Bournemouth University

The National Centre for Post-Qualifying Social Work and Professional Practice

Part of a series of MCA Guidance

The Mental Capacity Act requirements when an individual lacks the mental capacity to consent to treatment and care



SANN Safeguarding Adults National Network #SANNnhs

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Foreword



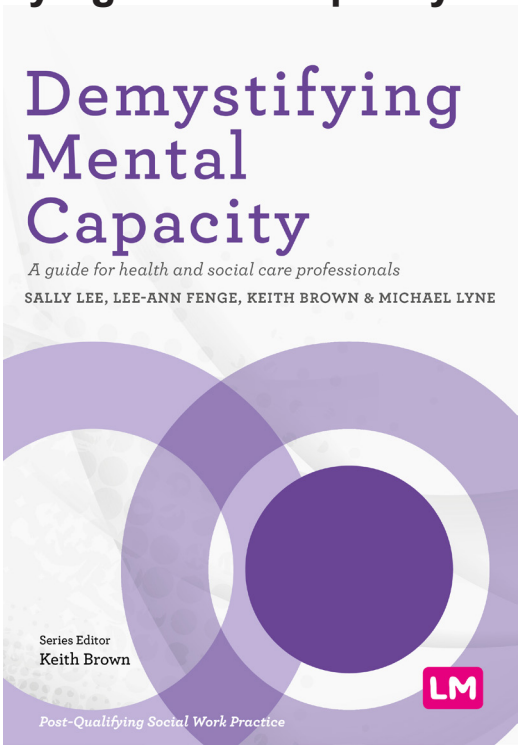
The National Centre for Post-Qualifying Social Work and Professional Practice has produced a series of brief guides to help all health and social care professionals navigate through and apply the principles of the Mental Capacity Act for decisions regarding treatment and care. This is one of those guides and should be read in conjunction with the other guides in the series. These guides can be downloaded for free from www.ncpqsw.com.

We trust that these resources will assist all health and social care professionals in delivering the very best possible care in this difficult time of the Covid 19 response and also into the future when we get to the other side of the Covid 19 pandemic.

Prof Keith Brown (April 2020)
Director

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The new Demystifying Capacity Sage book available to order at https://uk.sagepub.com/en-gb/eur/demystifying-mental-capacity/book269861



Set against the backdrop of the Mental Capacity Act 2005, this book explores and addresses issues raised by mental capacity within adult safeguarding, and provides clear guidance on the use and value of the MCA, and how to ensure that the rights and choices of individuals are heard, listened to and acted upon.

With contributions from a range of subject experts across the legal, social work, nursing and healthcare disciplines, this book will be invaluable to practitioners in the health and social care profession, and indeed any role where issues of mental capacity may be a concern. Case studies, reflection points and exercise are used to develop understanding and support critical engagement with practice.

Factors affecting mental capacity to consent to treatment and care

There are a range of health conditions which may affect an individual's mental capacity to consent to care or treatment: neurological diseases, mental health issues, learning disabilities, brain injury (traumatic or surgical), delirium, chronic brain failure such as dementia, effects of medication or anaesthesia. However, the presence of a disease or condition of the brain does not, in itself, indicate a lack of capacity (NICE 2018) – it is only when the resulting impairment of brain function caused by a condition affects the person's ability to make decisions, that the level of impairment/ cognitive ability needs to be assessed and any incapacity recorded (Brown et al. 2015). A diagnosis may define why someone may lack capacity, but the outcome of this in terms of the individual's ability to make their own decisions, must be assessed and recorded (BMA 2018). It is also important to acknowledge that a formal diagnosis may not be available and is thus not strictly necessary to the operation of the Act.

Clinical decisions where the individual lacks capacity to consent to treatment or care

All health professionals should understand their responsibilities and the legal requirements of obtaining consent to treatment. This equally applies to the treatment or care for those people unable to provide informed consent, due to a lack of mental capacity. The Mental Capacity Act is clear that every reasonable step should be taken to support an individual to make decisions regarding treatment and care for themselves. Where it is clear that the person lacks capacity to consent to treatment or care, the clinical decision-makers need to seek alternative arrangements for the care and treatment to be lawful. The Act sets out a number of alternatives.

