

CAPACITY, REFUSAL OF CARE, AND DEPARTURE BEFORE COMPLETION

Protocol 51: Supported Decision-making, Decision-specific Capacity Assessment, Informed Refusal, Emergency Treatment Without Consent, Self-directed Departure, Unplanned Departure, Elopement Response, and Follow-up of Outstanding Results

DRAFT FOR EMERGENCY MEDICINE, NURSING, MENTAL HEALTH, PAEDIATRICS, SOCIAL WORK, SAFEGUARDING, SECURITY, AMBULANCE / TRANSFER SERVICES, HEALTH INFORMATION, RISK MANAGEMENT, AND CLINICAL GOVERNANCE

STATUS: This is a draft clinical-governance document. It must be reconciled with current national law, mental-health legislation, child-protection law, hospital policy, professional standards, security procedures, documentation systems, and referral / follow-up capacity before approval.

AUTONOMY AND SAFETY RULE: A patient with decision-making capacity may refuse recommended care, including care needed to prevent serious disability or death. Disagreement, an unwise choice, intoxication, mental illness, disability, age, homelessness, or a wish to leave does not by itself prove incapacity. Capacity must be supported, assessed for the specific decision, and documented.

FORM RULE: A signature on an “against medical advice” form does not create capacity, prove understanding, or replace a respectful informed-refusal conversation. A patient who declines to sign must still receive appropriate care, harm-reduction measures, written information, follow-up, and an open invitation to return.

| Document control | Details |
|------------------------|--|
| Document owner | Emergency Department / Medical Services Directorate / Nursing Services / Clinical Governance / Legal and Risk Management |
| Clinical leads | Emergency Medicine; Nursing; Mental Health; Paediatrics; Social Work; Safeguarding; Security; Ambulance / Transfer Services; Health Information; Quality and Risk |
| Applies to | Adults, adolescents and children who refuse an investigation, treatment, admission or transfer; request to leave before care is complete; leave without informing staff; or are missing from the Emergency Department after registration or clinical contact. |
| Exclusions | Routine discharge agreed by the treating team; formal end-of-life decisions under Protocol 52; psychiatric detention procedures governed by local law; persons not yet registered or under the hospital duty-of-care process, except where staff become aware of an immediate emergency. |
| Interfaces | Protocols 1-8; Protocol 17 Altered Mental Status; Protocol 29 Poisoning / Intoxication; Protocol 32 Head Injury; Protocol 40 Paediatric Assessment; Protocol 42 Mental-Health Crisis; Protocol 43 Safeguarding; Protocol 48 Airway; Protocol 52 Palliative Emergencies. |
| Version / status | Draft 1.0 for local multidisciplinary and legal validation |
| Approval date / review | Approval: _____ Review: _____ Earlier review after serious harm, elopement, restraint event, complaint, legal change, or national guidance update. |
| Supersedes | New protocol / existing consent, self-discharge, missing-patient, mental-health and safeguarding procedures to be reconciled before approval. |

1. Purpose

To provide a humane, legally aware and operationally reliable pathway for supporting patient decisions; assessing decision-making capacity; responding to refusal of care; treating emergencies when valid consent cannot be obtained; reducing harm when a patient chooses to leave; managing unplanned departure or elopement; following up outstanding results; and learning from departures associated with preventable harm.

2. Core principles

- Presume that an awake patient can make the decision unless there is a reasonable basis to doubt capacity. Capacity is decision-specific, time-specific and may fluctuate.
- Support the patient before testing capacity: treat pain, hypoxia, hypoglycaemia and distress; provide an interpreter, hearing / visual aids, communication tools, quiet space, time, trusted support and information in an understandable form.
- The clinician must not equate compliance with capacity. A patient can make a risky or unconventional choice and still have capacity.
- Use shared decision-making and curiosity. Ask why the patient wishes to refuse or leave; address waiting time, fear, cost, family duties, stigma, withdrawal, transport, communication failures and prior negative experiences where possible.
- Use the least restrictive lawful response. Physical force, sedation, security or police involvement is never a substitute for clinical assessment and must not be used merely to prevent a capacitous adult from leaving.
- Do not abandon the patient. Offer accepted elements of care, symptom relief, prescriptions, safer alternatives, written advice, follow-up and a clear invitation to return without criticism.
- Protect privacy and disclose information only when authorized, required by law, or proportionate to prevent serious harm under the applicable legal framework.

