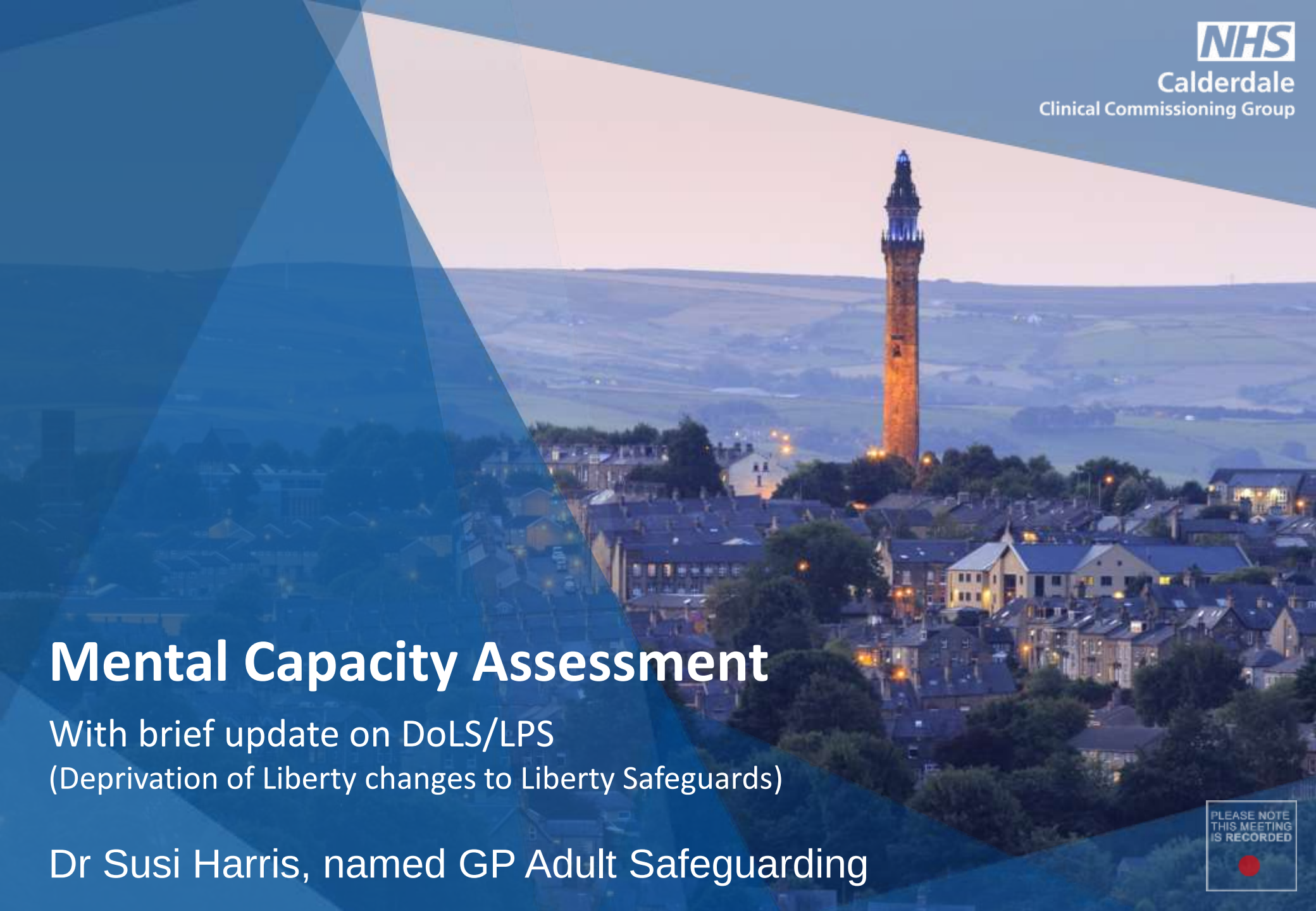

NHS
Calderdale
Clinical Commissioning Group

Mental Capacity Assessment

With brief update on DoLS/LPS
(Deprivation of Liberty changes to Liberty Safeguards)

Dr Susi Harris, named GP Adult Safeguarding

PLEASE NOTE
THIS MEETING
IS RECORDED

Mental capacity assessment – traditional teaching

1. Is there an impairment of mind or brain? (What is it?)

If so, you can continue to second part

2. Assess capacity: The familiar 4 functional tests:

- **Understand** the information
- **Retain** info (for long enough to make decision)
- **Weigh up** pros and cons
- **Communicate** decision

Mental Capacity Act – in real life!