Advance Decisions to Refuse Treatments

Advance Decisions to Refuse Treatments (ADRT) may have been made by an individual, regarding any treatment including life-sustaining treatment, to be considered at a future time when they may lack mental capacity to refuse treatments. ADRTs must be made when the individual has mental capacity to make an informed decision to refuse a treatment; they cannot be used to request or demand treatments, nor can they be used to refuse general care and treatment such as the provision of food, fluids, personal care (The National Centre for Post-Qualifying Social Work & Professional Practice - 2019). Where individuals have made clear statements, perhaps to others at a time when they had the mental capacity to do so, to refuse certain treatments through an ADRT, the clinical team must abide with this refusal of treatment. Treatment which has been commenced in advance of the discovery of an ADRT should be discontinued as long as the clinician is happy that the ADRT is "valid and applicable".

It is important to remember that an ADRT may not be in the form of a written document. Verbal ADRT are legally binding in most circumstances. The exception is life-sustaining treatment. In this instance, the ADRT has to be in writing, be witnessed by a third party and contain a statement which acknowledges that "this ADRT stands even if my life is at risk".

Your Trust may have policy and guidance for staff on the recording of verbal and written ADRT. For more information see The National Centre for Post-Qualifying Social Work & Professional Practice (2019a) and https://compassionindying.org.uk/

Lasting Power of Attorney for Health & Welfare

A person who lacks capacity may have appointed a *Lasting Power of Attorney for Health & Welfare (LPA)*. This person(s) may have legally binding powers to make decisions on behalf of an individual, regarding medical care and treatment, including life-sustaining treatment, ongoing care provision, long-term changes to a care setting and any issues/complaints/safeguarding concerns regarding care provided.

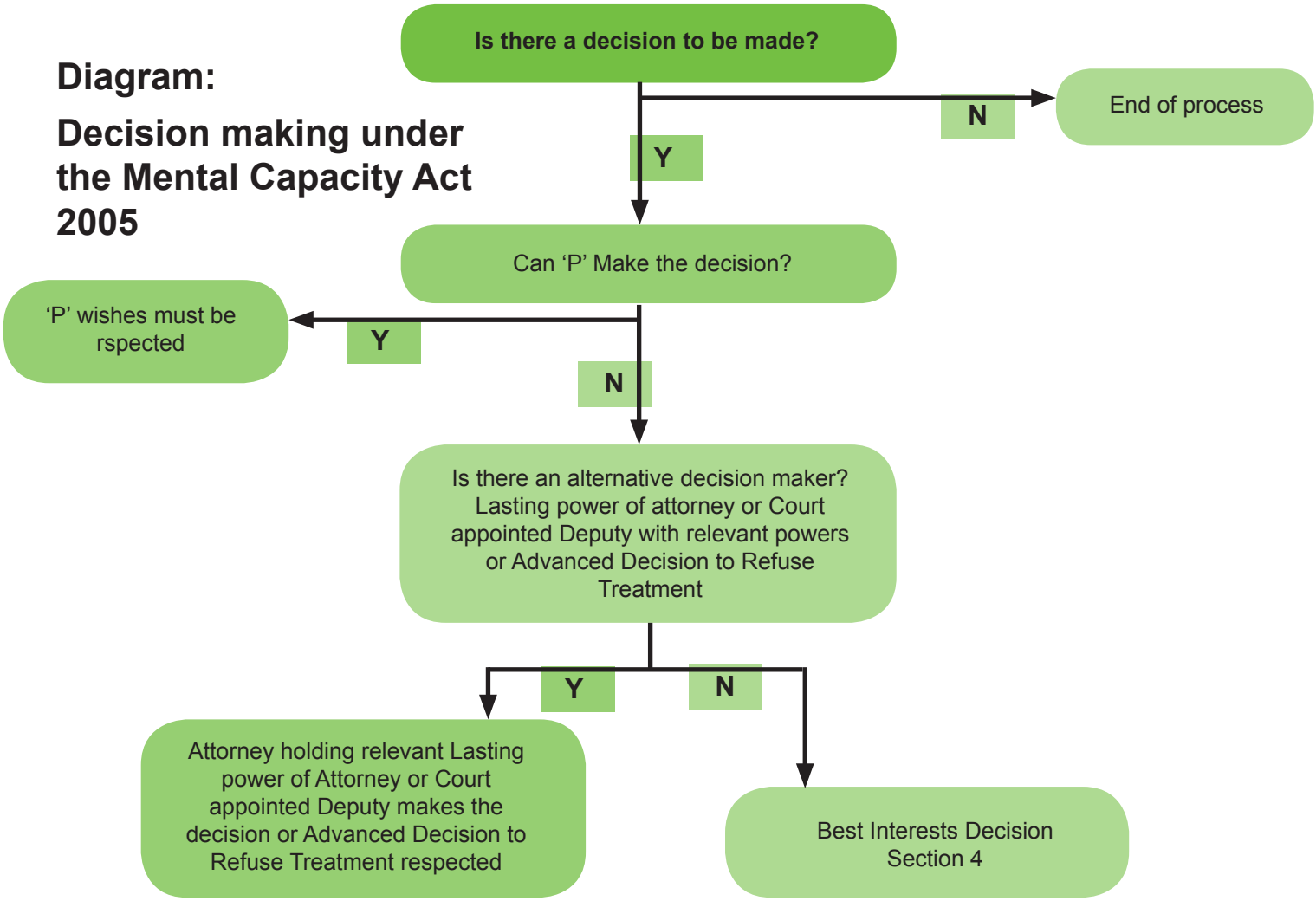
Nurses and other health and social care practitioners need to ascertain if an individual has anyone nominated as an Attorney for Health & Welfare under a LPA, as these people play a vital and legal role and are likely to be the 'decision-maker' for the clinical decisions of people unable to consent to care and treatment themselves; they need to be involved in all clinical decisions and their opinion and decision sought by the clinical team and clinical decision-maker (Griffiths 2017; NICE 2018).