3. Definitions and preferred terminology

| Term | Operational meaning |
|-----------------|---|
| Refusal of care | A patient declines a specific examination, investigation, treatment, admission, transfer or other proposed intervention while remaining engaged with staff. |

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| Term | Operational meaning |
|-----------------------------------|---|
| Informed refusal | A refusal made with decision-making capacity after reasonable support and discussion of the proposed care, material benefits and risks, alternatives, uncertainties and likely consequences of refusal. |
| Departure before completion (DBC) | Umbrella term for leaving before the planned emergency-care episode is complete. Use specific subcategories below for audit and response. |
| Left before clinical assessment | The patient departs after registration / triage but before an appropriate clinician completes the initial assessment. |
| Self-directed departure | The patient informs staff that they intend to leave or leave after an informed-refusal discussion. Legacy coding may use "self-discharge" or "against medical advice". |
| Unplanned departure | The patient leaves without completing the agreed process and without staff being aware at the time. |
| Elopement / absconding | A locally defined high-risk unplanned departure in which impaired capacity, detention status, vulnerability or imminent danger may justify an active search and external notification. Use only where the local definition and legal authority are clear. |
| Missing vulnerable patient | A child, dependent adult, patient with impaired capacity, high suicide risk, severe cognitive impairment, or other person whose unexplained absence creates a safeguarding or immediate-safety concern. |
| Capacity | The clinical-legal ability to make the specific decision at the relevant time. The exact statutory test and age rules must follow local law. |
| Competence | A term that may refer to a court or statutory determination. Do not use it as a casual synonym for a bedside capacity assessment unless local law does so. |

4. Immediate danger screen when refusal or departure is raised

| Red flag | Immediate action |
|---|--|
| Airway, breathing or circulatory instability; severe hypoxia; shock; active major haemorrhage | Move to resuscitation, call senior help and treat immediate threats. Assess consent / capacity in parallel; use emergency authority only to the extent necessary and lawful. |
| Hypoglycaemia, severe metabolic disturbance, delirium, coma, seizure, acute stroke or serious head injury | Correct reversible causes and reassess capacity. Do not accept a high-risk refusal without a documented decision-specific assessment. |
| Overdose, toxic exposure, severe intoxication or withdrawal | Assess time course, delayed toxicity, co-ingestants, suicidality and fluctuating capacity. Use Protocol 29 and mental-health / toxicology support. |
| Self-harm, suicidal intent, psychosis, severe mood disorder or threat to others | Use Protocol 42; assess capacity and suicide / violence risk separately; apply local mental-health law when criteria are met. |
| Child, unaccompanied minor, dependent adult, suspected abuse / trafficking or unsafe caregiver | Use Protocols 40 and 43; involve safeguarding / social work and senior staff immediately. Do not release to an unsafe person. |
| Pregnancy emergency, possible ectopic pregnancy, postpartum haemorrhage, neonatal concern | Activate obstetric / neonatal support; explain time-critical risks and arrange safe specialist review or transfer. |
| Abnormal vital signs or high-risk symptom before assessment: chest pain, dyspnoea, focal deficit, syncope, severe headache, fever / sepsis, GI bleeding | Prioritize immediate senior review. If the patient has already left, initiate the high-risk departure callback pathway. |
| IV cannula, central line, drains, oxygen, monitor, custody restraint or hazardous device still attached | Protect staff and patient safety; attempt immediate contact; involve senior nurse / security and external services only as proportionate and lawful. |

5. Supported decision-making before capacity assessment

| Barrier | Required support |
|---|--|
| Pain, breathlessness, nausea, thirst, withdrawal or prolonged waiting | Treat symptoms, meet basic needs, explain delays honestly and provide realistic next steps before concluding that refusal is fixed. |
| Language difference | Use a qualified interpreter whenever practicable; do not rely on children, police or an alleged abuser. Document interpreter identity / method. |
| Hearing, vision, speech or communication disability | Provide aids, writing, pictures, supported communication or specialist assistance. Allow extra time and confirm the patient's own communication method. |
| Learning disability, autism, dementia or neurodivergence | Use simple concrete language, one decision at a time, familiar supporters, sensory adjustment and the patient's communication passport or care plan. |
| Fear, mistrust, stigma or previous trauma | Use a private, non-confrontational and trauma-informed approach; acknowledge concerns; offer a different clinician or chaperone where feasible. |
| Financial, family, work, transport or caregiving pressure | Involve social work / care coordination; offer staged care, transport support, communication with family / employer, outpatient alternative or brief observation where safe. |
| Fatigue, intoxication or potentially reversible confusion | Allow time and repeat assessment after treatment / observation when delay is safe. No arbitrary alcohol concentration establishes or excludes capacity. |
| Patient declines information | Explore why and how much they wish to know. Provide the minimum information necessary for safe consent / refusal and follow local professional and legal guidance. |

