Mental Capacity in Elderly

Dr K K Shankar
Consultant Old Age Psychiatrist

Steven Neary a reflection on DoLS a lesson for AMCP

- Steven's case London Borough of Hillingdon v Neary [2011] became such a landmark decision it needs to be essential reading for everyone involved in DoLS or LPS. Mark Neary's comments feature on his son in Ch 2 Court of Protection Handbook (2019) – a reflection on the "good, bad and complete madness of the Mental Capacity Act"

Interface Safeguarding & MCA

- Analysis of Report on 27 SARs in London
- There are “fundamental flaws” in how MCA is understood & applied in practice
- Mental capacity raised in 21 of 27 reports: Missing or poor capacity assessments, absence of best interest decision making
- Lessons learnt are rarely confined to isolated poor practice of practioners

-*Braye & Preston-Shool* 2017

Sequence of events

- MHA 1983
- Common law
- Bournewood 1997

"The Bournewood Case"

HL v UK v ECHR (2004)

- Harry admitted to Bournewood Hospital July 1997
- Discharged back to his carers in December 1997 following Court of Appeal ruling
- The Enderbys took the case to The European Court of Human Rights to stop arbitrary detentions of people like Harry who lacked capacity to consent
- The ECHR ruled that Harry's Article 5 rights had been violated

Sequence of events

- MHA 1983
- Common law
- Bournewood 1997
- MCA 2005 (2007)
  - -DoLs
  - -IMCA
  - -LPA rather than EPA

Definition

The Mental Capacity Act says that a person lacks capacity to make a decision if they have an 'impairment of or disturbance in the function of their mind or brain' (either temporary or permanent), and as a result they cannot do **one or more** of the following:

-**Understand** the information relating to this particular decision (including its benefits and risks)
-**Retain** the information for long enough to make this decision
-**Weigh up** the information involved in making this decision
-**Communicate** their decision in any way.

DoLS Assessments

The six assessments needed in order to satisfy the requirements of the MCA DOLS, and usually completed in the following order, are:

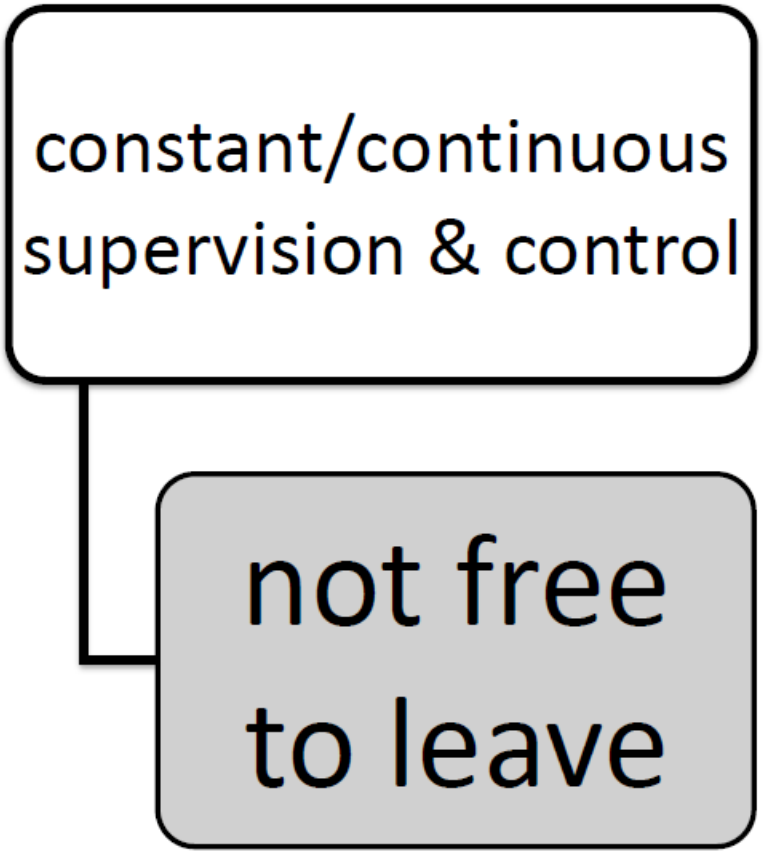
Age assessment
No refusals assessment
Mental capacity assessment
Mental health assessment
Eligibility assessment
Best interests assessment.