As stated above, if an Attorney with the relevant powers exists, they are likely to be the decision maker, thus negating the need for the best interest decision process outlined below. Attorneys are still charged with acting in the individual's Best Interests, but the professional role becomes one of support to the Attorney in making that decision rather than making the decision themselves. It is important not to take the existence of LPA at face value. Professionals need to satisfy themselves that the LPA is registered by the Office of the Public Guardian and need to identify the scope of the powers donated. For further information see https://www.gov.uk/government/organisations/office-of-the-public-guardian and https://www.gov.uk/find-someones-attorney-deputy-or-guardian

With the promotion of LPAs and ADRTs, by charities, patient groups, legal firms, The Office of the Public Guardian and practitioners – more people will make provision for future decisions to guide care and treatment, for times when they lack capacity to consent themselves. Health and social care practitioners need to be aware of the legal standing of LPAs and ADRTs to comply with the MCA, and how to use these in decisions regarding the care and treatment of those individuals who lack mental capacity.

Diagram:

Decision making under the Mental Capacity Act 2005



The Court of Protection

The Mental Capacity Act (2005) also introduced a new Court of Protection, with legal powers to approve LPAs and a duty to preside over difficult or contentious decisions regarding serious medical treatment or care. A Court Appointed Deputy for Welfare may be appointed, to work with the clinical teams, where there is no appropriate LPA and ongoing decisions are required regarding complex or contentious clinical treatments. Deputies with welfare powers are likely to be less frequent than Attorneys with these powers as the Court prefers treatment decisions to be taken by multi-disciplinary teams in conjunction with the persona and their family and friends.

Clinical decisions requiring referral to Court of Protection:

- Proposal to withhold/withdraw clinically-assisted nutrition and hydration from patients in Prolonged Disorder of Consciousness (PDOC), where there is disagreement or contest from the person's family or between clinicians. If there is full agreement within the clinical team, family and friends that continued treatment is not in the person's best interest, withdrawal can be done without court involvement *(An NHS Trust and others (Respondents) v Y (by his litigation friend, the Official Solicitor) and another (Appellants) [2018] UKSC 46).*
- Organ or bone marrow donation by a person who lacks capacity to consent to donation.
- Proposed sterilisation of a person who lacks capacity.
- Cases where there is doubt or dispute about a proposed treatment being in the best interests of the person without capacity (MCA Code of Practice (2007) Department for Constitutional Affairs).