6. Decision-specific capacity assessment

CAPACITY QUESTION: Can this patient make this particular decision, at this time, after reasonable support? Do not ask whether the patient is generally "competent" or whether the clinician agrees with the choice.

| Step | Assessment and documentation |
|------------------------|--|
| 1. Define the decision | State the exact choice: e.g., CT head now, IV antibiotics, blood transfusion, admission, transfer, remaining for troponin / observation, or leaving with an incomplete assessment. |

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| Step | Assessment and documentation |
|------------------------------------|---|
| 2. Identify reason for doubt | Record the clinical concern: delirium, brain injury, hypoxia, intoxication, psychosis, severe distress, cognitive impairment, communication barrier or inconsistent choice. A risky decision alone is not enough. |
| 3. Provide support and information | Explain the current concern, proposed care, material benefits / burdens, alternatives, uncertainties and consequences of refusal in plain language. Use teach-back rather than yes / no questions. |
| 4. Understand | Can the patient describe the essential information and available options in their own words? Perfect recall or medical vocabulary is not required. |
| 5. Appreciate / apply | Can the patient recognize that the information and consequences may apply to them, rather than denying a clearly established reality because of impairment? |
| 6. Reason / weigh | Can the patient compare options, give a coherent rationale linked to their values and consider foreseeable benefits and harms? The rationale need not be one the clinician would choose. |
| 7. Communicate a stable choice | Can the patient communicate a choice by speech, writing, gesture or assistive method? Explore rapid or unexplained reversals and reassess if the clinical state changes. |
| 8. Conclude and review | Document capacity present, absent or uncertain for the named decision; who assessed; supports used; senior / specialist input; and when reassessment is required. Capacity may differ for different decisions. |

7. When capacity is present

- Respect the refusal or decision to leave after an informed-refusal process. The clinician may recommend strongly, but must not threaten, shame, deceive, obstruct the exit, or use security to coerce agreement.
- Offer partial or alternative care: essential observations, symptom control, oral rather than IV treatment, a limited investigation set, a shorter observation period, outpatient testing, direct specialist review, or transfer by a method the patient will accept, when clinically reasonable.
- Clarify that the patient can change their mind at any time and may return. Do not reduce the quality of care, prescriptions, discharge information or follow-up because the departure is self-directed.
- Assess practical safety: ability to walk, safe transport, no driving after sedatives / intoxicants, access to medicines, responsible support, and ability to seek help. A capacitous patient may still decline these measures; document the offer.
- If the patient wishes, involve family, a trusted person, primary clinician, religious / cultural support or advocate. Do not disclose information without permission unless lawful prevention of serious harm requires it.

8. Informed-refusal conversation

| Element | Minimum standard |
|-----------------------------------|---|
| Recommendation | State what is recommended, why, and how urgent it is. |
| Benefits and material risks | Explain likely benefits and risks important to this patient, including serious but plausible outcomes such as disability, deterioration or death when applicable. |
| Alternatives | Discuss reasonable alternatives, including no treatment, delayed care, another facility, outpatient review, observation, or accepted partial treatment. |
| Uncertainty | Be explicit about what is not yet known because the assessment or tests are incomplete. |
| Consequences of refusal / leaving | Link the risk to the actual condition and time course. Avoid generic statements such as "you could die" without explanation. |
| Teach-back | Ask the patient to explain what they understand, what they are choosing and what they will do if symptoms worsen. |
| Reason for refusal | Record the patient's own explanation and any modifiable barriers addressed. |
| Harm reduction | Provide accepted treatment, prescriptions, equipment, safety plan, follow-up, warning signs, return instructions and transport advice. |
| Documentation / witness | Record the discussion and capacity assessment. A witness or form may support the record but is not a substitute. Do not require a signature as a condition of leaving or receiving information. |

9. When capacity is absent or uncertain

| Situation | Response |
|---|--|
| Immediate threat to life or serious irreversible harm; delay unsafe | Provide only the treatment immediately necessary under the applicable emergency / necessity authority; use the least restrictive approach; seek senior help; identify any valid advance decision, surrogate or known wishes as soon as possible. |
| Non-immediate decision; reversible impairment likely | Treat reversible causes, provide support, observe and reassess. Delay non-urgent irreversible interventions where safe. |
| Surrogate / authorized decision-maker available | Confirm identity and legal authority. Use substituted judgement / known wishes where applicable and best-interest standards under local law. The surrogate cannot demand clinically inappropriate treatment. |
| Conflict among clinicians, family or surrogate | Seek senior clinician, ethics / legal and specialty review. Preserve life and comfort while resolving urgent uncertainty, using the least restrictive temporary plan. |
| Patient attempts to leave and lacks capacity with serious imminent risk | Use trained de-escalation and the minimum proportionate lawful restriction. Call senior clinical leadership; apply mental-health or other statutory authority when criteria are met; monitor continuously; document justification and review frequently. |
| No lawful basis to detain despite concern | Provide the safest achievable plan, communicate risk, arrange support and follow-up, and document. Security or police must not create a detention power that clinicians do not have. |
| Capacity recovers | Stop treatment or restriction not otherwise authorized, update the patient, seek consent for ongoing care and discuss what occurred. |