Sequence of events

- MHA 1983
- Common law
- Bournewood 1997
- MCA 2005 (2007)
  - -DoLs
  - -IMCA
  - -LPA rather than EPA
- Supreme court judgement in march 2014 “acid Test”

The acid test

P v Cheshire West & Chester Council, P & Q v Surrey CC [2014] UKSC 19



with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

- What does continuous supervision and restriction mean?
- Can patient in a domestic setting have a DoL?
- Huge increase in DoLs request
- Conflict between MHA/DoLS

DoLS figures 2018/19

- 240,455 applications made, relating to 200,225 people
- No. of applications completed was 216,005
- No. of uncompleted DoLS applications was 131,350
- The gap between applications made and applications completed has narrowed to 10.2%
- Proportion of completed applications not granted was 45.9% (main reason change in circumstances)
- 22% of applications completed within statutory timeframe of 21 days
- Average for completed applications was 147 days

Sequence of events

- MHA 1983
- Common law
- Bournewood 1997
- MCA 2005 (2007)
  - -DoLs
  - -IMCA
  - -LPA rather than EPA
- Supreme court judgement in march 2014 “acid Test”
- Mental Capacity Amendment act (?2020)

- DoLs replaced by LPS

Liberty Protection Safeguards – in one slide!

- Setting neutral (eg can cover domestic settings)
- Portable - can apply to multiple arrangements
- Includes 16/17 year olds
- Responsible body is NHS for NHS hospitals & CHC, local authority for all other cases (eg self-funders)
- 3 assessments: capacity, medical and necessary & proportionate
- Additional scrutiny by AMCP in "objection" cases
- Rights to IMCA or appropriate person
- Revised role for Court of Protection

The Liberty Protection Safeguard process

Assessments

- Responsible Body(RB): NHS Trust, CCG's, Local Authority (LA's), Health Board (Wales)
- Statutory responsibility to organise & authorise LPS assessments:
- Mental capacity assessment- consent to arrangements
- Mental disorder assessment, as per Sec 1(2) of MHA 1983
- Arrangements are necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of harm to the person

- Are they objecting? If yes, an AMCP must be requested

Pre-Authorisation Review

- RB reviews information to determine whether it is reasonable to conclude the criteria are met
- Carried out by person not directly involved in day to day care or by an AMCP
- RB decides who conducts the pre authorisation review

Authorisation

- RB is satisfied that any duty to apply for an appropriate person or IMCA has been complied with
- RB authorises the LPS if it is satisfied the criteria is met & a satisfactory pre-authorisation review has taken place
- RB publishes & provides information about the authorisation to patient within 72 hours
- If not, RB must review & record why not

A New definition for DoL

A person **is not deprived** of their liberty if

1. the person is free to leave that place permanently OR

2. The person is not subject to continuous supervision AND is free to leave the place temporarily (even if subject to supervision)OR

3. The arrangements…are in place in order to give medical treatment and they are the same as anyone else receiving that treatment

NB A person is free to leave even if they are unable to leave …but would be enabled to leave if they expressed a wish to

A New Definition of DoL

A person **is deprived** of their liberty if…

1. They are confined to a place for more than a negligible period of time and

2. They have not given valid consent to the confinement and

3. The arrangements….are due to an action by a person/ body responsible to the state

NB A person is subject to confinement if…

They are prevented from leaving permanently where they are required to reside AND

