

KATHARINE HOUSE HOSPICE

MENTAL CAPACITY POLICY

Approved by:

Date of approval:

Originator: Medical Director

Aim and Scope

The Mental Capacity Act (2005) represents a complete overhaul of previous legislation in this very important area. The Katharine House Hospice Mental Capacity Policy summarises the key points in this new legislation that clinical staff at the hospice must follow and observe.

Parts of the Mental Capacity Act will be implemented in April 2007 and from then on it will become a criminal act to ill-treat or neglect a person who lacks capacity. The Act will be implemented in full in October 2007 but individual organisations should start to comply with the Act in its entirety as soon as is practicable during the interim period.

Policy Area

Clinical.

Related Procedures

Procedure for Clinical Decision Making

Procedure for Obtaining Patient Consent for Clinical Procedures

Responsibilities

Director of Nursing (Registered Manager) Ultimate responsibility for ensuring that the organisation is fully aware of the Mental Capacity Act (2005) and its implications. Ensuring that satisfactory policy and procedures have been put in place.

All Clinical Staff Following the relevant policies and procedures.

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Introduction

For the wish or decision of a patient to carry authority, the patient must have “capacity” to make that wish or decision at the time it is made.

A person is deemed to lack capacity if unable to make a decision for themselves because of an impairment of the functioning of the mind or brain. The decision regarding whether a person lacks capacity is decided upon a balance of probabilities. People are able to make their own decisions if they can perform all of the following:

1. Understand the information relevant to the decision.
2. Retain and use that information as part of the decision-making process.
The decision-making capacity of some people may fluctuate over time. People who can only retain relevant information for a short period are able to make their own decisions whilst they retain that information.
3. Communicate the decision by any understandable means.
4. Understand the consequences of making or not making a decision.

All people are assumed to have capacity unless it is established otherwise, and all possible steps must be taken to help people reach their own decisions. Only if these steps fail can somebody else make a decision on their behalf. Decisions that might appear unwise to third parties are valid if the person making them has the capacity to make them. Whenever a decision is made on behalf of a person who lacks capacity, this must be made in the best interests of that person and in accord with their known wishes, beliefs, values and feelings. The decision-making process should involve consultation with as many relevant people as practically possible and appropriate, but does not need to include paid home care providers. The decision must also be minimally restrictive of that person’s rights and freedoms.

The capacity of a patient is a crucial consideration in matters of informed consent for clinical procedures, advanced refusal and Lasting Power of Attorney. It can also have important implications in clinical research. All these matters are considered in detail in the Mental Capacity Act (2005), which applies to all patients coming into contact with the hospice. The Lord Chancellor has been instructed to issue a Code of Practice regarding the procedure for assessing whether a person has capacity. At Katharine House Hospice, any matters concerning capacity must be handled in compliance with the Mental Capacity Act (2005) and any Code of Practice issued by the Lord Chancellor.

Key points in the Mental Capacity Act (2005) of particular relevance to clinical staff at the hospice are summarised below.

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Lasting Power of Attorney

(Sections 9 to 23 of the Mental Capacity Act 2005)

When a patient confers decision-making authority about themselves to one or more donees (i.e. gives them lasting power of attorney):

- The patient may revoke a lasting power of attorney at any time that s/he has the capacity to do so.
- The extent of conferred authority is highly individualised and is detailed in the specific Instrument for that particular lasting power of attorney. The authority need not necessarily extend to decision-making about medical treatments.
- When two or more individuals have been conferred this authority, they might each have authority to make independent decisions or they might be required to only make joint decisions. When there is doubt over which condition applies, the legal assumption is for all decisions to be made jointly.
- Threat or use of force, and any restriction of the liberty of movement of the patient, are all interpreted as acts of restraint. Restraint is only allowed in very exceptional circumstances that are carefully described in the Act. Restraint can only be used to prevent harm to the patient when it is believed the patient lacks capacity regarding the risk of harm, and in these circumstances the extent of restraint must not exceed that considered appropriate for the perceived risk.