RESTRICTION RULE: Any restraint, sedation, locked-door restriction or forced treatment must have a clear legal and clinical basis, be necessary and proportionate to the immediate risk, use the least restrictive option, include physiological monitoring and dignity safeguards, and end as soon as the justification no longer applies.

10. Special clinical situations

| Situation | Key safeguards |
|--|--|
| Intoxication | Intoxication does not automatically remove capacity. Assess the actual effects on understanding, appreciation, reasoning and communication; consider delayed toxicity, head injury, hypoglycaemia and co-ingestion; repeat assessment as the state changes. |
| Delirium / dementia | A diagnosis does not settle capacity. Seek baseline from carers, treat reversible illness, use communication support and assess the specific decision. Fluctuation requires timed reassessment. |
| Mental illness / self-harm | Mental illness and suicide risk do not automatically remove capacity. Assess both separately. A patient may have capacity yet meet local statutory criteria for protective mental-health intervention. |
| Severe pain, fear or anger | Treat symptoms and de-escalate. Strong emotion may affect processing but is not itself incapacity. |
| Opioid reversal / post-seizure / post-sedation | Capacity may be temporarily impaired or fluctuate. Observe for recurrent toxicity / postictal confusion and reassess before accepting high-risk refusal. |
| Advance directive or prior expressed wishes | Verify applicability, validity and any appointed surrogate under local law. In an unresolved time-critical emergency, seek senior / legal advice while providing proportionate stabilizing care. |
| Patient in police / correctional custody | Custody does not by itself remove autonomy. Law-enforcement personnel are not the medical decision-maker. Seek private clinical communication where safe, minimize restraints for examination and follow local law for confidential information and return to custody. |
| Patient with disability | Do not infer incapacity from diagnosis, appearance, speech or dependence. Provide reasonable communication and environmental adjustments and document them. |

11. Children, adolescents and parental refusal

- Apply the current local age, maturity, consent and parental-responsibility rules. Involve the child or adolescent to the greatest extent possible and seek assent even when an adult provides legal consent.
- Assess whether an adolescent can understand, appreciate and weigh the specific decision; a capable young person's confidentiality and views may have legal significance. Obtain senior paediatric and legal / safeguarding advice for serious conflict.
- Where delay threatens life or serious health and a parent / guardian is unavailable, emergency treatment may proceed under the applicable legal authority. Document urgency and attempts to contact the authorized decision-maker.
- If a parent refuses treatment necessary to prevent serious harm, do not simply discharge the child. Escalate immediately to senior paediatrics, safeguarding / social services and legal / judicial processes under local law; provide stabilizing emergency care.
- A parent may not remove a child to an unsafe environment or prevent a required safeguarding assessment. Use Protocol 43 and the local missing-child procedure.
- For a child who leaves or is removed before assessment, a senior clinician must review the triage information promptly, assess likely harm, attempt contact and determine whether safeguarding services or police notification is required.

12. Patient announces an intention to leave

1. Acknowledge the request without confrontation and ask the patient to remain briefly for a focused safety discussion.
2. Bring the treating clinician and senior nurse promptly; do not leave the patient waiting for a routine review when departure is imminent.
3. Perform the immediate-danger screen, identify reversible impairment and define the specific decision.
4. Support and assess capacity; seek senior / specialty / mental-health input when risk is high, the decision is complex or capacity is uncertain.
5. Complete informed refusal, address the reason for leaving and offer acceptable alternatives or partial care.
6. Remove IV access and hospital devices when safe; provide wound / medication / equipment care and ensure property is returned.
7. Provide written information, warning signs, outstanding-test plan, prescriptions, follow-up, safe transport advice and an open invitation to return.
8. Document the disposition using accurate terminology. Do not code "AMA" solely because the patient declined one element while continuing care.