They are subject to continuous supervision and control

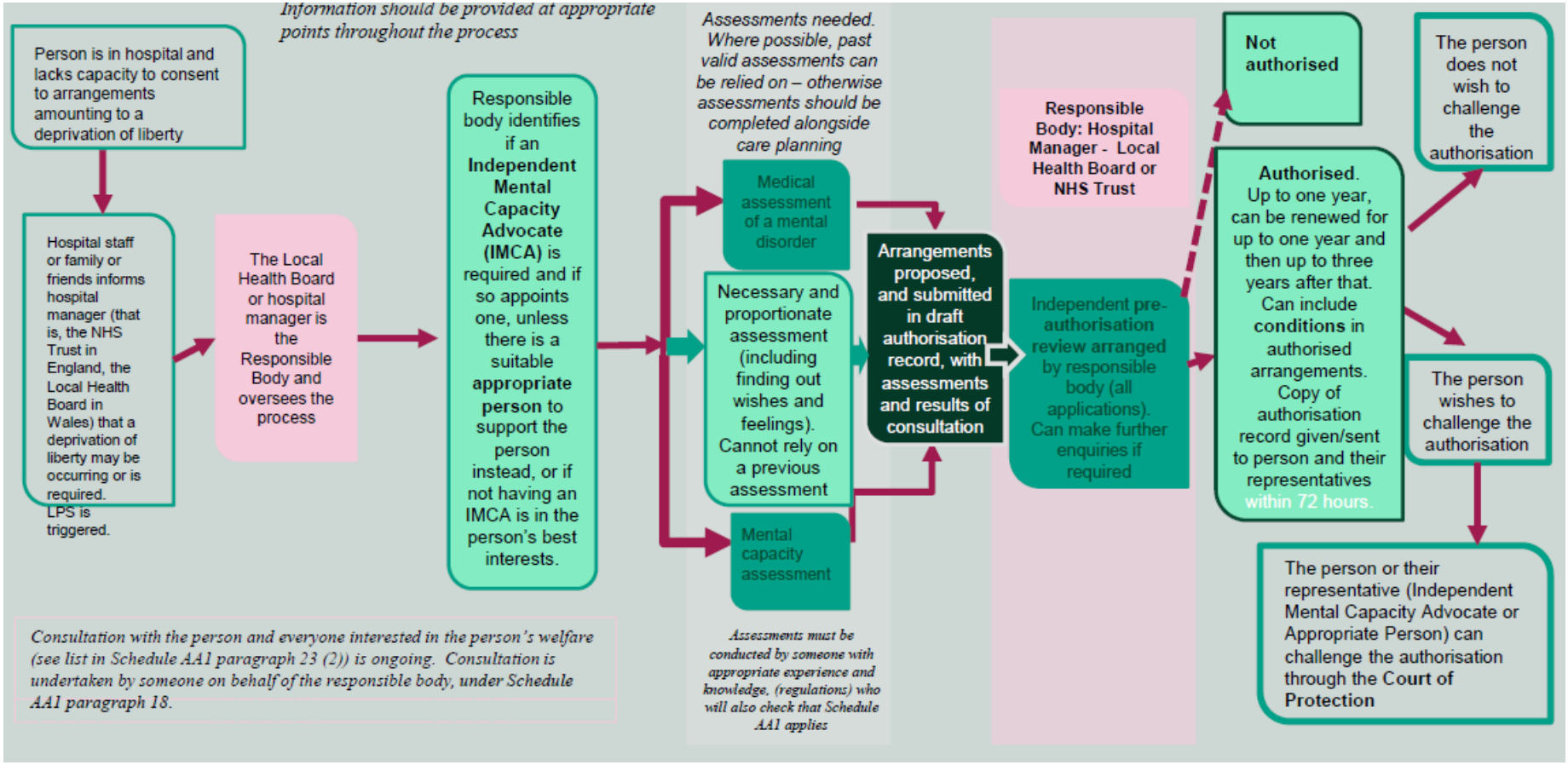
A current definition for DoL

A person is deprived of liberty if…

1. They lack capacity to consent to the arrangements And

2. They are subject to continuous supervision and control and

3. They are not free to leave


Information should be provided at appropriate points throughout the process
Person is in hospital and lacks capacity to consent to arrangements amounting to a deprivation of liberty
Hospital staff or family or friends informs hospital manager (that is, the NHS Trust in England, the Local Health Board in Wales) that a deprivation of liberty may be occurring or is required. LPS is triggered.
The Local Health Board or hospital manager is the Responsible Body and oversees the process
Responsible body identifies if an Independent Mental Capacity Advocate (IMCA) is required and if so appoints one, unless there is a suitable appropriate person to support the person instead, or if not having an IMCA is in the person's best interests.
Assessments needed. Where possible, past valid assessments can be relied on – otherwise assessments should be completed alongside care planning
Medical assessment of a mental disorder
Necessary and proportionate assessment (including finding out wishes and feelings). Cannot rely on a previous assessment
Mental capacity assessment
Assessments must be conducted by someone with appropriate experience and knowledge, (regulations) who will also check that Schedule AA1 applies
Arrangements proposed, and submitted in draft authorisation record, with assessments and results of consultation
Responsible Body: Hospital Manager - Local Health Board or NHS Trust
Independent pre-authorisation review arranged by responsible body (all applications). Can make further enquiries if required
Not authorised
Authorised. Up to one year, can be renewed for up to one year and then up to three years after that. Can include conditions in authorised arrangements. Copy of authorisation record given/sent to person and their representatives within 72 hours.
The person does not wish to challenge the authorisation
The person wishes to challenge the authorisation
The person or their representative (Independent Mental Capacity Advocate or Appropriate Person) can challenge the authorisation through the Court of Protection
Consultation with the person and everyone interested in the person's welfare (see list in Schedule AA1 paragraph 23 (2)) is ongoing. Consultation is undertaken by someone on behalf of the responsible body, under Schedule AA1 paragraph 18.

Process of planned Hospital Admission

- GP contacts the admitting consultant
- Consultant/ team contacts hospital managers (RB) for authorisation
- RB appoints IMCA or Appropriate person
- RB commissions Medical/ mental capacity/ necessary &proportionate assessment(NPA)
- NPA accessor refers to RB
- RB refers to Pre Authorisation Reviewer (PAR)
- PAR refers back to RB or to AMCP
- AMCP back to RB
- The Hospital admission!! *Finally*

Definition

The Mental Capacity Act says that a person lacks capacity to make a decision if they have an 'impairment of or disturbance in the function of their mind or brain' (either temporary or permanent), and as a result they cannot do **one or more** of the following:

-**Understand** the information relating to this particular decision (including its benefits and risks)
-**Retain** the information for long enough to make this decision

-**Weigh up** the information involved in making this decision

-**Communicate** their decision in any way.

Assessing capacity

Anyone assessing someone's capacity to make a decision for themselves should use the two-stage test of capacity.

• Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)

• If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Assessing ability to make a decision

• Does the person have a general understanding of what decision they need to make and why they need to make it?

• Does the person have a general understanding of the likely consequences of making, or not making, this decision?

• Is the person able to understand, retain, use and weigh up the information relevant to this decision?

• Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?

Assessing capacity to make more complex or serious decisions

• Is there a need for a more thorough assessment (perhaps by involving a doctor or other professional expert)?

Case Scenario 1

- 76 y old lady recently diagnosed with Alzheimer's disease. Became friendly with 81 year old man.
- 4 children 2sons and 2 daughters
- Apart from 1 son rest against relationship.
- Daughter was the main carer and overseeing her finances.
- Her friend meets her once a week and takes her to the restaurant. He gave her the wrong medication to her once.
- On my assessment patient clearly verbalised that her daughter is not happy with the relationship but she likes the company and the cuddle.

Decisions concerning family relationships (section 27)
Nothing in the Act permits a decision to be made on someone else's behalf on any of the following matters:
Mental Capacity Act Code of Practice

- consenting to marriage or a civil partnership
- consenting to have sexual relations
- consenting to a decree of divorce on the basis of two years' separation
- consenting to the dissolution of a civil partnership
- consenting to a child being placed for adoption or the making of an adoption order
- discharging parental responsibility for a child in matters not relating to the child's property, or
- giving consent under the Human Fertilisation and Embryology Act 1990.

Decisions concerning family relationships (section 27)
Nothing in the Act permits a decision to be made on someone else's behalf on any of the following matters:
Mental Capacity Act Code of Practice

- consenting to marriage or a civil partnership
- consenting to have sexual relations
- consenting to a decree of divorce on the basis of two years' separation
- consenting to the dissolution of a civil partnership
- consenting to a child being placed for adoption or the making of an adoption order
- discharging parental responsibility for a child in matters not relating to the child's property, or
- giving consent under the Human Fertilisation and Embryology Act 1990.

HOWEVER,

Although the Act does not allow anyone to make a decision about these matters on behalf of someone who lacks capacity to make such a decision for themselves (for example, consenting to have sexual relations), this does not prevent action being taken to protect a vulnerable person from abuse or exploitation.

Mental Health Act matters (section 28)

Where a person who lacks capacity to consent is currently detained and being treated under Part 4 of the Mental Health Act 1983, nothing in the Act authorises anyone to:

- give the person treatment for mental disorder, or
- consent to the person being given treatment for mental disorder.

Further guidance is given in chapter 13 of the Code.

Voting rights (section 29)

Nothing in the Act permits a decision on voting, at an election for any public office or at a referendum, to be made on behalf of a person who lacks capacity to vote.

Unlawful killing or assisting suicide (section 62)

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

The five statutory principles

1. A person must be **assumed to have capacity** unless it is established that they lack capacity. (DECISION SPECIFIC)

2. A person is not to be treated as unable to make a decision unless all practicable steps to **help** him to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he makes an **unwise decision**.

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his **best interests**.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is **<u>less restrictive</u>** of the person's rights and freedom of action.

Mental Capacity Act 2005 – 5 principles

1. A presumption of capacity
2. Individuals supported to make their own decision
3. Unwise decisions
4. Best interests
5. Less restrictive option

After Shropshire Council

Scenario: Taking steps to help people make decisions for themselves

Mr Jackson is brought into hospital following a traffic accident. He is conscious but in shock. He cannot speak and is clearly in distress, making noises and gestures.

From his behaviour, hospital staff conclude that Mr Jackson currently lacks the capacity to make decisions about treatment for his injuries, and they give him urgent treatment. They hope that after he has recovered from the shock they can use an advocate to help explain things to him.

However, one of the nurses thinks she recognises some of his gestures as sign language, and tries signing to him. Mr Jackson immediately becomes calmer, and the doctors realise that he can communicate in sign language. He can also answer some written questions about his injuries.

The hospital brings in a qualified sign-language interpreter and concludes that Mr Jackson has the capacity to make decisions about any further treatment.

Is communication support different from Support to make the decision

DE Vs NHS Trust EWHC 2562….COURT OF PROTECTION

- A Trust applied to CoP for various decisions for DE who was 37, IQ of 40 and a mental age of 6 to 9. He had LD, was profoundly mentally impaired; non verbal; lived with his parents.
- He was supported extensively and positively over 15 years, to learn the skills, travel alone on the bus; go to shops; attend a leisure centre; swim etc. He had a girl friend. A good life.
- Then she got pregnant. Safeguarding involved. Stopped from travelling alone. Supervised for everything. Assessed as not having capacity to sexual relationship. Loss of freedom and skills and most of his autonomy.