If it becomes apparent that an application needs to be made to the Court of Protection, then this should be done as soon as possible with the assistance of the Trust's legal advisors. Any such application should not cause undue delay to the treatment or care of an individual who lacks capacity. The clinical team should always act in the individual's best interest, including making appropriate and timely referrals to other teams, organisations or the Court of Protection.

Advance Care Plans

Use of LPAs and ADRTs becomes even more important in planning for end-stage illnesses and/or end-of-life care for people living with frailty (Lewis 2019). Patients with terminal cancer or progressive long-term conditions including mental health issues will often be supported by healthcare professionals to set out Advance Care Plans (ACPs) with a range of decisions and wishes recorded to influence future care. Nurses are often in a good position to support individuals to consider some of the difficult decisions about treatments for end-stage care and have the sensitive discussions about ACPs with the patient's family members; to enable individuals to influence their future care, be engaged and involved in decisions and take control of their lives (Lyne & Mucci 2018).



Independent Mental Capacity Advocates

Where the individual who lacks capacity to consent to treatment and care has no family, friends, Lasting Power of Attorney or Court Appointed Deputy to support them, the clinical team may need to engage and involve an Independent Mental Capacity Advocate (IMCA). The IMCA serves to meet with the individual, clinical team and other relevant people, to provide an independent and objective view of the individual's wishes, beliefs and former decisions, in order to work with the clinical team to protect the person's rights and agree the best interests for specific clinical decisions. The IMCA will never be the decision maker.

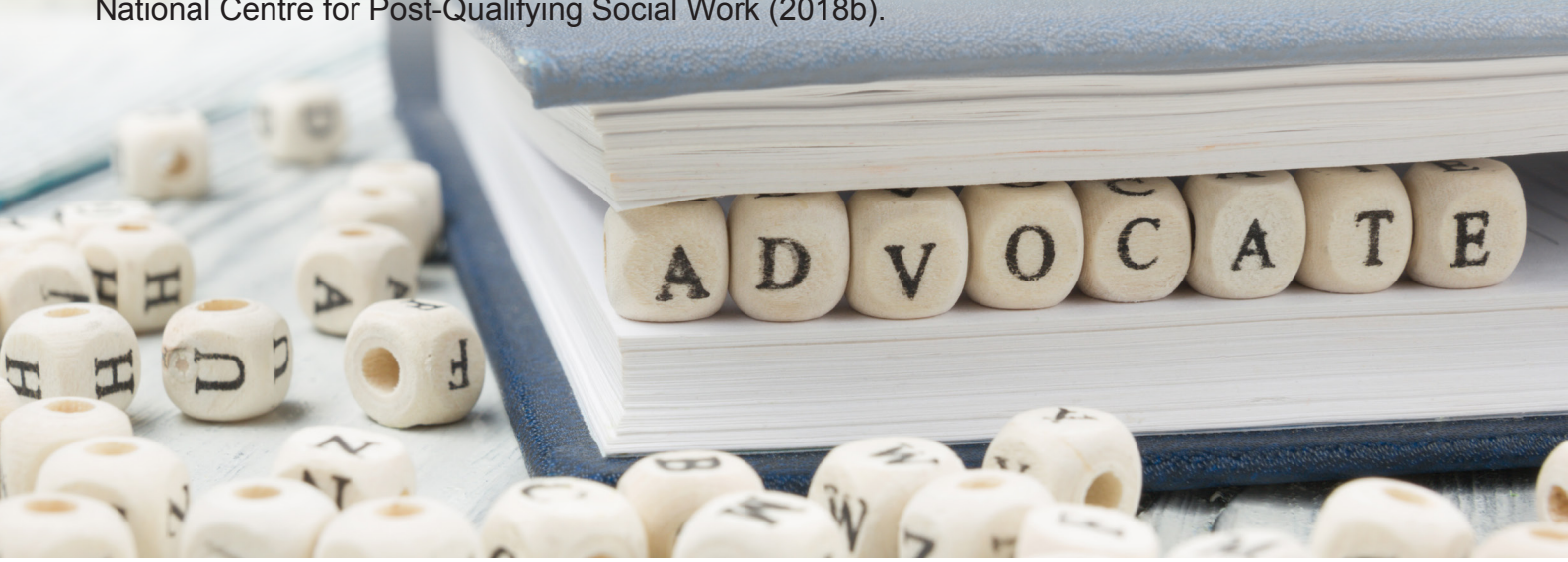
When is IMCA involvement required?