13. Patient leaves before being seen or before staff know

| Action | Standard |
|-------------------------|--|
| Recognize and timestamp | Record last known location / time, stage of care, observed mental / physical state, companions, devices and property. Notify the nurse in charge and responsible clinician. |
| Clinical risk review | A clinician of locally defined seniority reviews triage observations, presenting complaint, safeguarding flags, prior notes, available results and likely consequences of delay. |
| Internal search | Check treatment areas, toilets, waiting areas and hospital grounds according to policy without delaying urgent external action. Staff must not place themselves at risk. |

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| Action | Standard |
|-------------------------|---|
| Attempt contact | Call / text through approved systems; state the concern, request return or emergency help, and provide a direct contact route. Do not include sensitive details in voicemail / text beyond what is necessary. |
| High-risk escalation | For imminent serious harm, missing vulnerable patient, child, detention status or severe incapacity, activate the local missing-patient / elopement procedure and consider security, safeguarding, emergency medical services or police under lawful, proportionate criteria. |
| Representative / family | Contact only with consent or when legally justified to prevent serious harm or protect a child / vulnerable person. Share the minimum necessary information. |
| Outstanding tests | Assign a named clinician / service to review all pending results and act on critical abnormalities. Departure does not close the duty to manage results already generated. |
| Record and report | Document every attempt, advice, person notified and outcome. Complete a safety incident report when policy criteria are met. |
| Return | Welcome the patient back without blame, repeat triage, reassess capacity / risk and continue care. Do not place them at the end of the queue as punishment. |

14. High-risk callback and welfare-check criteria

| Risk category | Suggested response for local policy |
|---|--|
| Critical vital signs, time-sensitive emergency, critical imaging / laboratory result, suspected sepsis, ACS, stroke, ectopic pregnancy, major bleed | Immediate clinician call; request return by ambulance / emergency service; escalate through approved emergency-contact process if unreachable. |
| Overdose, self-harm, suicidal intent, severe psychosis, violence risk, missing detained patient | Immediate senior and mental-health review; follow Protocol 42 and local mental-health / police liaison procedure. Capacity and legal status must be documented or inferred only cautiously from known facts. |
| Child or vulnerable adult; suspected abuse, trafficking or unsafe caregiver | Immediate safeguarding lead / statutory service review; police involvement where required or necessary for immediate safety. |
| Moderate risk but clinically stable; incomplete test with foreseeable deterioration | Prompt call during the same shift, clear return / follow-up plan and assigned responsibility for repeated attempts. |
| Low-risk departure after triage with normal observations and no safeguarding concern | Document risk review and approved contact / information process. Local policy may use automated written advice, but clinician review remains required for flagged symptoms or abnormal observations. |
| Unable to contact | Document number / method / time; verify contact details; use alternative authorized contacts and welfare-check escalation only in proportion to the anticipated harm and privacy law. |

15. Outstanding investigations and results after departure

- Mark the encounter clearly as departure before completion without cancelling pending tests that remain clinically useful.
- Assign named clinical responsibility for reviewing results, including results finalized after the shift. Use the same closed-loop critical-result process as for discharged patients.
- For critical or materially abnormal results, attempt direct patient communication promptly, provide clear action, and document successful understanding. Escalate failed contact according to risk and local privacy / welfare-check policy.
- Communicate with the patient's primary clinician or receiving service when authorized or necessary for continuity and serious-harm prevention. Do not assume an electronic message will be seen; use direct conversation for urgent action.
- Document incidental or delayed findings, attempts, advice and final closure. Include the process in audit and serious-incident review.

16. Safe harm-reduction discharge package

| Domain | Offer even when recommended care is refused |
|---------------------------|--|
| Immediate treatment | Any accepted stabilizing treatment, analgesia, wound care, splinting, tetanus / prophylaxis, oral medicines or rescue medication that remains clinically safe. |
| Information | Plain-language summary of what is known, what remains uncertain, recommended next step, specific warning signs and when / how to return. |
| Medicines | Prescription and safe-use instructions; avoid withholding necessary medication as punishment. Explain limits created by incomplete assessment. |
| Follow-up | Direct appointment, primary-care / specialist contact, test review plan and responsible service. Give dates, numbers and urgency where possible. |
| Transport and supervision | Recommend ambulance, responsible adult, no driving, or observation as appropriate. Document if declined. |
| Social safety | Food, shelter, domestic-violence / trafficking safety, substance-use support, mental-health crisis plan, caregiving and communication needs. |
| Return invitation | State clearly: the patient may return at any time, will be reassessed without blame, and should call emergency services if severe warning signs occur. |

17. Documentation standard

- Patient's exact words and stated reason for refusal / departure; time intent was expressed or absence identified.
- Clinical status, vital signs, relevant examination and immediate-danger screen; what assessment / tests remained incomplete.
- Specific decision and reason capacity was questioned or presumed; support provided; capacity domains assessed; conclusion and reviewer.
- Information discussed: recommendation, benefits, material risks, alternatives, uncertainty and consequences; patient teach-back and questions.