DE Vs NHS Trust EWHC 2562….COURT OF PROTECTION

- The court heard that he may be able to “gain capacity” to make decisions about sexual relationships, could be taught to understand consent and could resume his relationship and previous freedoms. Court orderd that it is tried.
- A nurse and a psychologist were commissioned to work with him. It took **twelve one hour sessions** over a 2 month period for capacity to be sufficiently increased for him to get back his freedom.

Interventions to help them make decisions

- **Spend time** in explaining why a decision needs to be made (eg carer support)
- Talk about options and what it entails
- Assist in developing “weighing up” skills
- Identify ways to communicate
- Involve Family/ trusted friend

May need to involve (especially if treatment involves significant risk)

- Advocate, Speech and language therapist, clinical psychologist, Psychiatrist, CoP- if no agreement is reached.

The kind of support people might need to help them make a decision varies. It depends on personal circumstances, the kind of decision that has to be made and the time available to make the decision. It might include:

- using a different form of communication (for example, non-verbal communication)
- providing information in a more accessible form (for example, photographs, drawings, or tapes)
- treating a medical condition which may be affecting the person's capacity or
- having a structured programme to improve a person's capacity to make particular decisions (for example, helping a person with learning disabilities to learn new skills).

Anyone supporting a person who may lack capacity **should not use excessive persuasion or 'undue pressure'.**[1] This might include behaving in a manner which is overbearing or dominating, or seeking to infl uence the person's decision, and could push a person into making a decision they might not otherwise have made. However, it is important to provide appropriate advice and information.

- MCA CODE OF PRACTICE

To help someone make a decision for themselves, check the following points:

Providing relevant information

• Does the person have all the relevant information they need to make a particular decision?

• If they have a choice, have they been given information on all the alternatives?

Communicating in an appropriate way

• Could information be explained or presented in a way that is easier for the person to understand (for example, by using simple language or visual aids)?

• Have different methods of communication been explored if required, including non-verbal communication?

• Could anyone else help with communication (for example, a family member, support worker, interpreter, speech and language therapist or advocate)?

Making the person feel at ease

• Are there particular times of day when the person's understanding is better?

• Are there particular locations where they may feel more at ease?

• Could the decision be put off to see whether the person can make the decision at a later time when circumstances are right for them?

Supporting the person

• Can anyone else help or support the person to make choices or express a view?

- MCA CODE OF PRACTICE

Principle 3 Unwise decision

- 67 year old man with mild LD living with his wife who had mental health problem. When wife was admitted to hospital for her illness he left home (? Abuse from neighbours) and booked himself in the local hotel.
- When his money ran out he took an O/D of tablets and was seen in the A&E. Seen by the RAID team sent back to hotel with Crisis team follow up.He was not keen to engage.
- He threatened to take another O/D if evicted from the hotel. Again taken to A&E. Again seen by a different consultant to whom he said he will not take an O/d if he is sent to a hospital or a nursing home. No mental illness.
- Social worker argues that as he threatened O/D there is a mental health problem and needs admission.

Interest Vs Best Interest

- There can be a tension/ confusion between supporting the interests of those who have capacity and safeguarding the best interest of those who don't.
- We should always strive to promote a persons "interest" however our duty is to act in a persons "best interest"
- Where there is a conflict- under MCA- "best interest" trumps
- "Best Interests are personal"

Interest Vs Best Interest

- The difference is the “Risk”
- Risk has two factors:
- **Likelihood**- How likely is it that something will happen if we do nothing
- **Seriousness** – how serious will that outcome be?

Likelihood is an *objective judgement* on the part of assessor

Seriousness is *subjective judgement* from the person who has to live with the risk

Interest Vs Best Interest

- The same risk may be acceptable to one person and unacceptable to another
- People who are risk averse overestimate the likelihood and also the seriousness
- People who are risk-blind or risk deniers underestimate the seriousness and usually also the likelihood

Case scenario

76 year old lady, living in a supported accommodation, increasingly paranoid over building workers. Travelled to Ipswich to meet her friend and decided to sleep rough. Admitted under section of MHA to the local hospital. Refused to go back to her supported accommodation. Diagnosed with early dementia. After a month discharged back home with no support.

She was shouting at the warden, Gp visited refused to engage with him. Crisis team involved. Screaming and shouting at them.

Warden wanted her admitted as she may travel again. Ambulance crew concerned that she has no food and weekend is coming on.

Case Scenario

- 81 year old lady with a previous history of dementia, not developed a degree of cognitive impairment. Lives alone, nephew in Scotland.
- Started to stay upstairs in the bedroom. After efforts by friend, CPN, OT agreed to have carers (paid by direct debit)
- Stays in her bed reading her books accepts care, takes herself to the toilet. Unclear of her personal hygiene but not smelly
- Heating system broke down. Not willing to pay for new boiler
- Seen by the paramedics who wanted to admit her due to risk of Hypothermia. They raised safe guarding and discussed she should be admitted under the MHA.
- Team bought her an oil heater. She stayed at home for further 7 months!!

