Case Study Ten: Mrs Q – inadequate capacity assessment made when deciding on treatment for lymphoma

Summary
Mrs Q required tests for unexplained weight loss. The tests were carried out and a diagnosis of lymphoma was made. As Mrs Q could not consent to treatment, she was discharged with no treatment plan and the GP wanted to implement a 'do not resuscitate' order. Following IMCA intervention, it was discovered that lack of capacity had been assumed and the IMCA set about undertaking an accurate capacity assessment. Unfortunately Mrs Q passed away before this could be completed.

Background
Mrs Q is an 82-year-old lady with suspected dementia. She resides in a care home, where she has been for many years. She was referred to the IMCA service by her GP due to recent rapid weight loss and loss of appetite. Mrs Q has a history of non-compliance with any investigation and has always refused any intervention, investigation and blood tests in the past.
The GP requested information from IMCA around the use of the MCA and reasonable measures that could be taken to attempt to get Mrs Q to hospital for investigation of any potential underlying causes for her weight loss.

IMCA report
'I established with the GP that the IMCA referral was made for serious medical treatment investigation decision and any investigation was to be ultimately undertaken in hospital. It was unclear what the hospital intended to undertake for investigation purposes at this point but the GP requested MCA guidance around getting Mrs Q to hospital for this. The GP had reasonable belief that Mrs Q lacked capacity for this decision and that she had no one that could be consulted. We agreed that I would undertake this work in order to provide MCA guidance for the GP. It was evident that further work would be needed by IMCA with the hospital to ascertain what their intentions were for investigation. An IMCA report was submitted to the GP around use of the MCA and guidance around appropriate/proportionate restraint.
During my annual leave Mrs Q was admitted to hospital and tests were completed. It was confirmed that she had lymphoma. She was discharged back to the care home. There appeared to be no plan for providing any treatment. I discussed treatment options with the haematologist (decision-maker) and it was agreed that blood tests would be completed and a possible blood transfusion in the near future and (if appropriate) other treatment options would also be considered. I facilitated discussion between the care home manager and the haematologist in order that they could discuss Mrs Q's situation and her options for treatment and a plan forward. In the meantime the GP was considering a Do Not Attempt Resuscitation (DNR) for Mrs Q. Upon meeting Mrs Q it was evident that she was very hard of hearing and it should not be assumed she lacked capacity for the decision because of this barrier to communication. I challenged the GP's reasonable belief that she lacked capacity for the DNR decision and he agreed to reassess her. We had a discussion around Mrs Q's capacity and I provided guidance around assessing capacity and how the outcome determined whether or not it was a best interests decision or Mrs Q's

decision, using MCA guidance. This discussion included asking him to consider consulting with the manager and staff of the home for ways of communicating with Mrs Q considering her hearing deficit. I explained the importance of evidencing his findings in order to document the outcome.'

Barriers which were overcome

Persistent contact with the haematologist to ensure treatment options were considered, as Mrs Q was discharged back to the care home without any future treatment plans. The IMCA had to ensure that a 'decision not to treat' was understood to be as much of a best interests decision (and subject to the MCA framework) as a 'decision to treat'. There was a general lack of knowledge by the haematologist and GP around the MCA and how to apply this, which the IMCA provided support on, including: applicable and appropriate capacity assessments; principles; how to implement the framework for this patient; and information of when to instruct an IMCA. The GP had to be educated around how to adequately assess capacity and implementation of the MCA in decision-making and restraint issues.

Outcome

During the process of the GP assessing capacity for the DNR, Mrs Q unfortunately died, therefore ending decision-making processes that were in place.