- Accepted and refused elements of care; symptom treatment; prescriptions; transport / supervision; written advice and follow-up.
- Family / surrogate / interpreter / advocate involvement and consent for disclosure; safeguarding, mental-health, legal, security or police input.
- If the patient could not be assessed: facts known, senior risk review, contact / search attempts, people notified and rationale for escalation or non-escalation.
- Outstanding results, named reviewer and closed-loop communication plan.
- Any restraint, sedation or detention: legal / clinical basis, alternatives attempted, duration, monitoring, injury check and review.
- Clinician name, grade, time and final disposition. A form may supplement but never replace the clinical record.

18. Staff roles

| Role | Responsibilities |
|---|--|
| Triage / reception | Identify imminent departure and high-risk complaints; notify clinical staff; confirm contact details; document departure time and last known location. |
| Primary nurse | Engage, address immediate needs, obtain observations, alert clinician, remove devices when safe, provide information and document accepted / refused care. |
| Treating clinician | Define decision, support and assess capacity, conduct informed refusal, mitigate harm, arrange follow-up and document. |
| Senior ED clinician / nurse in charge | Review high-risk or uncertain cases, authorize missing-patient escalation, coordinate specialty / legal / security input and ensure outstanding-result ownership. |
| Mental-health team | Assess mental state, suicide / violence risk and statutory criteria; advise on observation, lawful restriction, safety planning and follow-up. |
| Paediatrics / safeguarding / social work | Protect children and vulnerable adults; assess caregiver safety; coordinate statutory reporting and safe placement. |
| Security | Support a safe environment, search and proportionate response under clinical direction and hospital policy. Security does not determine capacity or authorize medical detention. |
| Police / emergency services | Assist only under the applicable legal framework and proportionate risk criteria; medical information shared must be limited to what is authorized / necessary. |
| Health information / laboratory / imaging | Preserve accurate disposition coding, route critical results and support tracking / audit. |
| Governance / legal | Maintain policy, training, incident review, legal updates and organizational learning. |

19. Quality and safety indicators

| Indicator | Suggested measure |
|--------------------------------|--|
| Decision-specific capacity | Percentage of high-risk informed refusals with a documented capacity assessment and supports used. |
| Senior review | Percentage of high-risk DBC events receiving documented senior clinician / nurse review within the locally approved time. |
| Contact attempts | Percentage of high-risk unplanned departures with timely, documented patient contact and escalation appropriate to risk. |
| Information and harm reduction | Percentage of engaged self-directed departures receiving written warning signs, return advice, prescriptions / accepted care and follow-up. |
| Outstanding results | Percentage of DBC encounters with pending tests assigned to a named reviewer; percentage of critical results with closed-loop communication. |
| Children / vulnerable adults | Percentage with senior and safeguarding review according to local criteria. |
| Restriction safety | Number, duration and complications of restraint / sedation / detention used to prevent departure; evidence of legal basis and monitoring. |
| Outcomes | Return within 72 hours, ICU admission, death, serious harm, complaint or safeguarding event after DBC; structured case review. |
| Equity | DBC rate and outcomes reviewed by age, sex, disability, language, ethnicity where lawful, housing, mental-health / substance-use status and time of day to identify systemic barriers. |
| Patient experience | Reasons for leaving, communication failures and practical barriers used for service redesign rather than blame. |

20. Training and simulation

- All ED staff receive orientation on supported decision-making, capacity, informed refusal, documentation, missing-patient response, confidentiality, safeguarding and least-restrictive practice.
- Annual simulation should include: intoxicated head injury refusing CT; overdose leaving before toxicology review; capacitous patient refusing blood; delirious older adult trying to leave; adolescent / parental conflict; suicidal patient missing from the department; and critical result finalized after departure.
- Security and clinical teams train together on roles, de-escalation, lawful restriction, safe search, police liaison and post-event review.
- Audit findings and serious incidents are fed back to staff with system improvements addressing waits, communication, environment and social barriers.

21. Local configuration required before approval

☐ Current national capacity, consent, mental-health, child-protection, confidentiality, missing-person and emergency-treatment law reviewed by legal counsel.

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- ☐ Age / maturity rules, parental responsibility, adolescent confidentiality and emergency treatment of minors defined.
- ☐ Authorized decision-maker / surrogate hierarchy, advance directives and emergency exception defined.
- ☐ Criteria and authority for restraint, sedation, security, police contact and welfare checks defined.
- ☐ Operational definitions and coding for refusal, left before assessment, self-directed departure, unplanned departure and elopement approved.
- ☐ High-risk symptom / observation / test triggers and maximum callback times approved.
- ☐ Missing-patient search areas, communication chain, contact methods and documentation form approved.
- ☐ Outstanding-result ownership and after-hours escalation process approved.
- ☐ Interpreter, disability-support, safeguarding, social-work, mental-health, security and legal contacts embedded in the protocol.
- ☐ Patient information sheet and informed-refusal / departure documentation approved in locally relevant languages.
- ☐ Quality dashboard, incident thresholds and case-review ownership assigned.