Finding a less restrictive option- may need to be creative

Common GP scenarios

Financial issues

- LPA
- COP3 Form
- Testamentary capacity

Treatment issues

- Covert medication
- Consent to treatment

Accommodation issues

- Transfer to hospital
- Moving to a nursing home

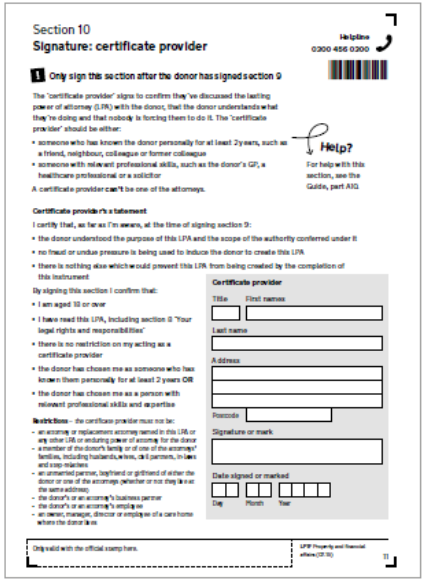
LPA - LASTING POWER OF ATTORNEY

Part A10 – signature: certificate provider

Fill in section 10

The certificate provider must sign **after** the donor but **before** the attorneys.

The certificate provider must read LPA sections 8 and 10 before they sign your LPA. They can then fill in their name and address, and sign and date section 10.



Section 10
Signature: certificate provider

Helpline
0300 456 0300

1 Only sign this section after the donor has signed section 9

The 'certificate provider' signs to confirm they've discussed the lasting power of attorney (LPA) with the donor, that the donor understands what they're doing and that nobody is forcing them to do it. The 'certificate provider' should be either:

- someone who has known the donor personally for at least 2 years, such as a friend, neighbour, colleague or former colleague
- someone with relevant professional skills, such as the donor's GP, a healthcare professional or a solicitor

A certificate provider **can't** be one of the attorneys.

Help?
For help with this section, see the Guide, part A10.

Certificate provider's statement

I certify that, as far as I'm aware, at the time of signing section 9:

- the donor understood the purpose of this LPA and the scope of the authority conferred under it
- no fraud or undue pressure is being used to induce the donor to create this LPA
- there is nothing else which would prevent this LPA from being created by the completion of this instrument

By signing this section I confirm that:

- I am aged 18 or over
- I have read this LPA, including section 8 'Your legal rights and responsibilities'
- there is no restriction on my acting as a certificate provider
- the donor has chosen me as someone who has known them personally for at least 2 years **OR**
- the donor has chosen me as a person with relevant professional skills and expertise

Restrictions – the certificate provider must not be:

- an attorney or replacement attorney named in this LPA or any other LPA or enduring power of attorney for the donor
- a member of the donor's family or of one of the attorneys' families, including husbands, wives, civil partners, in-laws and step-relatives
- an unmarried partner, boyfriend or girlfriend of either the donor or one of the attorneys, whether or not they live at the same address
- the donor's or an attorney's business partner
- the donor's or an attorney's employer
- an owner, manager, director or employee of a care home where the donor lives

Certificate provider

Title | First names

Last name

Address

Postcode

Signature or mark

Date signed or marked

Day | Month | Year

Only valid with the official stamp here.

LPTF Property and financial affairs (07.15)

11

Now that you are getting more forgetful,
who do you think is the best person to look after your finances?/
who do you think will be the best person to make decisions on your health?

Certificate provider's statement

I certify that, as far as I'm aware, at the time of signing section 9:

- the donor understood the purpose of this LPA and the scope of the authority conferred under it
- no fraud or undue pressure is being used to induce the donor to create this LPA
- there is nothing else which would prevent this LPA from being created by the completion of this instrument

By signing this section I confirm that:

- I am aged 18 or over
- I have read this LPA, including section 8 'Your legal rights and responsibilities'
- there is no restriction on my acting as a certificate provider
- the donor has chosen me as someone who has known them personally for at least 2 years **OR**
- the donor has chosen me as a person with relevant professional skills and expertise

Restrictions – the certificate provider must not be:

- an attorney or replacement attorney named in this LPA or any other LPA or enduring power of attorney for the donor
- a member of the donor's family or of one of the attorneys' families, including husbands, wives, civil partners, in-laws and step-relatives
- an unmarried partner, boyfriend or girlfriend of either the donor or one of the attorneys (whether or not they live at the same address)
- the donor's or an attorney's business partner
- the donor's or an attorney's employee
- an owner, manager, director or employee of a care home where the donor lives

Certificate provider

Title

First names

Last name

Address

Postcode

Signature or mark

Date signed or marked

Day Month Year

Those who don’t have LPA

- An **appointee** is a person who has been chosen by the Department of Work and Pensions (DWP) or local authority to receive welfare benefits on behalf of someone.
- A **Deputyship** works **in the** same way as an Appointeeship but offers the additional protection of the client's assets, savings or property. **Deputies** are usually close relatives or friends of the person who needs help making decisions. This is through Court of Protection

Used when there is no LPA and the patient has lost capacity

COP 3 12.17

Court of Protection

Assessment of capacity

For office use only
Date received
Case no.

