



MCA MCA/DoLS Primary Care Briefing Note #1

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Introduction

The Mental Capacity Act 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with (and/or caring for) an adult who may lack capacity to make specific decisions, must be able to provide evidence of compliance with the principles of the Act. This rule applies whether the decisions are life-changing events or everyday matters.

Who is affected?

The Act applies to any person who has a condition that causes an *impairment of, or disturbance in the functioning of the mind or brain*. This might include somebody with dementia, learning disabilities, brain injury (for example, stroke or physical trauma to the brain), mental health problems, autism or confusion (for example, from an infection or due to substance misuse).

Mental Capacity Act principles

Professionals have to work within the five principles of the Mental Capacity Act 2005:

1. Start from the presumption that people have the capacity to make their own decisions, unless there is evidence that they might not be able to;
2. Do everything in your power to maximise a person's capacity: there are lots of ways to do this, including using pictures and suitable language, finding a quiet place at the time of day the person is most alert, or simply allowing the person time to think;
3. Remember that just because somebody makes a decision that others might consider unwise, that doesn't necessarily mean the person lacks capacity;
4. If someone does lack capacity to carry out a specific decision, those deciding on behalf of the person must act in their best interests, rather than the best interests of the care provider, or the individual's family;
5. You must always look for the least restrictive option that meets the need – this means choosing the option that restricts the person's freedoms and rights as little as possible.



Definition of Incapacity

The Mental Capacity Act 2005 defines lack of capacity in the following way:

A person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Capacity is decision and time specific. Capacity assessments refer to a person's ability to make a particular decision at a particular moment in time; they are not a blanket judgment on a person's ability.

The test of capacity

There is a two-stage test of capacity in order to decide whether an individual has the capacity to make a particular decision, this test must be applied.

First stage

Is there an impairment of, or disturbance in the functioning of a person's mind or brain? If so, is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

It is essential that the decision makers uphold the principles of 'equal consideration'. The Act is clear that there should not be assumptions made about an individual's lack of capacity based on either their age or appearance or condition.

If the first stage of the test of capacity is met, the second test requires the individual to show that the impairment or disturbance brain or mind prevents them from being able to make the decision in question at that time.

Second stage - the functional test

This is a functional test focusing on how the decision is made, rather than the outcome or the consequence of the decision. The assessor must consider whether the person is able to:

- Understand the information relevant to the decision;
- Retain that information;



- Weigh that information as a part of the process of making a decision;
- Communicate his/her decision (whether by talking, using sign language or any other means).

This test must be complete and recorded; the documentation must demonstrate the above process. The decision about whether a person has capacity or not is made on the “balance of probabilities” – meaning, is it more likely than not, that the person has/doesn’t have capacity? So, you may want to ask another professional, or advocate, to assess the person’s capacity as well. If they lack capacity, you must make sure that any interference with what they want to do is proportionate to the likelihood of harm to that person, and to how serious that harm would be.

Best Interests checklist

Best interests are never simply medical; the whole person has to be considered. The questions in the best interest’s checklist (below) must be considered, provided there is time, in the search for what is in a person’s best interests.

Practitioners must consider the following when making a decision in the person’s best interests:

- Is there an advance decision to refuse treatment that prevents the treatment being given, or a lasting power of attorney with the power to make that decision?
- Find out in advance whether an interpreter is needed to aid communication;
- Might the person regain capacity and, if so, can the decision wait?
- Take account of the person’s past and present views, culture, religion and attitudes; involve the person in the decision as much as possible;
- Do not make assumptions based on the person’s age, appearance, condition or behaviour – concentrate on the actual person;
- Do not make assumptions based on the person’s age, appearance, condition or behaviour – concentrate on the actual person;
- Consult interested family and friends;
- Look for the least restrictive option that will meet the need.

Record Keeping

Make a record of your thinking, and the reasons you think the person does, or doesn’t, have capacity to make this specific decision, and what you have done to maximise their capacity.



Working within this process may sometimes create an uncomfortable situation, when you think a person is planning, with mental capacity, to take a risk that you may consider 'unwise or eccentric'. Among individuals generally there is a wide range of the types of risks we tolerate. Discuss your concerns with the person, and explain your worries. If the risk seems great, you may also discuss the matter with other involved professionals, such as the commissioners, medical practitioners, and the local safeguarding team.

Scope

When applying the MCA, certain categories of people are legally required to have regard to relevant guidance contained in the MCA code of practice.

These people include anyone acting in a professional capacity for, or in relation to, a person who lacks capacity, and anyone being paid for acts for, or in relation to, a person who lacks capacity.

