Assessing Capacity
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Capacity

Capacity is the ability to make a specific decision at the material time.

Why is it important to assess capacity?

- No capacity- No Consent
- To ensure that those who lack capacity are safeguarded

MCA (2005)

- Safeguards for the incapacitated
    - Defines who can make decisions
    - What principles should be followed if making decisions for the incapacitated

- Allows capacitous people to plan ahead-
    - Advance Decisions to refuse treatment under specific circumstances
    - LPA (property/affairs+ Personal welfare)

- Act does not permit decisions about **sexual relations, marriage, divorce, adoption, parental responsibility, HFEA**

- **NO ONE BUT LPA/DEPUTY/COURT CAN PROVIDE CONSENT**
- **BEST INTERESTS ONLY APPLIES TO INCAPACITATED**

Assessing Capacity- challenges

- Capacity is a legal concept

  Law – black and white

  Medicine- people and human behaviour complex, shades of grey

- Capacity issues often arise when treatment is refused

MCA 5 key principles

1. Presumption of capacity (not *in*capacity)
2. Maximisation of capacity
3. Unwise decisions
4. Best interests
5. Least restrictive option

Capacity Assessment- guidelines

Who: Professional responsible for delivering care and treatment

How:

Reasonable efforts to establish and maximise capacity

Material information

Practical

Balance of probabilities to guide judgement about capacity (if in doubt ask for 2nd opinion/Court order)

Recording

General day to day decisions Vs other significant decision

Which decision, what choices, what critical info patient needs to understand, each element of the test, why it is not just an unwise choice

Capacity Assessment

Decision specific and Time specific

Diagnostic test

1. Is there an Impairment of, or disturbance in the functioning of a person's mind or brain?
2. Is this impairment or disturbance of person’s mind or brain impacting on the decision making ability

Functional test- 4 stages

Understand- risks/benefits, alternatives,

Retain- even for a short time

weigh up- foreseeable consequences, apply information to their own situation

Communicate- by any means

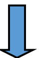
Impairment of mind/brain

Concern about capacity to consent to make a decision

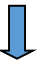
Maximise capacity (material information in an accessible form)

Assess capacity (on balance of probabilities)

1) Understand- risks/benefits, alternatives
2) Retain info (even for short time)
3) Weigh up- consequences of decision
4) Communicate decision



Yes

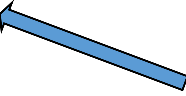


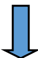
Respect wishes
even if decision is unwise

No

Check if valid Advance Decision to refuse treatment
LPA (bound by best interests code)

Yes





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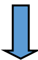


Act in Best Interests

Exceptions to the above-Children

Consent

- 16- 18- same rights
- <16- can consent if “Gillick Competent”.

  However parental consent to be obtained where possible/appropriate.
- Parent (one) can provide consent for younger children/ incompetent children

Refusal

- 16-18 yrs- court has used Children’s Act to override refusal. Especially when severe harm or death is likely

- If children under 16 refuse, courts or parents can overrule

Exceptions to the above-MHA

- Treatment of mental disorder under MHA
- Consequences of mental disorder if detained under the Mental Health Act
  - ED
  - Self harm
  - OD
  - ECT

Case- 1 Assessment of capacity

16 year old girl

- Ingested lithium ion batteries after disappointing exam results.
- Chest pain. Friend has convinced her to attend A and E.
- Needs endoscopic removal
- Refusing treatment, says she has intense fear of OT. Says she won't die, a friend who swallowed was ok. Trying to walk out at the mention of anaesthesia/ endoscopy. Highly anxious.
  - GE consultant suggests procedure under GA
  - Will need restraint for sedation/transfer/GA
  - Parents not reachable on the phone

- Does she have capacity?
- MHA or MCA?

Best Interests

- Long checklist- Reasonable steps
  - Age/Appearance/behaviour- no bias
  - If incapacity is temporary, can you wait?
  - Improve ability to make decisions
  - Not motivated to bring about death
  - Past, present wishes, written statements.
  - Beliefs and values
  - Other factors that may be important to the patient
  - Consult carers, friends, family, LPA, Court appointed deputy (practical, appropriate)
  - IMCA- unbefriended, serious medical treatment

- **Treatment of 16 year old girl with batteries?**

Advanced Decisions

Capacitous patient can refuse treatment at any time

Such refusal can be oral

Advance Decision to Refuse Treatment

- Must have capacity to do this. Comes into effect when patient loses capacity
- Can REFUSE but not INSIST
- Can refuse life-sustaining treatment. Specific about what treatments and circumstances in which it applies
- Must be WRITTEN AND WITNESSED if refusing life sustaining treatment
- If LPA made after AD- LPA takes priority
- If doubt about validity- can give treatment. But seek clarification

Case -2 Advance Decisions

63 yr Old Jehovah's witness

GI bleed (DU) Hb 3.7

Doctors decided that she had capacity to refuse and did not treat her with blood transfusion/blood products

She became comatose and lost capacity

Best interests?