- When an individual lacks mental capacity to consent to treatment and care.

AND

- The person has no family/friends who can be involved in decisions, or no LPA or Court of Protection deputy in place.
- For clinical decisions regarding serious medical treatments.
- For the detaining of an individual in a clinical setting for treatment or care.
- When there are proposed long-term changes to the care setting/accommodation (MCA Code of Practice - Department for Constitutional Affairs 2007).

However, it is common for patients who lack mental capacity to consent to the care and treatment they need, to present with no ACP or ADRTs in place, no identified LPA for Health & Welfare or without a Court Appointed Deputy. Family members, those identified as Next of Kin, care staff and even friends and neighbours, may all be highly relevant and appropriate to be involved in decision-making – but without the legal power of LPA for Health & Welfare, or without an ADRT or ACP, they have no legal rights to make the decision for the individual. For further information see The National Centre for Post-Qualifying Social Work (2018b).



Best Interest Decisions

The MCA (2005) is clear that an individual should be given support and practical help to make the decision regarding care and treatment themselves. Even if the person is unable to make the decision themselves, they should be encouraged and supported to be actively involved and included in the decisions (Brown et al. 2015). The decisions made for care and treatment for an individual who lacks mental capacity to consent, should follow the Best Interest principles as laid out in the MCA Code of Practice (Department for Constitutional Affairs 2007). The Best Interest checklist ensures that the process of decision making is fair, person-centred, with consideration of the individual and their wishes.

What is the Best Interest Checklist?

- Encourage participation.
- Identify all relevant circumstances – understand the individual and their likely views/ wishes.
- Find out the person's views – past and present wishes, known beliefs and values, previous decisions and actions taken.
- Avoid discrimination – decisions should not be made simply on grounds of age, condition, gender, race.
- Consider if the person is likely to regain mental capacity - can the decision be delayed until the person has capacity to consent.
- Does the decision concern life-sustaining treatment – the decision should not bring about the person's death.
- Consult others – anyone previously named by the individual, family, friends, an LPA or Court Deputy.
- Where the decision is regarding serious medical treatment or long-term accommodation and the individual has no-one available to be involved (they are deemed as 'un-befriended') an IMCA must be consulted and involved in the Best Interest decision.
- Avoid restricting the person's right – consider if there is a least restrictive option.
- Weigh up all of the above, to make a considered decision based on the person involved.

(Based on MCA Code of Practice –Department for Constitutional Affairs 2007)

The Best Interest checklist provides a guide for good practice, to ensure that care and treatment undertaken for an individual who lacks the mental capacity to consent, remains lawful and person-centred. When urgent care and treatment need prompt decision making, with no time to consult others, explore the individual's known wishes or make referral for an IMCA, the clinical team should still ensure that:

- Treatments and care are as less restrictive and least invasive as possible.
- Clinical decisions are not based on assumptions and discrimination.
- The individual's family are informed and involved at the earliest opportunity.
- Clinical decisions are made to provide the optimal outcomes for the individual.
- Clinical decisions involve relevant health and social care practitioners available at the time of urgent treatment or rapidly declining condition.
- Ongoing and further decisions are made following Best Interest principles.

Practitioners should ensure that every effort is made to help individuals make their own decisions, wherever possible. It is only when a person is shown to lack capacity to consent to their treatment or care, that the clinical team need to look for legal arrangements, as set out in the MCA, for alternative decision making. It is only with the lack of any alternative legal provision for decision making, that the MCA Best Interest checklist becomes relevant. At all times, the clinical team should follow the principles of the MCA – to ensure a person-centred approach to care, in which decisions are made jointly with the person and other relevant people; that treatment and care are the least invasive and restrictive and in line with the person's known wishes, beliefs and values as far as possible.

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