These 2 stages are reversed:

- We see they are struggling to make decision

1. Do the functional assessment **first** - **assume capacity (1)** and **try everything to facilitate (2)** understanding, recall, evaluation and communication of decision

- If all the functional competences are intact then they have capcity to make an **unwise decision – doesn't mean lack capacity (3).** **Arises from their own value system.**

2. If sure of functional difficulty, **then establish diagnosis** causing impairment of mind or brain (which is causing the difficulty)

MCA principles 4 and 5

- Make **Best Interest decision** on patient's behalf (4)
- Enacting decision in **least restrictive** way possible (5)

A. Mental Capacity Assessment applies **one decision at a time**

Decision-specific

- Stop saying: “He has capacity”
- Start saying: “He has capacity ***to make this decision”***

B. Capacity applies **at the time** the decision needs to be made

Time –specific

- Eg just had stroke, impaired swallow, poor nutrition - decision re NG or PEG feeding needs to be made
- Unable to communicate despite every effort to facilitate
- Later on may recover sufficiently to communicate decision
- "He lacks capacity to make this decision ***at this time***"

c. Establish **reason** they cannot make decision and **make the link with the functional impairment**

What is the impairment of mind or brain?

- Can be a working/*probable* diagnosis based on history and your clinical findings
- *Probable* means 51% or more

- Essential to **link** the diagnosis to the functional impairment –eg:
  - Can't retain information ***due to*** dementia
  - Can't weigh up information ***due to*** learning difficulty
  - Can't communicate ***due to*** stroke

4 parts to a full mental capacity statement:

"He lacks capacity ….

1. ..to make ***this*** decision…
2. …at ***this*** time…
3. ***..because*** he is unable to understand/retain/weigh up the information (the functional impairment)….
4. ***…because*** of probable dementia" (the diagnosis causing impairment of mind or brain).

(Mnemonic: wizard of Oz ☺)

Because, because…

What is the **relevant information**?

Enables them to:

- Understand **what** the decision is
- Understand **why** it needs to be made;
- Understand the range of choices available to them; **(what else?)**
- Understand the likely consequences of making or not making a decision. Both pros and cons **(what then?)**

Relevant info for C-19 vaccinations

What is information needed to make decision?

- It will involve 2 injections and it's important to attend for both
- Still need to follow social distancing/hand washing/face covering guidance x2 wks
- Advisable to continue hands/face/space even after 2 wks as risk onward transmission
- Dispel myths – eg cannot catch Covid from vaccination

Why do I need to make this decision?

- Need to make this decision because the vaccination will help to protect from both catching and also getting seriously ill from COVID-19
  - (add vaccination-specific information on degree of protection)
- **Why me?** Add personal risks as needed – eg: "You are particularly vulnerable due to medical conditions, demographic factors, occupation" etc
- **Why now?** Factor in Environmental risk – eg: "because the pandemic is increasing at the moment in this area"

‘Relevant info’ for C-19 vacc: Pros/cons

What are disadvantages?

- Risk of side effects – mild and severe as per PIL
- (NB no need to overcomplicate this – standard is ‘within pt’s level of understanding’)
- dispel myths as needed eg can’t catch C-19 from vaccine etc

What happens if I reject vaccination?

Pros

– no side effects!

Cons

– greater risk of catching Covid

- greater risk of severe illness and even death
- greater risk of passing to someone else

NB:- document everything!

Who is responsible for the capacity assessment?

- The person who is going to enact the decision
- If you use another person's assessment you must satisfy yourself

  a) the patient still lacks capacity

  b) the decision is in their best interests.

Case study – Elderly gent in nursing home with dementia, profoundly deaf.

- Check with everyone that knows them well what is best time of day for this patient. Mornings
- Who would be best to discuss with patient – avoid males!
- What is best method of communication profoundly deaf – R ear is best, + whiteboard
- Check medication – anything that might impair cognition? (eg for agitation) could withhold
- Avoid doing after meals
- Review understanding 15 mins later unable to recall conversation at all

Concluded:

- no capacity to make this decision
- as unable to retain information
- due to dementia

Documented

- Information given
- All measures taken to facilitate communication and understanding
- Patient response

If “doesn’t have capacity”

(vaccination example)

Is it their decision?