No written AD to refuse life saving treatment as required by MCA

Trust sought court order…..

Lasting Powers of Attorney (LPA)

- Capacitous individuals
    - can appoint attorneys to make decisions- Health Welfare decisions/Financial affairs
- Court of Protection can appoint deputies

- Attorneys
    - MUST BE REGISTERED WITH PUBLIC GUARDIAN
    - Wide ranging decisions:
        - Daily routine (for example, eating and what to wear)
        - Routine medical care/refusing – when and where this should happen
        - Moving into a care home
        - Refuse Life-saving or life-sustaining treatment- only if specified
        - Have access to medical records

- If any abuse- LPAs can be challenged in CoP/Public guardianship office

Case -2

- Jane is a 68 yr old woman with pre-senile dementia, COPD, poor lung function
- MMSE of 12 with poor short term memory/behavioural problems
- She lives in a nursing home
- She has vomited blood
- Endoscopy is recommended

- Pre op assessment
- Husband, carer accompanies her, refuses consent
- LPA

IMCA

- Extra safeguards for those who don’t have family, friends, LPA/deputy (unbefriended)

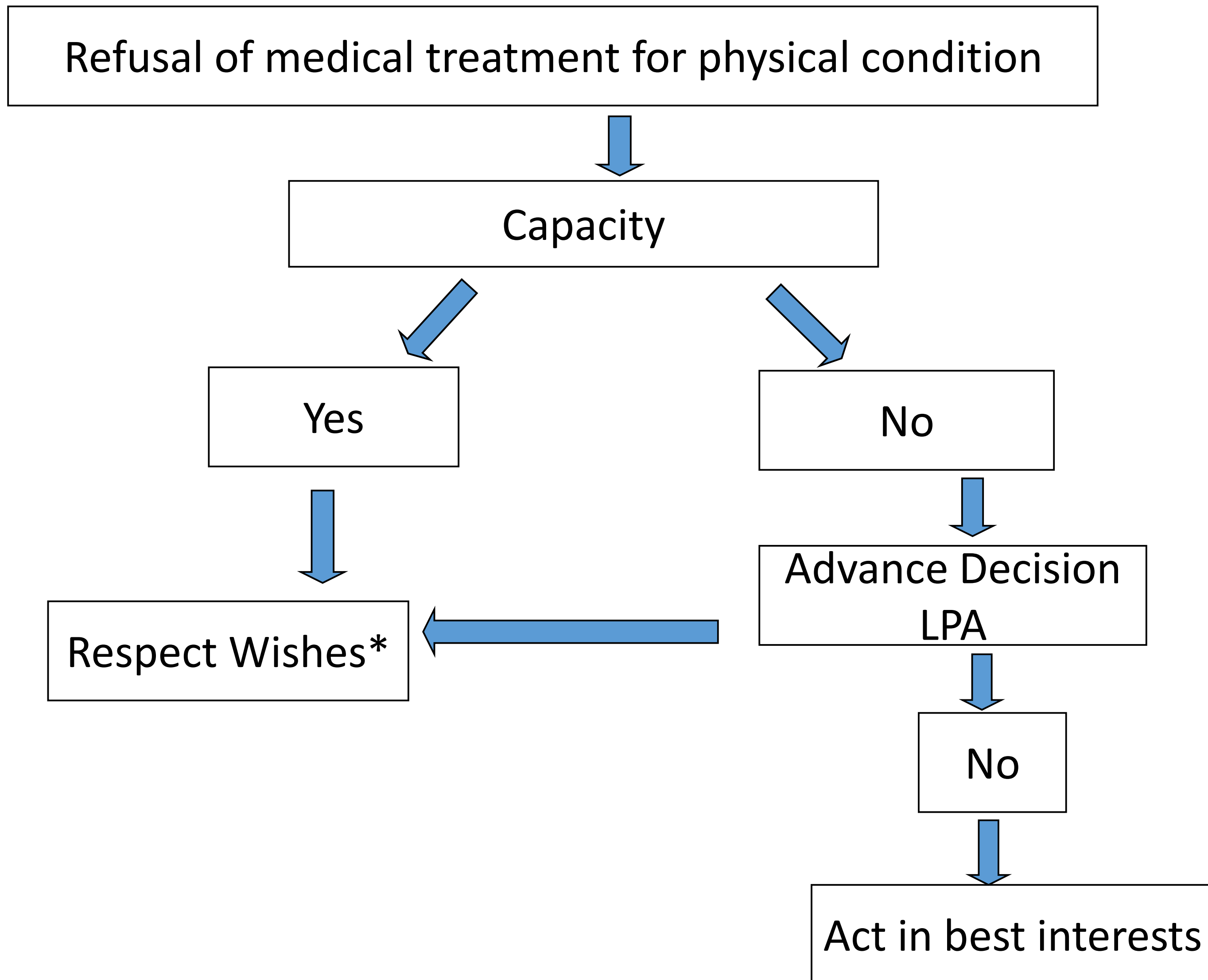
- Duty on NHS bodies/local authority to provide IMCA service
    - Must consult IMCA, if unbefriended
        - Serious medical treatment
        - Change in accommodation, 28 days in hospital/7 weeks in care home