22. Source guidance for local adaptation

| Source | Key use in this protocol |
|--|--|
| General Medical Council. Decision Making and Consent, effective 2020 and updated December 2024. | Shared decision-making, presumption of capacity, support for decisions, material risks, refusal, emergencies, recording and confidentiality interface. |
| Royal College of Emergency Medicine. The Mental Capacity Act in Emergency Medicine Practice, 2017; current listing reviewed / hosted 2024. | Decision-specific assessment, reversible causes, emergencies, refusal and ED case application. Legal provisions must not be copied outside the relevant jurisdiction without review. |
| Royal College of Emergency Medicine. Consent in Adults, Adolescents and Children in Emergency Departments, 2018. | Consent, emergency treatment, best interests, adolescents and parental conflict. |
| Royal College of Emergency Medicine. Best Practice Guideline: The Patient Who Absconds, 2024. | Duty of care after registration, risk assessment, search / contact, police liaison, documentation and governance following unplanned departure. |
| Royal College of Emergency Medicine. Providing Patient Information in the Emergency Department, May 2025. | Verbal and written information, warning signs, follow-up, documentation and accessible communication. |
| American College of Emergency Physicians educational and ethical resources on decisional capacity and refusal, including 2025 review of patients leaving against medical advice. | Patient-centred informed refusal, capacity assessment, addressing reasons for leaving, alternative discharge and avoidance of reliance on a form alone. |
| AHRQ Patient Safety Network resources on elopement and wandering. | Systems approach, supervision, search and organizational learning after high-risk unauthorized departure. |
| Current local law, Ministry / health-authority policy and professional standards. | Controlling authority for capacity test, age thresholds, surrogate hierarchy, detention, disclosure, police involvement, safeguarding and documentation. |

Annex A. One-page refusal and departure workflow

| Stage | Action |
|------------------------|--|
| 1. Engage | Respond promptly, respectfully and privately. Ask why the patient is refusing or leaving; address pain, delay, fear, communication and practical barriers. |
| 2. Screen danger | Identify instability, altered mental state, self-harm, intoxication, child / vulnerable adult, safeguarding and time-critical disease. |
| 3. Support | Interpreter / aids / advocate / quiet space; treat reversible impairment; give understandable information and time where safe. |
| 4. Define decision | Name the exact test, treatment, admission, transfer or continued observation being refused. |
| 5. Assess capacity | Understand; appreciate / apply; reason / weigh; communicate. Document decision-specific conclusion and senior review when needed. |
| 6A. Capacity present | Conduct informed refusal, offer alternatives and partial care, provide harm reduction, follow-up, written warning signs and safe transport. |
| 6B. Capacity absent | Treat immediate threats under lawful emergency authority; use surrogate / best-interest process; least restrictive temporary measures and frequent review. |
| 7. Departure | Remove devices safely, return property, document time / condition / destination if known and open invitation to return. |
| 8. Unplanned departure | Clinical risk review, internal search, contact attempts, high-risk escalation / safeguarding / police only as lawful and proportionate. |
| 9. Results | Assign pending results to a named reviewer and complete closed-loop communication for important abnormalities. |
| 10. Learn | Incident report and multidisciplinary review after harm, high-risk elopement, restraint, complaint or system failure. |

Annex B. Decision-specific capacity checklist

- ☐ Decision being assessed: _____.
- ☐ Reason capacity is questioned: _____.
- ☐ Reversible causes assessed / treated: hypoxia ☐ glucose ☐ delirium ☐ head injury ☐ intoxication ☐ pain ☐ shock ☐ other _____.
- ☐ Support used: interpreter ☐ hearing / vision aid ☐ communication tool ☐ quiet space ☐ time ☐ trusted person ☐ other _____.
- ☐ Information given: condition / uncertainty ☐ recommendation ☐ benefits ☐ material risks ☐ alternatives ☐ consequences of refusal ☐.
- ☐ UNDERSTANDS essential information and options: yes ☐ no ☐ uncertain ☐. Evidence / patient words: _____.
- ☐ APPRECIATES that information and consequences may apply personally: yes ☐ no ☐ uncertain ☐. Evidence: _____.

