. Available at
<http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/>



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