    - May consult IMCA
        - Care reviews, other decisions when no friends/family
        - Safeguarding matters

Court of Protection

Tension between saving life and respecting wishes are independently adjudicated.

- Serious Medical treatment-
  - fine balance between risks/benefits
  - Serious consequences
  - Prolonged pain, serious side effects
  - Serious impact on life choices
- Should bring to court
  - ANH
  - Organ donation/bone marrow donation
  - Non therapeutic sterilisation
- May be required
  - MTP
  - Untested ethical dilemma
  - Experimental treatments



*Unless treatment required for a consequence of mental disorder requiring treatment under MHA

END

Best Interests

- 68 year old. Severe Multiple Sclerosis. MCS for 8 years
- Medication/food through tube

- Family object to ANH
    - Based on patients wishes/beliefs
    - Treatment prolonging suffering indignity
    - No Advance decision
    - No LPA

Decisions under MCA

- “Care and Treatment”- Protection from liability
- Reasonable steps to establish P lacks capacity before the act
- Decisions were made in Best Interests
- Should not conflict with and Advanced decision or the decision of LPA
- Does not authorise DOLs (deprived of liberty)

Case Scenario- DNACPR incapacitated patient

- 28 year old Carl Winspear
- Cerebral palsy, Kyphosis, severe contracture
- Pneumonia, necessitating oxygen, fluids and antibiotics
- Lacking capacity to discuss his possible needs for resuscitation.
- Mother left ward at 21:00. Reg- DNACPR at 3:00 hrs, discuss with mother in morning
- DNACPR cancelled. Patient died later as artificial ventilation not suitable
- Mother went to court – human rights breached because a carer was not consulted

Planning Ahead

- Capacitous patient can refuse treatment at any time
- Advance Decision to Refuse Treatment
  - Must have capacity to do this. Comes into effect when patient loses capacity
  - Can REFUSE treatment in future, but can't insist on a certain treatment being provided
  - Can refuse life-sustaining treatment. Specific about what treatments and circumstances in which it applies
  - Must be written and witnessed if it applies to life sustaining treatment
  - If LPA made after AD- LPA takes priority
  - If doubt about validity- can give treatment. But seek clarification

Consent and Supported decision making

- The case of *Montgomery –v-Lanarkshire Health Board (2015)*
- Material information
  - whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would likely attach significance to it
  - assessment of whether a risk is material cannot be reduced to percentages.
  - doctor's advisory role involves dialogue- not merely bombarding information

Case Scenario- AD

- Kerrie Wooltorton had swallowed 350 millilitres of antifreeze. She called the ambulance on 16 Sep 2007
- She had a diagnosis of PD. Multiple overdoses of antifreeze. Number of admissions to psychiatric hospital
- In A and E, She stated that she did not require any medical intervention except to keep her comfortable.
- She was also in possession of a letter written by her and dated 14 September 2007
- She referred to the letter