Full name of person to whom the application relates
(this is the name of the person who lacks, or is alleged to lack, capacity)

Please read first

- If you are applying to start proceedings with the court you must file this form with your COP1 application form. The assessment must contain current information.
- You must complete Part A of this form.
- You then need to provide the form with Part A completed to the practitioner who will complete Part B. The practitioner will return the form to you or your solicitor for filing with the court.
- The practitioner may be a registered:
  - medical practitioner, for example the GP of the person to whom the application relates;
  - psychiatrist
  - approved mental health professional
  - social worker
  - psychologist
  - nurse, or
  - occupational therapist

  who has examined and assessed the capacity of
- When the form has been completed, its contents will be confidential to the court and those authorised by the court to see it, such as parties to the proceedings.
- Please continue on a separate sheet of paper if you need more space to answer a question. Write your name, the name and date of birth of the person to whom the application relates, and number of the question you are answering on each separate sheet.
- There are additional guidance notes at the end of this form.
- If you need help completing this form please check the website, www.gov.uk/court-of-protection, for further guidance or information, or contact Court Enquiry Service on 0300 456 4600 or courtofprotectionenquiries@hmcts.gsi.gov.uk
- Court of Protection staff cannot give legal advice. If you need legal advice please contact a solicitor.

Testamentary capacity
“Making a Will”

The person:

- Understands that the Will deals with the distribution of their property on their death
- Understands and recollects what is the extent of the property
- Understands if there are any people who could have a moral claim to their property
- Is not suffering from a disorder of the mind or 'insane delusions‘ **DOCUMENT VERBATIM**

Case scenario

- Dr in A&E wishes to obtain a blood sample from a dementia patient, who is awaiting surgery for fractured neck of femur. Doctor tries to explain the reason but patient shrugs and says that at her life time she does not want to be “pulled about” and is much happier to be left alone what ever is consequences.
- The patient an a few hours later looses her consciousness and a suspicion of internal bleed.

Consent to Treatment

- Essential elements of Consent

  Capacity, Information, Voluntariness

- Moral basis of Consent

  Non-Maleficence, Beneficence, respect for Autonomy

- When capacity is lost and no valid consent if obtainable- “best interest”, Consultation with LPA, IMCA and in line with advanced directives

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 Need for consent

The intention of this regulation is to make sure that all people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided. Providers must make sure that they obtain the consent lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment that they are asking consent for.

Consent is an important aspect of providing care and treatment, but in some cases, acting strictly in accordance with consent will mean that some of the other regulations cannot be met. For example, this might apply with regard to nutrition and person-centred care. However, providers must not provide unsafe or inappropriate care just because someone has consented to care or treatment that would be unsafe. See the glossary for the definition of 'relevant person' in relation to Regulation 11.

CQC can prosecute for a breach of this regulation or a breach of part of the regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action. See the offences section for more detail.

CQC must refuse registration if providers cannot satisfy us that they can and will continue to comply with this regulation.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11

11.—

1. Care and treatment of service users must only be provided with the consent of the relevant person.
2. Paragraph (1) is subject to paragraphs (3) and (4).
3. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*.
4. But if Part 4 or 4A of the 1983 Act** applies to a service user, the registered person must act in accordance with the provisions of that Act.
5. Nothing in this regulation affects the operation of section 5 of the 2005 Act*, as read with section 6 of that Act (acts in connection with care or treatment).

* Mental Capacity Act 2005

** Mental Health Act 1983

comply with this regulation.

Advanced directives(AD)/ Advance decision to refuse treatment (ADRT)

- “living Will” is a statement of preferences as patient’s wishes should capacity lost in future (DNR, ANH)
- For ADRT to be valid, an individual must be an adult over 18, competent at the time, must specify the treatment refused and circumstances in which refusal is to apply
- Dealing with the life-sustaining treatment must be written, signed and witnesses and include a statement that the decision applies even if life is at risk
- Doesn’t apply to Mental health Act, Basic care: provision of food, water, shelter, analgesics

Case scenario

- An 83 year old man, who has suffered from parkinsonism for 18 years, now experiencing on-off periods, speech and swallowing difficulty and cognitive impairment. He was admitted for pneumonia and delirium.
- His Son, who looks after him says he is a very religious man and belives that all life is scared, must be preserved at all cost. He requests all measures to save him considered.

Case scenario

- An 83 year old man, who has suffered from parkinsonism for 18 years, now experiencing on-off periods, speech and swallowing difficulty and cognitive impairment. He was admitted for pneumonia and delirium.
- His Son, who looks after him says he is a very religious man and belives that all life is scared, must be preserved at all cost. He requests all measures to save him considered.