Check for possible ***coercion or control***

Eg Gillick competent child doesn’t want vaccination but parent wants them to have it – or vice versa

Check for ***Alternative legal consent:***

a) Have they made an **Advance Decision to Refuse** this specific Treatment/Action? (For C-19 vaccination - did they make the ADRT before or after pandemic started?)

b) Is someone appointed as **Lasting Power of Attorney** (**LPA)** for Health and Welfare?

- *If yes, then they are decision-maker as a rule)*
- *But NB not LPA for finance*
- *And must be registered with Office of the Public Guardian (OPG)*

"Lacks Capacity" (continued with vaccination example)

Make a Best Interests decision (4)

- Any act done for a person who lacks capacity must be done in their **best interests;**
- Take into account not only benefits to their health, but also….
- T**heir own values** - ***"what they would have wanted"*** vaccination example – did they come regularly for vaccinations in past? Did they try to protect others from becoming unwell?)
- Consult widely with all the people that know them to agree best interests NB this is not "what the family wants for them" (eg antivaxxer son, had LPA but was acting in his interests not mum's)
- **If there is no agreement, you can't make a best interests decision**
- will have to go to Court of Protection to decide – **Seek CCG Support at this point -** Designated professional for Adult Safeguarding (Luke Turnbull)

Enact decision in Least restrictive possible way (5)

- Before the act is done, you MUST consider whether the purpose for which it is needed can be as effectively achieved in a way that is **less restrictive** of the person's rights and freedom of action.
- Any restriction must be **proportional to the benefits** of the proposed treatment/action
- (for vaccination, restraint may be acceptable but may be deemed disproportionately harmful – **recommended to seek advice from CCG**

Making your assessment robust

- Always start by presuming capacity
  - **You have to prove they don't** have capacity, **they don't have to prove** they do
- Do not treat as unable to make a decision unless **all practicable steps to help them** to do so have been taken without success;
- Consider if **coercion or control** could be involved
- **Check** for ADRT or LPA
  - NB ensure LPA is
    - valid (registered with OPG)
    - For Health and Welfare (not Finance)
- Do not treat as unable to make a decision merely because they make an **unwise decision;**
- If not capacitous **hold best interests meeting** and agree on decision – do not proceed without agreement of all concerned.
- **Document everything! Info, practicable steps, alternative legal consent yes/no, best interests meeting etc.**

Last aspect of capacity to consider: ***Executive function***

- Importance in capacity assessment recently recognised
- Not easy to assess – executive dysfunction tends to emerge over time
- Patient may have seemed to be able to make the decision but **unable to execute** the decision/allow it to be executed
- Typically: difficulty planning, organising, initiating, prioritising, focusing on and completing tasks
- Various causes, eg:
  - alcohol (confabulation)
  - ASD/ADHD (time blindness/distractibiity)
  - dementia (memory loss)

Executive dysfunction in self neglect

Self neglect common situation in which 'hidden' executive dysfunction may be revealed

- Eg know its important to take medication/eat and drink/keep clean and decide to do so but when the time comes, they don't enact
- REPEATEDLY REFUSE SERVICES

Professional conflict between

Duty of care to patient *and others,*

vs

respect for autonomy

when person *seems to have capacity*

- *But do they?*
- Question: **are they sufficiently in control to protect self/others from harm? Can they show you?**
- If not they may be deemed to lack capacity through executive dysfunction

Testing for executive dysfunction

- TAKES TIME –
- Executive dysfunction is demonstrated through what they DO, not what they SAY
- Difficult to determine when they have crossed the line
  - Keep repeating **capacity assessments – in depth**
  - Ask them to **demonstrate** understanding
  - Sometimes self neglect may indicate a need for a **Trauma informed approach**
  - (see youtube.com/watch?v=fhmfptpwNZc)

If still unsure, MDT decision

  - Call professionals meeting (eg social care, health, housing, fire services)
  - Agree if they are at risk to self/others
  - Agree actions to facilitate behaviour change
  - **Seek CCG advice** if tried everything and MDT agrees **significant risk to self/others**

DoLS and LPS - update

- More streamlined process
- Implementation date April ‘22
- CCGs, LAs and Trusts will be “Responsible Bodies”
- Applies in any setting (DoLS was just care home and hospitals and CoP application required for other settings)
- Applies to 16-17 yr olds (currently 18+)
- Awaiting Code of Practice and Regulations
- **GP will be asked to confirm diagnosis**
- Training will be provided following Code of Practice

Thank you!

Questions?