- To whom this may concern, if I come into hospital regarding taking an overdose or any attempt of my life, I would like for NO lifesaving treatment to be given. I would appreciate if you could continue to give medicines to help relieve my discomfort, painkillers, oxygen etc. I would hope these wishes will be carried out without loads of questioning.
- Please be assured that I am 100% aware of the consequences of this and the probable outcome of drinking anti-freeze, e.g. death in 95-99% of cases and if I survive then kidney failure, I understand and accept them and will take 100% responsibility for this decision.
- I am aware that you may think that because I call the ambulance I therefore want treatment. THIS IS NOT THE CASE! I do however want to be comfortable as nobody want to die alone and scared and without going into details there are loads of reasons I do not want to die at home which I realise that you will not understand and I apologise for this.
- Please understand that I definitely don't want any form of **Ventilation, resuscitation or dialysis**, these are my wishes, please respect and carry them out.

KW

- Is this AD?
- What did the doctors do in KW’s case?
- What did the coroner say?

- Criticisms
    - MHA – capacity irrelevant
    - Consequences of self harm can be treated under sec 63
    - MCA- does not support suicide or assisted dying

Deprivation of Liberty Safeguards

- Introduced in England & Wales on 1st April 2009
- An update to the Mental Capacity Act 2005
- Article 5 of ECHR- Right to liberty and security of person

Deprivation of Liberty

- Only if lawfully authorised
  - Arresting/imprisoning someone for a criminal offence
  - Sectioning someone under the Mental Health Act
  - DoLS authorisation from the local authority (registered homes and hospitals)
  - Direct authorisation from the Court of Protection (supported living, Shared Lives, own homes etc)

DOLs

- to provide the person with a representative – a person who is given certain rights and who should look out for and monitor the person receiving care (see The ‘relevant person’s representative’ – family or IMCA)
- to give the person (or their representative) the right to challenge a deprivation of liberty through the Court of Protection
- to provide a mechanism for a deprivation of liberty to be reviewed and monitored regularly

DOLS

- Applies to incapacitated over 18
- Any deprivations
  - best interests to protect them from harm
  - If it is a proportionate response to the likelihood and seriousness of the harm
  - Least restrictive option
- DOLS authorisation issued by LA (Supervisory body) following an assessment
  - Best interest assessor
  - Mental Health Assessor
- Valid for 12 months.

Urgent authorisations- up to 7 days by local hospitals

“Cheshire West” case

- P is 38 years old
- Cerebral Palsy & Down’s syndrome
- Lives in bungalow with 2 other residents. 24 hour care
- Full personal care- eating, dressing, self care.
- Some challenging behaviours- aggression
- Body suit- pulls and eats incontinence pads
- Does not refuse support or supervision, requires restraint on ocassions

"Cheshire West" case

- Court of Protection ruled this was a deprivation of P's liberty
- Court of Appeal ruled that it wasn't
- What do you think the Supreme Court said?

A person is deprived of his liberty if he is

"under continuous supervision and control and is not free to leave"

The “MIG and MEG” case

- Sisters with severe learning disabilities
- MIG (18) lived with foster mother
- MEG (17) lived in NHS facility. Some challenging behaviours
- Neither tried to leave
- Carers made it clear that they would restrain should the sisters try to leave

The“MIG and MEG” case

- Court of Protection ruled that neither MIG nor MEG was being deprived of her liberty
- Court of Appeal agreed
- What do you think the Supreme Court said?

The Supreme Court ruling

- A person is deprived of his liberty if he is:
- ***"under continuous supervision and control and is not free to leave"***
- Human Rights are universal: if it would be a deprivation of my liberty, or your liberty, or anyone else's liberty, then it would also be a deprivation of P's liberty, or MIG's liberty, or MEG's liberty
- ***"A gilded cage is still a cage"***

Impact of 2014 ruling

- ACID TEST
  - Incapacitous patient
  - under constant control and supervision of the hospital
  - not free to leave.

- This low threshold captures perhaps 30% of inpatients in most DGHs

- 10,000 to 167,000 applications after the ruling

Impact

- LA and hospitals inundated with automatic applications
- Mere paper exercise- clinicians and patients lose relevance and those truly deprived may experience delays

- Some trusts
  - Seek consent for deprivation if patient is capacitous on admission
  - If capacity is deemed to be temporary, delay application
  - If family/LPA consent and the deprivation is in best interests- DOLS application not made?? legal