When donees have authority regarding medical decisions,

- This cannot be exercised for any situations where or when the patient has capacity to decide for themselves.
- The decisions must be compatible with any valid advanced refusals previously made by the patient that reasonably pertain to the clinical situation.
- The extent of the authority is limited to giving or refusing consent to treatment that is either being offered or actually established by anybody providing health care to the patient.
- Unless explicitly stated in the Instrument, the authority does not extend to decisions on any matters relating to life-sustaining treatments.

The court has many powers. It can make declarations regarding the legal validity of any lasting power of attorney, the capacity of a patient or the lawfulness of any acts done by a donee. It can also make particular decisions on behalf of the patient or appoint deputies to do the same. These powers extend into matters of health care, and include the authority to hand over the responsibility for health care to a different person.

“Lasting Power of Attorney” replaces and is different from what was formerly known as “Enduring Power of Attorney”. Any “Enduring Power of Attorney” arrangements made before the Mental Capacity Act became law will remain valid for the lifetime of

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the patient, but new “Enduring Power of Attorney” arrangements cannot be made after the Act becomes law.

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Advanced decisions to refuse treatment.

(Sections 24 – 26 of the Mental Capacity Act 2005).

Any person aged 18 or over who has the capacity to do so can refuse a future treatment if all of the following have been satisfied:

- All pertinent details of the clinical situation have been described. (The description can be made in layman's terms)
- The treatment being refused has been specified. (The description can be made in layman's terms)
- The person lacks capacity when the clinical situation actually arises
- The person did not subsequently alter or withdraw the advanced decision whilst still having the capacity to do so.
- Any or all people with Lasting Power of Attorney for that person *have not* been conferred the power to give or refuse treatment on behalf of the person at a date later than the advanced refusal was made.

An advanced decision is not valid if:

- Certain pertinent details of the actual clinical situation are not described in the advanced refusal, or there are other good reasons to believe that the circumstances at the time are different from those that had been anticipated by the person at the time the advance decision was made.
- The proposed treatment is not described in the advanced decision
- The person does not lack capacity when the clinical situation actually arises
- Any or all people with Lasting Power of Attorney for that person have been conferred the power to give or refuse treatment on behalf of the person on a date later than the advanced refusal was made.

A person incurs liability for carrying out or continuing treatment in the knowledge that a valid and applicable advance refusal exists. A person does not incur liability for withdrawing or withholding treatment in the knowledge that a valid and applicable advance refusal exists.

Advanced refusals must be documented in writing, signed and witnessed in accordance with section 25(6) of the Act.

The court can make a declaration whenever there is uncertainty about the presence or validity of an advance refusal with regard to a particular clinical context. When genuine uncertainty exists, nobody incurs liability for any life-sustaining or other active treatment that may be given.

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Independent Mental Capacity Advocates

(Sections 35 – 41 of the Mental Capacity Act 2005).

If there are no appropriate kith or kin to refer to in a patient who lacks decision making capacity, the local social services department must make available an Independent Mental Capacity Advocate (IMCA). The IMCA ensures that all appropriate perspectives have been considered by the health care team as they reach their decision. However, the IMCA has no role in actually reaching that decision or responsibility for the decision that was reached.

Although the Mental Capacity Act 2005 only describes a role for IMCAS in NHS and local authority settings, it is believed that, for purposes of equity, referral to IMCAS will also be required in the independent healthcare sector when appropriate.

Clinical research

(Sections 30-33)

Internal governance structures at the hospice (including the Research Policy and Procedure) will ensure that sections 30 to 33 of the Mental Capacity Act are complied with.

Clinical decision making and Clinical Consent

There are separate procedures for Clinical Decision Making and for Obtaining Patient Consent for Clinical Procedures.

References

Mental Capacity Act (2005). Crown Copyright.

<http://www.opsi.gov.uk/acts/acts2005/20050009.htm>

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