Duty of candour – guidance for professionals

Candour is defined in Robert Francis' report as: "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

Mr Francis' recommendation 181 provides that there should be a statutory obligation of candour on healthcare providers, registered medical practitioners, nurses and other registered health professionals, where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury.

Provision of information should not of itself be evidence or an admission of civil or criminal liability, but not disclosing the information should entitle the patient to a remedy.

Candour (and its close allies openness and transparency) permeates throughout Mr Francis' report. Out of his 290 recommendations, several are drafted with those themes in mind. It is difficult to dispute that these are laudable recommendations.



Awaiting a response

The new duty will undoubtedly cause anxiety to those on the front line. How will providers ensure their staff receive the support they need to identify when the duty arises and then to discharge it?

The duty of candour is not a new concept. It was most recently the subject of a consultation by the Department of Health. The analysis of the responses to the consultation was published in November 2012. Despite only 50 per cent of responses agreeing that incorporating the duty of candour as a contractual term in the NHS standard contract would be an effective mechanism to require openness, the consultation concluded that it has “the greatest chance of being enforceable and therefore effective... none of the evidence presented provides a strong enough case for an alternative approach... we therefore plan to push ahead with implementation of a contractual duty of candour in the NHS standard contract in 2013/14”.

The DH did, however, also say: “We are also committed to giving full consideration to the findings of the Mid Staffordshire inquiry. If the inquiry finds that a statutory duty is preferable to a contractual one, and we are convinced by the arguments made, we will respond accordingly.”

The response of the department to Robert Francis’ report is eagerly awaited.

See link below to the full article in the Health Service Journal:

<http://www.hsj.co.uk/comment/what-a-duty-of-candour-means-in-practice/5055056.article>

Publication of guidance on cardiopulmonary resuscitation

Decisions relating to cardiopulmonary resuscitation. 3rd Edition. October 2014. British Medical Association, Resuscitation Council UK & Royal College of Nursing.

Summary: Healthcare professionals are aware that decisions about whether or not CPR will be attempted raise very sensitive and potentially distressing issues for patients and those emotionally close to them. As a consequence there has been stand-alone professional guidance on CPR decision making since the 1990s, and guidance published jointly by the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing since 2001 (sometimes referred to as the ‘Joint Statement’). The previous edition of this guidance was published in 2007 following extensive



consultation with key stakeholders including professional bodies, patient groups, regulators and charities.

The guidance has been revised in order to ensure its continued compliance with the Mental Capacity Act 2005, to respond to feedback on practical aspects of implementing the previous guidance, and to recognise the increasing importance of multidisciplinary working (for example by acknowledging the role of suitably experienced nurses in the CPR decision-making process in some nurse-led settings). These changes reflected emerging developments in healthcare professionals' roles and the way health care is delivered today.

Death whilst under a DoLS authorisation – Proposed approach to the management of DoLS, by Professor Paul Marks, Senior Coroner

The Coroners Act 2009 states that if someone has a Deprivation of Liberty Order in place they are theoretically and legally regarded as being in state custody and the person's death must be reported to the HM Coroner service. In light of the Cheshire West judgement, the Deprivation of Liberty Safeguards will apply to many more people and it is expected that this will have a considerable impact on the HM Coroner service.

The Chief Coroner is considering the problem and has not provided any guidelines for dealing with the problem thus far. However, HM Senior Coroner Professor Paul Marks has proposed a pragmatic and effective means of dealing with the additional work, which will involve the following approach:

- Individuals that die whilst under a DoL Order must be reported to the Coroner;
- The cause of death is likely to be known in the majority of cases and it would be unusual for a post-mortem examination to be required. In such circumstances it would be expected that the GP or hospital doctor looking after the individual in question would issue a short report providing the Coroner with a cause of death using the standard terminology E.g. 1a Senile dementia due to 1b Cerebral vascular disease;
- A dedicated Assistant Coroner would be called upon to hold a 'run through inquest' in which the case is disposed of in one sitting. This would need to be recorded and transcribed in the usual manner but all evidence would be heard pursuant to Rule 23 of the Coroners (Inquest) Rules 2013;
- A part time dedicated Coroners Officer dealing only with DoLS cases would need to be appointed and this individual would need to compile the necessary paperwork to permit the Inquest to be opened and heard in full and enter all the relevant details onto the Iris system. The Coroner's Office would be responsible for obtaining the short statement from the GP citing the cause of death and also providing the Assistant Coroner with the DoLS Order.



The advantage of this system is that those relatives who are already distressed by their loved one being technically in 'state custody' and having a terminal disease, would not be inconvenienced by any delay caused by the Inquest process, and any such delay would be kept to a minimum.