Comment: No one can demand treatment for himself or herself on behalf of an individual. However, son's view must be respected and used in assessing the patient's best interest. While AD/ADRT can be verbal, a vague statement made by the patient doesn't form a valid AD/ ADRT

“Covert” medication

- “Review the need”
- Lacks capacity
- “Best Interest”
- MDT discussion- Doctor, nurse, Pharmacist and Family
- **Document**

Driving

- UK law on driving and dementia is clear. A licence holder who is diagnosed with dementia must contact the relevant licensing agency promptly, or risk a fine of up to £1,000. In England, Wales and Scotland this is the Driver and Vehicle Licensing Agency (DVLA). In Northern Ireland it is the Driver & Vehicle Agency (DVA).
- The doctor who has diagnosed the person's dementia should talk to them and anyone attending the appointment with them about driving. The doctor should make it clear that the person needs to tell DVLA/DVA.
- A driver with a diagnosis of dementia should also immediately tell their car insurance provider. If they do not, their policy may become invalid. It is a criminal offence to drive without at least third-party cover.

Driving – difficult conversations!!

- In some cases the doctor will tell the licence holder that they should stop driving immediately. The person may need to stop driving permanently, perhaps because their dementia is more advanced, have poor visuospatial awareness or are having hallucinations. Or the doctor's advice to stop may only be as a precaution until further assessments are carried out. In either case, medical advice like this should always be followed even if it takes up to several weeks for DVLA/DVA to make a final decision.
- Doctors should disclose relevant medical information to the licensing agency if they believe the person's continued driving poses a serious risk to others. This is according to guidance that is issued to doctors. The doctor does not need the person's permission to do this, but they should tell them afterwards in writing that they have done it. This is often a very difficult issue for both parties.

Case scenario 2

- 76y old lady referred by SW in MDT. She was not seen outside the flat for many months. Neighbours could smell a foul smell coming from the flat. They thought she might have died! When agencies went in they found a dead cat in the sofa!! She wasn't bothered by that and continue to live there. SW wanted her to be sectioned and moved away from her accomodation as she will not accept any help.

Case scenario 2

- 76y old lady referred by SW in MDT. She was not seen outside the flat for many months. Neighbours could smell a foul smell coming from the flat. They thought she might have died!! When agencies went in they found a dead cat in the sofa. She wasn't bothered by that and continue to live there. SW wanted her to be sectioned as she will not accept any help.

Progress…….

- Visited by Doctor, Support worker, Social worker- diagnosis of probable atypical dementia made. Patient agreed to have blood test and CT Scan!!
- Carers got involved and stared giving her medication
- Had a fall and had to be admitted to hospital, later to a care home temporarily
- Opportunity of her absence used to get blitz cleaned
- Grandson got involved and came to live with Granny
- Discharged from psychiatry

Recap!

- MCA- the sequence of events
- MCA amendment act - Liberty Protection Safeguards
- Capacity Assessment – Understand, retain, weigh up and communicate
- 5 principles- presumption, help, unwise, best interest and least restrictive option
- Financial issues – LPA, Cop3, Testamentary capacity
- Treatment issues- Consent, AD/ ADRT, Covert medication,
- Others: driving, moving accommodation

6. London Borough of Hillingdon v Neary [2011] EWHC 1377 (COP) (Peter Jackson J)

Facts: Steven Neary had autism and a severe learning disability and could become very anxious at unexpected changes. Sometimes this would be manifested through lashing out at others. Steven had grown up with his parents Mark and Julie Neary and had lived with his father Mark after his parents separated, remaining in regular contact with Julie. Between January and May 2008 Steven had lived in a support Unit but then returned home. In December 2009 Mr Neary was unwell and agreed to Steven being placed in respite in a Unit. Staff found his behaviour difficult to manage and it was accepted that Steven wanted to go home. Mr Neary sought Steven's return home. Hillingdon had decided that Steven should not return home but did not tell Mr Neary its position until April 2010. Following an incident in April 2010 when Steven wandered off, an urgent authorisation was granted under DOLS, followed by a series of standard authorisations. Mr Neary was appointed as Steven's representative ("relevant person's representative" or RPR. He made it clear that he wanted to challenge the authorisation insofar as it was being used to enforce Steven's stay at the Unit. He had great difficulty in obtaining legal advice. In October 2010 the local authority applied to the Court of Protection seeking declarations which would allow it to make decisions as to Steven's residence and care. In November 2010 an IMCA's report raised serious questions about Hillingdon's refusal to allow Steven to return home and suggested a trial return home. In December 2010 Mr Neary appealed against the current authorisation to the Court of Protection. The Official Solicitor was appointed to represent Steven. On 23 December 2010 Mr Justice Mostyn terminated the standard authorisation and Steven returned home. An independent

Conclusion

Respect your patient

Consult widely

do the Best

Document