EMERGENCY DEPARTMENT CLINICAL PROTOCOL | CAPACITY, REFUSAL OF CARE, AND DEPARTURE BEFORE COMPLETION | DRAFT

☐ REASONS / WEIGHS options in relation to values and foreseeable outcomes: yes ☐ no ☐ uncertain ☐ Evidence:

☐ COMMUNICATES a stable choice by an effective method: yes ☐ no ☐ uncertain ☐ Method / consistency:

☐ Conclusion for this decision now: capacity present ☐ absent ☐ uncertain ☐ Reassessment time / trigger:

☐ Senior / specialty / mental-health / legal input: _____

☐ Assessor name / role _____ signature _____ date / time _____

Annex C. Informed-refusal and self-directed-departure record

| Field | Record |
|-------------------------------------|--|
| Patient / encounter | Name _____ DOB _____ number _____ date / time _____ |
| Proposed care refused | _____ |
| Current findings / uncertainty | _____ |
| Material benefits explained | _____ |
| Material risks of refusal / leaving | _____ |
| Alternatives offered | _____ |
| Patient's reason and values | _____ |
| Teach-back / understanding | _____ |
| Capacity conclusion / evidence | _____ |
| Accepted treatment / harm reduction | _____ |
| Medicines / equipment / transport | _____ |
| Warning signs / return advice | _____ |
| Follow-up / pending-result plan | _____ |
| Interpreter / family / witness | _____ |
| Patient signature — optional | _____ Declined / unable to sign <input type="checkbox"/> Signature is not a condition of care. |
| Clinician / senior review | Clinician _____ senior _____ date / time _____ |

Annex D. Unplanned departure / missing-patient response card

| Step | Action / completion |
|--------------------|--|
| 1. Alert | Nurse in charge _____ responsible clinician _____ senior ED clinician _____ time _____. |
| 2. Last known | Location _____ time _____ condition / clothing / companion / destination if known _____. |
| 3. Clinical risk | Complaint _____ observations _____ capacity concern _____ self-harm / violence _____ child / safeguarding _____ devices _____. |
| 4. Search | Cubicle / waiting area / toilets / hospital grounds / other approved areas checked by _____ at _____. |
| 5. Contact | Phone _____ at _____ result _____; text / approved message _____; alternate authorized contact _____. |
| 6. Escalate | Security _____ mental health _____ safeguarding _____ ambulance _____ police _____ Legal / risk rationale _____. |
| 7. Results | Pending tests _____ named reviewer _____ critical-result plan _____. |
| 8. Outcome | Returned _____ located safe _____ advised return _____ admitted elsewhere _____ still missing _____ time _____. |
| 9. Record / report | Clinical note completed <input type="checkbox"/> incident report <input type="checkbox"/> handover <input type="checkbox"/> follow-up owner _____. |
| 10. Review | Senior review / debrief / patient-family communication / duty-of-candour action: _____. |

Annex E. Children and adolescents — removal / refusal safety check

- ☐ Child / adolescent identity and age confirmed; accompanying adult's identity and parental / legal authority checked.
- ☐ Immediate danger, safeguarding, abuse, exploitation, trafficking and caregiver impairment assessed.
- ☐ Child / adolescent spoken with privately when appropriate and communication needs addressed.
- ☐ Young person's maturity / decision-making ability assessed under local law; views and assent documented.
- ☐ Parent / guardian received clear information on diagnosis / uncertainty, recommended care, material risks and alternatives.
- ☐ If refusal may expose the child to serious harm: senior paediatrics ☐ safeguarding / social work ☐ legal ☐ statutory child service ☐ police ☐ contacted.
- ☐ Emergency stabilizing treatment provided where lawful and necessary; least restrictive approach used.
- ☐ If child leaves / is removed: last known time and location, risk review, contact attempts and missing-child pathway completed.
- ☐ Safe destination / adult supervision / transport / medicines / written warning signs / follow-up confirmed.
- ☐ Named clinician / safeguarding professional responsible for pending results and next action: _____.

Annex F. Local legal and operational configuration table

| Item | Approved local rule / contact / document location |
|--|---|
| Statutory / common-law capacity test | _____ |
| Emergency treatment without consent | _____ |
| Surrogate / authorized decision-maker hierarchy | _____ |
| Advance directive / appointed proxy process | _____ |
| Adult mental-health detention authority | _____ |
| Child consent / assent / parental responsibility | _____ |
| Parental refusal and emergency court / child-protection contact | _____ |
| Safeguarding / domestic violence / trafficking contacts | _____ |
| Security / restraint / sedation authorization | _____ |
| Police / welfare-check criteria and contact | _____ |
| High-risk DBC callback times and responsible role | _____ |
| Outstanding-result owner after departure | _____ |
| Approved information sheet / documentation form | _____ |
| 24-hour senior ED / mental health / paediatrics / legal contacts | _____ |