Useful Resources

Advance care planning under the Mental Capacity Act 2005 in primary care.

Benedict Hayhoe, GP and Associate Tutor.

Aug 2011; 61(589): e537–e541

The British Journal of General Practice

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3145538/>

0 – 18 year olds guidance: Assessing best interests. General Medical Council.

[http://www.gmc-](http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_12_13_assessing_best_interest.asp)

[uk.org/guidance/ethical_guidance/children_guidance_12_13_assessing_best_interest.asp](http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_12_13_assessing_best_interest.asp)

Best Interests Guidance on determining the best interests of adults who lack the capacity to make a decision (or decisions) for themselves [England and Wales]. British Psychological Society, 2007.

http://pmlnetwork.org/resources/bps_best_interests_guide.pdf

Legal update

Do Not Attempt Resuscitation

R (on the application of Tracey) v Cambridge University Hospitals NHS Foundation Trust 2014.

Trusts and clinicians must take careful note of the Court of Appeal's decision about consulting patients when taking decisions involving life sustaining treatment. The conclusion was that there is a duty to consult a patient in relation to DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) unless the clinician thinks that consultation is likely to cause physical or psychological harm to the patient; this is more than just causing distress.

The case, *R (on the application of Tracey) v Cambridge University Hospitals NHS Foundation Trust*, was about consultation obligations specifically in relation to DNACPR decisions.



The Context

A DNACPR decision was placed on a patient's notes without consultation with the patient or family. It was removed 3 days later when the family became aware of it, but was put back in place when a further consultation with the family had taken place. Her family made an application to the High Court (subsequently considered by the Court of Appeal) concerning the decision to place the first DNACPR notice in the medical records, without consultation with the patient or family, to determine whether Article 8 of the European Convention on Human Rights (ECHR) 1950 was engaged, and whether the Trust's policy on the issue of DNACPR decisions was sufficiently clear and precise.

Important points to note are:

- There were two DNACPR decisions, only the first was the subject of complaint;
- At the relevant time the patient, Mrs Tracey, had the capacity to make decisions about her treatment and wanted to be involved in decisions;
- The decision covers issues about both professional practice in relation to individual patients but also about policies and record keeping;
- DNACPR orders are decisions made in advance of the actual need for treatment occurring. It is in that context that the obligation to consult was discussed by the Court. Actual resuscitation will, of course, only arise when the patient almost certainly lacks capacity to make decisions and there is no time to consult. The judgment should not be read as requiring actual treatment in the absence of discussion if the clinical decision is resuscitation is not appropriate.
- The decision does NOT require clinicians to provide treatment they consider to be inappropriate but underlines the patient's potential access to a second opinion.

The Decision

The judgment is based on the application of Article 8 ECHR (right to private and family life). This is important because public bodies, which include all NHS bodies, are required by the Human Rights Act 1998 to act in accordance with the European Convention on Human Rights.

Article 8 requires respect for private and family life. The leading judgment, with which the other two judges agreed, said:



“A decision as to how to pass the closing days and moments of one’s life and how one manages one’s death touches in the most immediate and obvious way a patient’s personal autonomy, integrity, dignity and quality of life”.

Article 8 was held to be engaged whenever a DNACPR order is in contemplation. The Court distinguished DNACPR from other life-saving treatment because DNACPR decisions are taken in advance and therefore present an opportunity for discussion with patients and their family members. Therefore, the decision stops short of saying all life-saving treatment decisions engage Article 8, but clearly there are other situations where the same reasoning could be applied to other types of decision, and Trusts and clinicians need to take note accordingly.

The judgment was that there is a presumption in favour of patient involvement. There need to be convincing reasons not to involve the patient.

If the clinician forms the view that involving the patient is likely to cause physical or psychological harm then it would be inappropriate to involve the patient, but it was said clinicians should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to only cause distress. The Court recognised this can be a difficult decision, and said it would be slow to find such decisions violate Article 8 if conscientiously taken.

However, and importantly, the Court rejected the argument that there was no need to involve the patient if CPR is considered to be futile. It is important for patients to know such an important clinical decision has been made and, further, the patient may want to have a second opinion.

The Court also held that there is no obligation under Article 8 to offer to arrange for a second opinion; especially where a MDT is involved and the whole team take the view a DNACPR order is appropriate. That does not mean a patient cannot ask for a second opinion. On this point regard should be had to professional guidance and the NHS Constitution.

Of importance to Trusts is a suggestion by the Court that merely having a policy on-line and primarily directed to clinicians may not make it sufficiently “accessible” to comply with Article 8. The Court approved of a leaflet the Trust had produced and was distributing to patients entitled “Talking to your doctor about treatments: a guide to patients” that summarised the DNACPR policy, plus some additional patient/family orientated information on the Trust website.

The Court rejected the need for national guidance - what does this mean?

The decision imposes an obligation on clinicians to discuss DNACPR decisions with patients, unless to do so would cause the patient physical or psychological harm. Failure to do so will be a breach of



Article 8 ECHR. That could be a matter of professional misconduct and would mean that the Trust would be acting unlawfully and subject to potential regulatory censure and/or a claim for damages.

There is nothing in the judgment that requires a clinician to force a discussion or explanation on a patient who does not want to engage with the topic, but in that situation it would be important to discuss the matter with the family etc. (subject to confidentiality issues). This is in fact what happened when a second DNACPR decision was made for Mrs Tracey, about which there was no complaint.

The judgment does not directly deal with the position of patients who lack capacity. The Mental Capacity Act 2005 requires decisions for those who lack capacity to be made in the individual's best interests. When deciding best interests a clinician is required to take in to account "if practicable and appropriate to consult them" the views of anyone, amongst others, engaged in caring for the individual or interested in their welfare. If there is no one else to consult then an Independent Mental Capacity Advocate (IMCA) must be appointed and, clearly, the Court considered a DNACPR decision to be one about serious medical treatment.

In other words, if you cannot talk to the patient then talk to the family. Confidentiality may, occasionally, be an issue - but do not let it become an artificial barrier to discussion or, worse, an excuse.

Action required

Clinicians

- Discuss DNACPR issues with patients before making a final decision, if they are willing and able to discuss them.
 - Note: this obligation to discuss is NOT a reason for putting off or failing to consider or make DNACPR decisions in order to avoid a discussion.
- Inform the patient of the final decision and consider offering a second opinion if the decision is to not resuscitate, even though the patient wants resuscitation. If the patient agrees, involve or inform family members. If the patient lacks the capacity to be involved then consult family member or other people concerned with the patient's welfare. If there is no one else to consult, appoint an IMCA.
- Record discussions and decisions in the clinical records, including efforts to discuss that have been declined, and/or reasons for not discussing the issue on the basis of likely harm.



- Note: a significant part of the facts underpinning the judgment relate to the lack of notes to support the clinician's recollection of the circumstances in which the first DNACPR decision was made.
- Complete any form for DNACPR decisions.
 - Note: unless the form itself allows for detailed recording of the process leading to the decision, good clinical notes need to be made in addition to completing the form.

Safeguarding and Article 5 European Convention of Human Rights

*Milton Keynes Council v RR & Ors [2014] EWCOP B19 (District Judge Mort)*¹

Summary

This case concerned an elderly lady with dementia who had been removed from her home by Milton Keynes Council in October 2012 following safeguarding concerns about her welfare, which included bruising to her face, over the previous few months. RR was taken from her home, which she was said to have left 'willingly' and placed in a care home. Her son, SS, was not present at home at the time and was not told for another 19 days where his mother was. There had been no safeguarding investigation into the concerns that had been raised. The council did not seek the Court's authorisation for the removal and placement in the care home. A standard authorisation was sought but not put in place for two weeks after removal.

The council applied to the Court of Protection 15 days after RR was removed from her home, and interim declarations were subsequently made in respect of RR's continued residence at the care home. During the court proceedings, many allegations were made against SS, who denied them. The council subsequently decided not to pursue the allegations. By this stage, it was some 16 months after RR had been removed from her home. The council then determined that it would not fund a package of care at home for RR, and that it would not provide direct payments to RR via SS. The proceedings were resolved by consent, with final declarations that RR lacked capacity to litigate, to decide where to live, and to make decisions about care and contact with others, and that it was in her best interests to reside at the care home and to have contact with SS, substantially in accordance with the general rules on visiting that the care home operated for all families. Thus, a declaration was granted that RR was unlawfully deprived of her liberty when she was removed from her home, and until the standard authorisation was granted. There was also a breach of RR's Article 8 rights



consequent upon her removal from her home. The Council was to send written apologies to RR and SS.

Comment

This case is another illustration of the failure to have embedded the MCA and the Deprivation of Liberty Safeguards into everyday practice that was identified by the House of Lords Select Committee. It is surprising that in late 2012, a local authority was not aware of the need to obtain advance authorisation for the removal of an incapacitated adult from their home, and alarming that safeguarding incidents were not investigated swiftly (or at all) despite RR's obvious vulnerability to harm. The declarations and apology do not appear likely to have much meaning to RR, given her advanced cognitive impairment, but the Court's decision on costs (yet to be handed down) and the naming of the council in this judgment may assist in reinforcing the need to pay attention to the requirements of the MCA.

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